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 _____	01/27/2011

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 For the standard Medicare/Medicaid recertification survey started on 01/25/11 and completed on 01/27/11 the sample included four residents for complete review, 10 residents for focused review, and three closed records. The sample included four additional residents to verify specific concerns during the survey.	F 000	F 225 1. All Licensed Nursing staff have been re-educated including definitions for "injuries of unknown cause". 2. All residents have the potential to be affected. 3. Reviewed policy titled "Accident/incidence Investigating and Reporting at the next nursing policy meeting 2/18/11. All license staff will be educated on the policy on 2/22/11. 4. The QA nurse will monitor twenty five items from the facility's "non-pressure skin condition report forms per month for six months to ensure compliance. If review shows continued compliance review according to normal practice. The results of the monitors will go directly to the DNS. If concerns are identified, immediate corrective action will be implemented. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action, to include monitoring, will be taken dependent on the results of the initial monitors.	2/24/11
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3/9/11

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.

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		

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

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.

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 01/07/10. Based on observation, record review, policy and procedure review, and staff interview, the facility failed to investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #10) with injuries of unknown origin. Failure to investigate this incident did not allow the facility to determine causative factors of this incident or implement preventive or corrective action, and placed the resident at risk for further potential injury. Findings include: Review of the facility's policy, "Accidents and Incidents - Investigating and Reporting," revised January 2011, occurred on the afternoon of 01/27/11. The policy stated, ". . . All accidents or incidents involving residents . . . occurring on our premises shall be investigated and reported to the Administrator. An incident is defined as any unusual event which did or may cause harm. . . . 2. Incident reports are to be completed in response to any unusual occurrence or near miss. Examples include: . . . d. Skin injuries of residents (Incident Report and Skin Log) . . ."	F 225		

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F 225	Continued From page 2 Review of the facility's policy titled "Abuse Prohibition Policy and Procedure" occurred on the afternoon of 01/27/11. The policy, revised July 2009, stated, "The facility will have evidence that all alleged violations are thoroughly investigated . . . All alleged violations . . . including injuries of unknown source . . . Injuries of unknown source will be regarded in the same regulatory light as mistreatment, neglect and abuse and will be reported if there is reasonable cause to believe or suspect that a nurse aide or other individual used by the facility has inflicted an injury upon a resident . . . the facility will establish a reasonable manner of determining whether or not injuries such as skin tears, bruises, abrasions, and other untoward events that occur in the facility are abusive or neglectful in nature or whether these occurrences are simply happenstance. . . ." - Review of Resident #10's medical record occurred on January 25-27, 2011. The resident's diagnoses included nonthrombocytopenic purpuras (red or purple discolorations on the skin caused by bleeding beneath the skin), peripheral vascular disease, varicose veins lower extremities, and dementia with behavior disturbances. The resident's current quarterly Minimum Data Set (MDS), dated 11/18/10, identified severely impaired memory and indicated the resident required extensive assistance of one to two persons for transferring, toileting, dressing, and bathing. During initial tour on the morning of 01/25/11, an administrative nursing staff member (#1) identified Resident #10 to have bilateral hematomas (a pocket or localized collection of blood within the tissue) on her lower legs. Observation of these bilateral hematomas to	F 225		

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F 225	Continued From page 3 Resident #10's lower legs occurred on 01/26/11 at 1:30 p.m. with an administrative nursing staff member (#1). The hematoma on the resident's right shin measured approximately 2 centimeters and the hematoma on her left shin measured approximately half a centimeter. Resident #10's Nurses' Notes identified on 12/30/10 at 7:00 a.m., "Res [resident] has a large dark purple bruise/hematoma to right shin of unknown origin, found and reported by WP [whirlpool] certified nursing assistant [CNA], will continue to monitor . . . " During an interview on the afternoon of 01/26/11, an administrative nursing staff member (#1) stated facility staff should have completed an incident report and conducted an investigation to determine the cause of the resident's hematomas. Failure to investigate Resident #10's injury of unknown origin, as identified in the facility's policy and procedure, did not allow the facility staff to determine any causative factors for this incident or if corrective action was appropriate; implement any appropriate corrective or preventitive action; track and trend this incident to determine any pattern or frequency; and rule out the possibility of abuse. This failure placed Resident #10 at continued risk and all facility residents at risk of potential injury or abuse.	F 225		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F	F 257		

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F 257	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview, and staff interview, and professional literature review, the facility failed to maintain a comfortable temperature level in 1 of 1 resident room (Resident #19) and 1 of 1 activity/dining room. Failure to maintain indoor temperatures within the mandated ranges creates resident discomfort. Findings include: During the initial tour of the facility on 01/25/11 at 7:00 a.m., observation showed Resident #19 laying on his bed fully clothed with numerous blankets on top of him. The resident stated it's "always cold" in his room. The 01/18/11 Resident Council Minutes stated, ". . . Social Services reviewed and made residents aware of the concerns expressed and followed through from Executive Council held on 12/15/10: . . . 2. The residents stated that the dining rooms are cold. . . . Staff sometimes turn down the heat, so maintenance will put a sign up to leave the thermostats alone. . . ." During the group interview on 01/25/11 at 10:45 a.m., when asked if the air temperature was uncomfortable, both Resident #20 and #21 (identified by the facility as interviewable) stated "The dining room is always cold." During an interview on 01/25/11 at 1:35 p.m., Resident #9 stated, "Dining rooms are cold; the bitter wind gets chilly."	F 257	F257 We strongly disagree with this compliance conclusion and filed for IDR. In the spirit of cooperation and as required by the regulations we submitted the following as required: 1. Resident #19 has moved to a different room. There is no resident in that bed or side of the room. Audits of the dining room since the survey as shown in the IDR have ranged from 73 to 75 degrees even on the day the outside temperature was -24 with a wind chill of -48 degrees. 2. All Residents have the potential to be affected by temperature control. 3. Eden Pure Model Gen3 1000 Electric "cool to the touch" electric heaters are available in the building and will be used to add extra warmth as requested or as monitor shows heat in room below 71 degrees. The boilers controlling the heat in the remaining existing building will be replaced before the next heating season by new electric heat in every room with thermostats for comfort control during the second phase of construction. Social Services will assess through interview process with resident/responsible party to find those residents who normally require extra warmth beyond normal room temperature and will add extra measures to My Daily Needs Plan through the care planning process. The question of comfort will be included in the Executive/Resident council minutes with concerns followed through on the	2/18/11

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F 257	Continued From page 5 On the morning of 01/27/11, the following temperatures recorded on a thermometer: * Resident #14's room temperature: 69 degrees * Red Wing Activity/Dining room temperature: 69 degrees During the environmental tour on 01/27/11 at 9:00 a.m., when told of Resident #19's concern, the Administrative staff member (#6) stated, "If it's cold, it's due to all the windows. He has an extra blanket. You know this building is going to be torn down."	F 257	Executive/Resident council concern report. 4. Monitoring of the heating system will be governed by Environmental Services manager or designee if the outside temperature falls below 10 degrees, daily. The results will be reported to the Administrator at that time and the QA committee with quarterly compilation. Executive/Resident council concern reports will be sent to QA quarterly.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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	F 278		

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F 278	Continued From page 6 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of standards of practice, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 6 of 8 sampled resident (Residents #1, #7, #8, #9, #10, and #13) coded on the MDS as on a toileting plan. Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: The Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, July 2010, stated, " . . . 1. Review the medical record for evidence . . . showing that the following three requirements have been met: implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern, evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and subsequent evaluations, as needed, notations of the resident's response to the toileting program and subsequent evaluations, as needed. . . . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is	F 278	F278 1. Residents #1, #7, #8, #10, and #13 toilet plans were re-evaluated and changes were made as necessary. 2. All residents have the potential to be affected. 3. The MDS nurses on 2/11/11 reviewed the MDS definition of a urinary toileting program. The management team will assess each resident's status at regular MDS assessment times or as continent status changes, implementing individualized toileting plans as needed. All CNA staff will be re-educated and tested on reading and implementing each resident's individual toileting plan on 2/18/11. 4. Supervisory nursing staff will monitor compliance with following the urinary toileting plans randomly across all shifts 5 days per week for two weeks and then once a week for one month. The results of the monitors will go directly to the DNS. If concerns are identified, immediate corrective action will be implemented. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action, to include monitoring, will be taken dependent on results of the initial monitors.	2/18/11

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F 278	Continued From page 7 consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene. . . ." - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, and incontinence. Resident #7's quarterly MDS, dated 11/09/10, identified Resident #7 rarely/never makes herself understood, sometimes understands others, severely impaired cognition, frequently incontinent of urine, and on a urinary toileting program. Review of Resident #7's current care plan stated, "ADLs [Activities of Daily Living] . . . I am incontinent of urine daily and incontinent of bowels several times a week . . . See my daily living needs plan . . ." The resident's "My Daily Needs" care plan stated, "Toileting Plan: Assist me to commode before and after meals, check or change me every 2-3 hours at night and as needed . . ." Observation on 01/25/11 at 2:40 p.m. showed Resident #7 lying on her bed as two certified nursing assistants (CNAs) (#10 and #12) assisted her with personal cares. A CNA (#10) removed the brief soiled with stool, cleansed the perineal area, and applied a new brief. The two CNAs assisted Resident #7 to her wheelchair. The CNAs failed to offer Resident #7 the use of the commode. - Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses	F 278		

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F 278	Continued From page 8	F 278		

included dementia and incontinence. The resident's current MDS, dated 11/25/10, identified her as frequently incontinent of urine and on a urinary toileting plan. Resident #8's "My Daily Needs" care plan stated, "Toileting Plan: Check and change me before and after meals and at bedtime. Check and/or change me every 2-3 hours at night and as I request."

Observation on 01/25/11 at 11:15 a.m. showed Resident #8 seated in her wheelchair in her room. A CNA (#5) asked if they (the CNAs) could check and change her and stated, "you haven't been checked since 8:00 a.m." The two CNAs (#5 and #17) utilized a full body lift and transferred the resident to her bed. A CNA (#17) removed Resident #8's brief soiled with stool. As the CNA (#17) cleansed the resident's perineal area, the resident voided and the CNA placed a bedpan under the resident.

On 01/26/11 at 9:05 a.m., a CNA (#5) stated she and another CNA checked Resident #8's brief earlier that morning and found it soiled with urine and stool so they cleaned her up and changed the brief.

The MDSs for Resident #7 and #8 identified an individualized toileting plan but observations, care plans, and interview with staff members identified the residents as a check and change every 2-3 hours or assist to the commode every 2-3 hours, not an individualized toileting plan.

- Review of Resident #10's medical record occurred on January 25-27, 2011. The resident's diagnoses included female stress incontinence. The current quarterly MDS, dated 11/18/10, identified the resident as frequently incontinent of

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F 278	Continued From page 9 urine and on a urinary toileting program. Resident #10's "Urinary Continence Evaluation," dated 11/15/10, identified the resident with a voiding problem of dribbling with "functional incontinence (related to inability to toilet due to cognitive and/or physical functioning)." The evaluation identified the appropriate type of intervention for this resident as "habit training/scheduled voiding program." Resident #10's "My Daily Living Needs" plan of care identified the toileting plan of "Take me to the bathroom before and after meals, at bedtime, and every 2-3 hours at night and as I request." During an interview on the morning of 01/26/11, a CNA (#4) identified she had caught Resident #10 transferring herself to the bathroom at approximately 9:00 a.m. The CNA stated she prompted the resident to toilet (at that time) because she knows it's the resident's routine to toilet at 9:00 a.m. The toileting plan of before and after meals, even though staff aware, did not include toileting at 9:00 a.m. The toilet plan of before and after meals is a general plan which lacks specific times individualized for the resident to promote continence and fall prevention. - Review of Resident #9's medical record occurred on January 25-27, 2011. The resident's diagnoses included functional urinary incontinence and hypertonicity of bladder. The resident's current quarterly MDS, dated 11/24/10, identified the resident as having no long-term memory problems and frequently incontinent of bladder and on a urinary toileting program. The	F 278		

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F 278	Continued From page 10 facility identified Resident #9 as interviewable. Resident #9's "Urinary Continence Evaluation," dated 11/22/10, identified the resident had functional incontinence, an overactive bladder, and a voiding problem of dribbling constantly. The evaluation stated "No [change] in toileting. Cont [continue] current plan of "habit training/scheduled voiding program." Resident #9's "My Daily Living Needs" plan of care identified the toileting plan of "Assist me to the commode before and after meals, every 2-3 hours at night and as needed. If I refuse to use the commode, please assist me to change my brief." Interviews with Resident #9 and the CNAs identified the following: * on 01/26/11 at 4:00 p.m., Resident #9 stated "water [urine] just comes." * on 01/27/11 at 10:00 a.m., a CNA (#17) identified the resident is sometimes dry. The CNA stated she refuses toileting then will ask to be toileted an hour later. The resident doesn't know if she has urinated as the resident will ask if she is wet or dry. * on 01/27/11 at 10:15 a.m., a CNA (#4) identified the resident is not usually dry when toileted. The resident has refused toileting more in the last two weeks and before that used to press call light for assistance with toileting. Based on the above interviews, Resident #9 cannot maintain or improve continence as she lacks control of her bladder. - Review of Resident #13's medical record occurred on January 25-27, 2011. The resident's diagnoses included Parkinson's disease and	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 _____	01/27/2011

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

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F 278	Continued From page 11 Alzheimer's dementia with psychosis. Resident #13's "Urinary Continence Evaluation," dated 11/04/10, identified the resident with "functional incontinence (related to inability to toilet due to cognitive and/or physical functioning)." The evaluation identified the appropriate type of intervention for this resident as "habit training/scheduled voiding program." Resident #13's annual MDS, dated 11/05/10, identified the resident as frequently incontinent and on a urinary toileting program. Resident #13's "My Daily Living Needs" plan of care identified the toileting plan of "Offer me the bedpan or the commode before and after meals and check and change me on rounds at night." During an interview on the afternoon of 01/27/11, an administrative nursing staff member (#1) agreed Resident #13's and the identified residents' toileting schedules were not individualized and facility staff may "catch her [Resident #13] by chance [to void]" but her continence is not improving. This staff member stated facility staff would have to change how they viewed toileting schedules. - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included dementia with delusions, Alzheimer's disease, and kidney disease. The most current quarterly MDS, dated 12/01/10, indicated the resident required extensive assistance of one for toileting, severely impaired for cognition, frequently incontinent of urine, and on a urinary toileting plan.	F 278		

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	355063	A. BUILDING _____ B. WING _____	01/27/2011

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F 278	Continued From page 12 Review of the resident's "My Daily Living Needs" (a part of the care plan)stated the resident's toileting plan as, "Assist me to the toilet before and after meals and every 3-4 hours at Night. Also, when I request." Observation on January 26-27, 2011 identified the following: * 01/26/11 at 6:55 a.m. - Resident #1's nightgown and brief visibly wet and the bed linens saturated with urine. A CNA (#23) assisted the resident to the toilet. * 01/26/11 at 11:10 a.m. - The CNA (#25) assisted Resident #1 to the toilet. Observation showed the resident last used the toilet four hours earlier. The CNAs failed to toilet her after breakfast. * 01/27/11 at 6:40 a.m. - Resident #1 in bed and her brief visibly wet. The above observations failed to follow the assessment and plan of care identified for Resident #1. During an interview on 01/27/11 at 9:30 a.m., a management nursing staff member (#15) stated that Resident #1 is not on a individualized toileting program. This contradicts both the most recent MDS and care plan developed for this resident.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, professional reference review, and staff interview, the facility failed to provide necessary care and services regarding feeding assistance for 1 of 1 sampled Resident (Resident #2) observed to be fed in bed by a staff member, and for 1 closed record (Resident #15) regarding the provision of appropriate diet consistencies. Failure to provide appropriate feeding assistance may result in choking and/or aspiration. Failure to ensure the proper diet texture resulted in Resident #15 experiencing hypoxemia, tachypnea, labored breathing, coughing, and subsequently resulted in an admission to the hospital. Findings include: The Source for Dysphagia: Third Edition by Nancy B. Swigert copyright 2007 LinguiSystems, Inc., page 125 and educational handouts, identified the following: * "Compensatory Treatment Techniques: . . . 1. Appropriate Seating During the oral intake of medicines, food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . ." * "Teaching Sheet for PO Feeding . . . 3. Signs and symptoms of aspiration: . . . Throat clearing . . ." * ". . . Why is it important for patients to sit at 90 degrees when eating? . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . ."	F 309	F309 1. Resident #2 was care planned to eat at a ninety-degree angle. Staff was re-educated on 1/26/11. Resident #15 was deceased before survey date. 2. All residents with assessed swallowing problems have the potential to be affected. 3. Dietary will pull menu forms or diet cards from circulation immediately after a diet texture; liquid consistency change is received in kitchen. New menu forms or diet cards will be issued after changes made. CNA staff will be educated on how to properly position a resident for dining on 2/18/11. 4. The dietary manager or designee will review all menu forms or diet cards for proper diet textures/liquid consistencies monthly for three months, then quarterly. If concerns are identified, immediate corrective action will be implemented. The results of the monitors will go directly to the DNS and the QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Supervisory nursing staff will randomly monitor resident positioning while eating in the room three days per week for one month. (cont. next page)	2/18/11

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F 309	Continued From page 14 Review of the facility policy titled "Dining Assistance" occurred on 01/27/11. This policy, reviewed/revised 05/10/10, stated, "Purpose To assist the resident with dining as is necessary in order to meet his/her nutritional needs. . . . Procedure . . . 4. If dining in the room, raise the head of the bed as indicated. Need to have head of bed elevated . . . be sitting up to make swallowing easier and reduce the risk of aspiration and choking. . . ." - Review of Resident #15's medical record occurred on 01/27/11. Diagnoses included dementia with behavioral disturbance. Record review identified Resident #15 went to the hospital on 01/12/11 with a diagnosis of aspiration pneumonia. A swallowing evaluation done at the hospital determined Resident #15 required a pureed diet with honey-thick liquids. Nurses notes revealed the following: *01/19/11 @ 12:50 p.m.: "Res. [resident] returned from hospital . . . diag [diagnosis] of pneumonia . . . Res. diet texture has [changed] to pureed diet [and] liq. [liquids] are now honey thickened due to trouble [with] swallowing . . ." *01/21/11 @ 12:45 p.m.: "Resident coughing. Increased respirations 30. Use of stomach muscles. Oxygen increased to 3L[liters]/NC [nasal cannula]. [Oxygen] at 80%. BP [blood pressure] 99/51. P [Pulse] 69. T [temperature] [97.6]. . . ." *01/21/11 @ 1:05 p.m.: "Res. suctioned by Unit Coordinator. Ambulance and ER [emergency room] notified. . . ." *01/21/11 @ 3:38 p.m.: "ER called. Stated resident going to be admitted with pneumonia and possible sepsis. . . ."	F 309	Then results of the monitor will go directly to the DNS. If concerns are identified, immediate corrective action will be implemented. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action to include monitoring, will be taken dependent on results of the initial monitors. In the future computerized menu ordering for dietary thus narrowing the window of opportunity for duplicate or old forms to be used.	

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	355063	A. BUILDING _____ B. WING _____	01/27/2011

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F 309	Continued From page 15 An incident investigation form completed on 01/21/11 by the facility indicated Resident #15 received a lunch tray with mechanically soft foods and thin liquids from the dietary department on 01/21/11. The resident ate a few bites of food and drank two sips of tomato juice. Upon realizing the resident received the wrong tray, facility staff gave Resident #15 a new tray with pureed foods and honey thickened liquids. The resident consumed a few bites of food and his liquids from the new tray. The resident then started coughing, and was subsequently transported to the hospital. During an interview on 01/27/11 at 10:50 a.m., an administrative dietary staff member (#16) stated dietary staff placed menu selection slips labeled with Resident #15's name in the activity room (where Resident #15 ate his meals) prior to his admission to the hospital. When Resident #15 returned from the hospital, an unidentified CNA completed one of these slips for Resident #15 (which still identified the resident required a mechanical soft diet with thin liquids), and the kitchen also received a change of diet order to a pureed diet. Kitchen staff prepared a second tray. Dietary staff delivered both trays in a cart to the dining room. The staff member stated it was dietary staffs' responsibility to ensure dietary staff did not prepare two trays. During an interview on the morning of 01/27/11, a social services staff member (#26) stated a CNA, not realizing Resident #15 had a new diet order, gave Resident #15 the tray with the mechanically soft food and thin liquids. The staff member (#26) stated, "That should not have happened." Resident #15 returned to the facility with a new diet order on 01/19/11. However, on 01/21/11	F 309		

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	355063	A. BUILDING _____ B. WING _____	01/27/2011

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F 309	Continued From page 16 (three days later), facility staff failed to ensure Resident #15 received the appropriate diet and fluid consistency which then resulted in an admission to the hospital. - Observation on 01/26/11 at 8:45 a.m., showed a CNA (#7) feeding Resident #2 as he laid in bed on his right side. The staff had previously raised his bed to an approximate 40 degree angle. The resident lifted his head off the pillow, accepted a sip of his liquid or bite of food, and laid his head back down on the pillow before chewing and/or swallowing. Resident #2 cleared his throat twice during the observation. Resident #2's medical record, reviewed January 25-27, 2011, identified current diagnoses of Alzheimer's dementia with behaviors and subdural hematoma. The resident's quarterly MDS, dated 09/17/10, identified problems with long term memory and moderately impaired decision making skills. His quarterly MDS, dated 12/15/10, identified extensive assistance from one person for eating, mechanically altered diet, and therapeutic diet. The Dietary Quarterly Assessment, dated 12/16/10, identified the following: * "Mechanically Altered Diet: mech. [mechanical] soft . . ." * "Eating Ability: supervision to total assist . . ." * "Meal Intake: [less than] 75% @ [at] meals/range 15-70%. . ." The Physician Orders, dated 01/12/11, identified the following: * "Regular diet, mechanical soft with whole meats cut into dime size pieces." * "Food @ [at] bedside . . ."	F 309		

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F 309	Continued From page 17 The current care plan entitled My Daily Living Needs, dated 12/17/10, identified the following: * "Elevate: Head of Bed; 90 degrees when eating . . ." * "Eating: Assist . . ." During an interview on 01/27/11 at 11:00 a.m., a management nursing staff member (#15) agreed residents should not be offered liquids and/or food while they are in a reclined position.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide necessary assistance to meet the needs of 3 of 11 residents (Resident #1, #4, and #5) dependent on staff for incontinence cares. Failure to provide assistance to residents who cannot independently carry out activities of daily living (such as incontinence cares) places them at risk for functional decline, impaired skin integrity, urinary tract infections, and a loss of dignity and comfort. Findings include: Review of the facility policy "Urinary Continence and Incontinence - Assessment and	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 18 Management" occurred on 01/27/11. This undated policy stated, " . . . A 'check and change' strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current Minimum Data Set (MDS), dated 01/12/11, identified Resident #5 required extensive assistance from one person for toilet use and personal hygiene and was always incontinent of bowel and bladder. Resident #5's "Daily Living Needs" (a part of the care plan) indicated a toileting plan of checking and changing the resident's brief before and after meals and on all night rounds. The care plan also stated, ". . . I do not have a call light, I am unable to use one due to my condition. Please check on me every 2 hours to ensure my needs are being met. . . ." Observations of Resident #5 on 01/25/11 from 1:00 p.m. to 4:00 p.m. showed the resident sleeping in bed on her left side in the same position throughout the afternoon. CNA charting indicated staff positioned Resident #5 on her left side around 12:00 noon. At 4 p.m., two certified nursing assistants (#12 and #13) entered Resident #5's room to reposition her, but failed to check the Resident's brief. A CNA (#12) stated they reposition her every two hours and would check on her around 6:00 p.m. Observations of Resident #5 on 01/26/11 at 6:48 a.m. and 7:36 a.m. showed the resident lying supine in bed. At 8:38 a.m., observation showed	F 312	F 312 1. Resident #1, #4, and #5, care plans were updated and staff re-educated on 1/27/11 regarding following the care plan for toileting. 2. All residents that are assessed as incontinent or have the potential to be incontinent have the potential to be affected. 3. CNA staff will be formally educated and tested on reading and implementing each resident individualized toilet plan on 2/18/11. 4. Supervisory nursing staff will monitor compliance with following urinary toilet plans randomly across all shifts five days per week for two weeks the random one day per week for one month. The results of the monitors will go directly to the DNS. If concerns are identified, immediate corrective action will be implemented. QI nurse will submit a report of the monitors to the QA committee at each scheduled meeting. Further action, to include monitoring, will be taken dependent on the results of the initial monitors.	2/18/11

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 _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 19	F 312		

the resident lying on her right side, and the room smelled of bowel movement (BM). In an interview at 8:43 a.m., a CNA (#14) stated she turned the resident "just a few minutes ago," and that she did not check Resident #5's brief. She also stated, "That [the brief change] was done before I got here. When nights got her up."

An interview with a night shift CNA (#11) occurred on 01/26/11 at 7:50 a.m. The CNA stated she changed Resident #5's brief between 5:30 a.m. and 6:00 a.m.

Observations on 01/26/11 at 9:14 a.m., 10:22 a.m., and 11:28 a.m. showed Resident #5 in the same position on her right side. Although a CNA (#10) entered Resident #5's room at 10:29 a.m. to offer her a snack, the CNA failed to check the resident's brief. At 11:44 a.m., two CNAs (#10 and #14) entered Resident #5's room and changed her brief, six hours after the previous brief change. Observation showed the brief was saturated with urine and a moderate amount of stool.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included chronic diarrhea, and a history of vancomycin-resistant enterococci (VRE) infection in the rectal area. The current MDS, dated 11/22/10, identified Resident #4 required total assistance from one person for toilet use and personal hygiene and was always incontinent of bowel.

Resident #4's care plan, reviewed 11/28/10, identified the following: ". . . Problem . . . My skin is very fragile and I have open sores. I have diarrhea often and that is very irritating to my skin.

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 _____	01/27/2011

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F 312	Continued From page 20 . . ." The "Daily Living Needs" for Resident #4 included a toileting plan of checking and changing her incontinence brief every 2 hours. Review of Resident #4's "Pressure Ulcer Record" revealed a stage IV pressure ulcer to the resident's coccyx. Observations of Resident #4 from 1:20 p.m. to 4:45 p.m. on 01/25/11 showed the resident asleep/in bed on her left side in the same position throughout the afternoon. CNA charting indicated staff positioned Resident #4 on her left side at 1:00 p.m. At 4:45 p.m. (nearly four hours later), two CNAs (#8 and #9) entered the room to check the resident's brief. Observation on 01/26/11 at 7:46 a.m. showed two CNAs (#10 and #11) entered Resident #4's room and transferred her to a wheelchair using a full body mechanical lift. The CNAs failed to check Resident #4's brief. An interview with a CNA (#11) at this time indicated the CNA had last checked and changed Resident #4's brief around 5:30 a.m. At 9:24 a.m. (nearly four hours later), two CNAs (#10 and #14) checked Resident #4's brief after transferring her into bed. Observations of Resident #4 on 01/26/11 from 1:15 p.m. to 4:29 p.m. showed Resident #4 asleep/in bed on her back in the same position throughout the afternoon. CNA charting indicated staff positioned Resident #4 on her back at 12:30 p.m. At 4:29 p.m. (four hours later), two CNAs (#8 and #12) entered Resident #4's room and checked her brief. An interview with a supervisory nursing staff member (#1) occurred on 01/27/11 at 1:15 p.m. She confirmed Resident #4 and #5 should be checked and changed every two hours.	F 312		

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 _____	01/27/2011

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

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F 312	Continued From page 21 - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included dementia with delusions, Alzheimer's disease, and kidney disease. The most current quarterly MDS, dated 12/01/10, indicated the resident required extensive assistance of one person for bed mobility, transfer, walk in room, dressing, toilet use, and personal hygiene. The resident's cognitive assessment, BIMS (Brief Interview for Mental Status) indicated severely impaired. The resident's urinary continence assessment indicated frequently incontinent and on a toileting plan. The MDS indicated the resident is at risk for pressure ulcers. Review of the resident's "My Daily Living Needs" (part of the care plan) indicated the toileting plan stated, "Assist me to the toilet before and after meals and every 3-4 hours at Night. Also, when I request." Review of a quarterly MDS narrative, dated 12/03/10, indicated Resident #1 is on a toileting program and is frequently incontinent of urine. An observation on 01/26/11 at 6:55 a.m., showed Resident #1 lying in her bed on her right side. A CNA (#23) assisted her to stand and walk to the bathroom where she sat on the toilet and voided. Observation showed Resident #1's nightgown, and brief visibly wet and bed linens saturated through to the mattress with urine. The residents' room smelled of urine. An observation on 01/26/11 at 11:10 a.m., showed a CNA (#25) assisted Resident #1 to the toilet and she voided. Observation showed the resident last toileted at 6:55 a.m. 4 hours earlier.	F 312		

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ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 312	Continued From page 22 Nursing staff failed to assist Resident #1 with toileting after breakfast. During an interview on 01/27/11 at 9:30 a.m., a management nursing staff member (#15) indicated the Resident #1 is not on an individualized toileting plan. This statement contradicts both the most recent MDS and the current care plan.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of standards of practice, and staff interview, the facility failed to provide necessary treatment and services to aid in the prevention and promote the healing of pressure ulcers for 2 of 4 sampled residents (Resident #1 and #4) identified with a pressure ulcer and 1 of 14 sampled residents (Resident #5) at risk for pressure ulcers. Failure to consistently implement interventions to prevent and promote healing of pressure ulcers resulted in the deterioration of an existing facility acquired pressure ulcer (Resident #1 and #4), and placed Resident #5 at risk for developing a pressure ulcer.	F 314		

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 _____	01/27/2011

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ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 314	Continued From page 23 Findings include: The Centers for Medicare and Medicaid Services (CMS) have outlined the standards of practice regarding pressure sores. Some residents have many risk factors for developing pressure ulcers, such as diabetic neuropathy, frailty, cognitive impairment, and under nutrition. The facility should have a system/procedure to ensure: assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the practitioner, and addressed. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing. The facility failed to ensure Resident #4 received repositioning/pressure redistribution, incontinence care management, and/or adequate nutritional interventions for the treatment of a coccyx pressure ulcer. - Review of Resident #4's medical record occurred on all days of survey. The facility admitted the resident in June 2009. Diagnoses included chronic diarrhea, diabetes mellitus, dementia, and a stage IV pressure ulcer to the coccyx. The record also identified unstaged pressure ulcers to Resident #4's right heel (onset date 02/09/10) and left heel (onset date 01/13/11). Resident #4's current Minimum Data	F 314	F314 1. Resident #1 was care planned for blue boots when in bed. Staff re-educated to follow the care plan regarding pressure-relieving devices. Resident # 4 and # 5 were to be repositioned every two hours. Staff re-educated on 1/27/11 and care plan updated on 1/31/11 and staff re-educated that same day. Resident # 4 was to receive supplement at meals three times per day. Dietary staff re-educated to follow dietary cards by Dietitian. 2. All resident who are at risk for skin break down and who receive supplements have the potential to be affected. 3. CNA staff will be formally educated and tested on reading and implementing each residents individualized toilet plan, pressure relieving device, and repositioning plans on 2/18/11. CNA staff and dietary staff will be educated on following the dietary cards regarding supplements. Dietary staff will label all dietary supplements to ensure administration by 2/18/11 4. Supervisory nursing staff will monitor compliance with following the urinary toilet and position schedule plans randomly across all shifts three days per week for two weeks. (cont. next page)	

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F 314	Continued From page 24 Set (MDS), dated 11/22/10, identified one stage III pressure ulcer, extensive assistance from two people with bed mobility, and always incontinent of bowel. Resident #4's care plan, updated 11/28/10, identified the following: ". . . Problem . . . I have very poor circulation to my feet and legs. My skin is very fragile and I have open sores. I have diarrhea often and that is very irritating to my skin. . . . Goal . . . I do not want my sores to get any worse and I do not want any new sores through my next review date. . . ." The "Daily Living Needs" (a part of the care plan) for Resident #4 included a toileting plan of checking and changing her incontinence brief every two hours, as well as a schedule to reposition every two hours and as needed. During the initial tour of the facility on the morning of 01/25/11, facility staff indicated they initially identified the pressure area to Resident #4's coccyx in February 2010. Review of Resident #4's "Pressure Ulcer Record" revealed facility staff measured the coccyx ulcer weekly. The measurements included, in part: * 10/20/10: Stage III, 1.4 x 0.2 cm (centimeters) in size (length x width), 0.2 cm in depth * 11/3/10: Stage III, 1.5 x 0.4 cm in size, 0.2 cm in depth, with the comment: "slightly larger, has had [increased] episodes of loose stools" * 11/30/10: Stage III, 1.4 x 0.7 cm in size, 0.2 cm in depth, with the comment: "larger, more loose stools throughout the day" * 12/08/10: Stage III, 2 x 1.6 cm in size, 1 cm in depth, with the comment: "larger - tunnel noted to [upper] border" * 12/20/10: Stage IV, 1.2 x 1.6 cm in size, 1 cm in depth	F 314	The results of the monitors will go directly to the DNS and dietary designee. If concerns are identified, immediate action will be implemented. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action, to include monitoring, will be taken dependent on the results of the initial monitors. Dietary staff will monitor whether supplement is added/containers labeled by checking all residents' trays with supplements one day per week for one month and then one day per month for eleven months. Any problems with dispensing supplements will be corrected immediately by dietary supervisor or designee.	2/18/11

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F 314	Continued From page 25 * 12/28/10: Stage IV, 1.2 x 1.3 cm in size, 1.2 cm in depth, purulent/bloody exudate, with the comment: "signs of infection, CN [charge nurse] notified to update physician." * 01/03/11: Stage IV, 1.5 x 1.5 cm in size, 2 cm in depth, 3.7 cm undermining, purulent/bloody exudate, with the comment: "coccyx has gotten worse, undermining starting." * 01/11/11: Stage IV, 1.7 x 2 cm in size, 1.5 cm in depth, 2.2 cm undermining, with the comment: "has gotten bigger around but decreased in depth. Still yellow drainage." * 01/17/11: Stage IV, 1.5 x 2 cm in size, 1.5 cm in depth, 2.7 cm undermining, with the comment: "coccyx seems to stay the same in size. But undermining has gotten worse." * 01/25/11: Stage IV, 2.7 x 2 cm in size, 2 cm in depth, 3.7 cm undermining Observations of Resident #4 from 1:20 p.m. to 4:45 p.m. on 01/25/11 showed the resident asleep/in bed on her left side in the same position throughout the afternoon. CNA charting indicated staff positioned Resident #4 on her left side at 1:00 p.m. At 4:45 p.m. (nearly four hours later), two CNAs (#8 and #9) entered the room to check the resident's brief and transfer her to the wheelchair. Observation on 01/26/11 at 6:46 a.m. and 7:46 a.m. showed Resident #4 asleep in bed on her left side. CNA charting indicated staff positioned Resident #4 on her left side at 3:00 a.m. At 7:46 a.m. (nearly five hours later), two CNAs (#10 and #11) entered Resident #4's room and transferred her to a wheelchair using a full body mechanical lift. The CNAs failed to check Resident #4's brief. An interview with a CNA (#11) at this time indicated the CNA had last checked and changed	F 314		

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F 314	Continued From page 26 Resident #4's brief around 5:30 a.m. At 9:24 a.m. (nearly four hours later), two CNAs (#10 and #14) checked Resident #4's brief after transferring her into bed. Observations of Resident #4 on 01/26/11 from 1:15 p.m. to 4:29 p.m. showed Resident #4 asleep/in bed on her back in the same position throughout the afternoon. CNA charting indicated staff positioned Resident #4 on her back at 12:30 p.m. At 4:29 p.m. (four hours later), two CNAs (#8 and #12) entered Resident #4's room to check her brief and transfer her to a wheelchair. Review of Resident #4's Positioning Records (completed by CNAs) from October 2010 through January 26, 2011 occurred on 01/27/11. The CNA documentation showed facility staff failed to consistently reposition Resident #4 every two hours as identified in her care plan. According to documentation, Resident #4 lay on her back (placing direct pressure on her coccyx) in excess of 2 hours on 45 different occasions. A quarterly dietary assessment, dated 11/28/10, revealed Resident #4 currently received 4 ounces of "Kemp's" (a nutritional supplement) three times a day, and 1 ounce of ProSource (a liquid protein supplement) three times a day. During an interview on 01/26/11 at 10:35 a.m., a supervisory dietary staff member (#16) stated the dietary staff add ProSource to Resident #4's chocolate milk at each meal except breakfast when they add it to her cereal. The staff member stated this is done before Resident #4's tray leaves the kitchen. The following observations of meals occurred during the survey: *On 01/25/11 at 11:42 a.m., an unidentified	F 314		

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 _____	01/27/2011

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

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F 314	Continued From page 27 certified nursing assistant (CNA) delivered a lunch tray to Resident #4. The CNA opened a carton of chocolate milk and poured it in a glass. Observation showed no ProSource added to the milk or to the meal. *On 01/26/11 at 11:35 a.m., a CNA (#28) delivered a lunch tray to Resident #4. The CNA opened a carton of chocolate milk and poured it in a glass. The CNA stated that sometimes the kitchen opens the carton but today she opened it. Observation showed no ProSource added to the milk or to the meal. *On 01/26/11 at 8:35 a.m., an unidentified CNA recorded meal intakes for Resident #4 upon completion of breakfast. CNA charting indicated Resident #4 consumed 100% of her protein, 100% of her starch, 100% of her bread, 25% of her juice, 25% of her milk, and 100% of her supplement. However, observation of Resident #4's meal tray showed Resident #4 consumed 50% of her protein, 100% of her bread, 25% of her juice, and none of her starch, milk, or supplement. A CNA (#5) confirmed the other CNA incorrectly charted the meal intakes. The CNA (#5) then re-recorded Resident #4's intakes in the meal intake record. Failure to accurately record resident intakes may result in the dietary department receiving an erroneous depiction of meal intakes, and may therefore delay initiation of additional dietary interventions or modification of existing dietary interventions. During an interview on the morning of 01/27/11, a supervisory dietary staff member (#16) confirmed Resident #4 is supposed to receive ProSource at each meal and stated she needed to re-educate dietary staff regarding its use.	F 314		

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	355063	A. BUILDING _____ B. WING _____	01/27/2011

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

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F 314	Continued From page 28 - Resident #1's medical record, reviewed on all days of the survey, identified diagnoses of dementia with delusions, Alzheimer's disease, and anemia. Review of Resident #1's care plan and nurses notes indicated a reddened area on right ankle on 08/21/10, resolved 08/27/10. Review of a quarterly MDS, dated 09/01/10, indicated a stage I pressure ulcer on the resident's right outer ankle. Review of a quarterly MDS narrative, dated 09/03/10, stated, ". . . Skin is intact however has a reddened area on her rt [right] outer ankle (stage I). She now wears blue pressure relieving boots when in bed." Resident #1's most current MDS, dated 12/01/2010, identified the resident required extensive assistance of one person for bed mobility, transfer, toilet use, and personal hygiene. The resident's cognitive assessment, BIMS (Brief Interview for Mental Status) indicated severely impaired. The resident's urinary continence indicated frequently incontinent. The MDS indicated the resident at risk for pressure ulcers. Review of the resident's current "My Daily Living Needs" lacked a positioning schedule. Pressure relieving devices listed included "blue boots when in bed" and PRM (pressure relieving mattress). Review of a faxed communication, dated 12/26/10, to Resident #1's physician stated, "scab noted to rt [right] outer ankle we will cont [continue] to monitor until resolved already has	F 314		

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ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 314	Continued From page 29 pressure relief mattress & [and] blue boots for pressure in place." The fax from the physician, dated 12/28/10, stated, "noted." Review of Resident #1's "Pressure Ulcer Record" listed date of onset: 12/24/10 and site/location: right ankle. The record continued: * 12/28/10 right ankle stage I size 0.5 cm (centimeters) x 0.5 cm scab to right ankle denies pain. * 01/03/11 right ankle stage I size 0.5 cm x 0.5 cm scab to right ankle no change * 01/14/11 right ankle stage I size 0.5 cm x 0.5 cm no change * 01/17/11 right ankle stage I size 0.5 cm x 0.5 cm no change * 01/25/11 right ankle stage I size 0.5 cm x .05 cm no change During an interview, on 01/26/11 at 8:40 a.m., a management nursing staff member (#19) stated Resident #1's pressure ulcer as a "stage II." This conflicts with the documentation on 01/25/11 at a stage I pressure ulcer. An observation on 01/25/11 at 11:30 a.m., showed a nursing staff member (#27) assessing Resident #1's pressure ulcer on her right outer ankle and showed a scab on the area. An observation on 01/26/11 at 6:55 a.m., showed Resident #1 lying in her bed on her right side without the protective blue boots on her feet. An observation showed the protective blue boots in the resident's closet. An observation on 01/27/11 at 6:40 a.m., upon awaking, showed Resident #1 lying in bed on her right side without protective blue boots on her	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 30 feet. A CNA (#24) reported the resident should be wearing the blue boots and located the boots in the resident's closet. The CNA (#24) removed the elastic topped slipper socks revealing a indentation above her ankles and placed the blue boots on the residents feet. During an interview on 01/27/11 at 9:30 a.m., a management nursing staff member (#15) stated the pressure ulcer on Resident #1's right ankle is a stage II, but made no comment regarding the failure of nursing staff to place the protective blue boots on the resident's feet while in bed. Failure of facility staff to provide the appropriate/ordered pressure relief to Resident #1's feet placed the resident at risk for further skin breakdown and does not promote timely healing of the existing pressure ulcer on the resident's right ankle. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and neuropathy. The current MDS, dated 01/12/11, identified Resident #5 required extensive assistance from two people with bed mobility and was always incontinent of bowel and bladder. Resident #5's "Daily Living Needs" indicated a toileting plan of checking and changing the resident's brief before and after meals and on all night rounds, as well as a schedule to reposition every two hours. The care plan also stated, ". . . I do not have a call light, I am unable to use one due to my condition. Please check on me every 2 hours to ensure my needs are being met. . . ." Observations of Resident #5 on 01/25/11 from 1:00 p.m. to 4:00 p.m. showed the resident	F 314		

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 _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 31	F 314		

sleeping in bed on her left side in the same position throughout the afternoon. CNA charting indicated staff positioned Resident #5 on her left side around 12:00 noon. At 4 p.m. (four hours later), two CNAs (#12 and #13) entered Resident #5's room to reposition her, but failed to check the Resident's brief. Observation showed a reddened area to Resident #5's right hip, and a lightly padded, self adhesive dressing to her left hip. A CNA (#12) stated the dressing was "for her protection" because "her skin is so thin." She also stated they reposition her every two hours and would check on her again around 6:00 p.m.

Observations of Resident #5 on 01/26/11 at 6:48 a.m. and 7:36 a.m. showed the resident lying on her back in bed. CNA documentation indicated staff positioned Resident #5 on her back at 3:00 a.m. At 8:38 a.m. (over five hours later), observation showed the resident lying on her right side, and the room smelled of bowel movement (BM). In an interview at 8:43 a.m., a CNA (#14) stated she turned the resident "just a few minutes ago," and that she did not check Resident #5's brief. She also stated, "That [the brief change] was done before I got here. When nights got her up."

An interview with a night shift CNA (#11) occurred on 01/26/11 at 7:50 a.m. The CNA stated she changed Resident #5's brief between 5:30 a.m. and 6:00 a.m.

Observations on 01/26/11 at 9:14 a.m., 10:22 a.m., and 11:28 a.m. showed Resident #5 in the same position on her right side. Although a CNA (#10) entered Resident #5's room at 10:29 a.m. to offer her a snack, the CNA failed to check the resident's brief or reposition her. At 11:44 a.m.,

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 _____	01/27/2011

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F 314	Continued From page 32 two CNAs (#10 and #14) entered Resident #5's room and changed her brief, six hours after the previous brief change. Observation showed the brief was saturated with urine and soiled with a moderate amount of stool. Observation also showed a reddened area to Resident #5's right hip, and a lightly padded, self adhesive dressing to her left hip. An interview with a supervisory nursing staff member (#1) occurred on 01/27/11 at 1:15 p.m. She confirmed Resident #4 and #5 should be checked and changed every two hours, as well as repositioned every two hours.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly use a gait belt for 1 of 1 sampled resident (Resident #7) observed during a gait belt transfer and 1 of 4 sampled residents (Resident #9) observed during a stand-lift transfer. Failure to utilize a gait belt and stand-lift properly creates the potential to for residents to experience pain or injury. Findings include:	F 323		

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 _____	01/27/2011

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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 323	Continued From page 33 Review of the facility policy titled "Ambulation" occurred on 01/27/11. This policy, dated 05/10/10, stated, ". . . Equipment: 1. Assistive device as care planned. 2. Gait belt as care planned. Procedure: . . . 3. . . . Use gait belt as directed by My Daily Living Needs Plan. 4. Assist resident to standing position with use of gait belt. . . . 6. Support resident firmly with gait belt; . . ." - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease and osteoarthritis. The most current Minimum Data Set (MDS), dated 11/09/10, identified Resident #7 required extensive assistance with transfers and toilet use. The current "My Daily Needs" care plan stated, ". . . Assist me to the commode . . ." Observation on 01/26/11 at 11:30 a.m. showed two certified nursing assistants (CNAs) (#4 and #5) assisted Resident #7 to the commode next to her bed. One CNA (#5) applied a gait belt around the resident's waist and stood on the right side and the other CNA (#4) stood on the left side. Both CNAs assisted Resident #7 to a standing position, however, the CNA (#4) failed to utilize the gait belt and placed her left arm under the resident's left arm and lifted upward. During an interview on 01/27/11 at 10:45 a.m., an administrative nurse (#1) stated she expected facility staff to utilize a gait belt when assisting Resident #7. - Review of Resident #9's medical record occurred on January 25-27, 2011. The resident's diagnoses included osteoporosis, closed dislocation of cervical vertebrae, and scoliosis	F 323	F 323 1. Resident # 9 had a care plan change due to declining health on 2/10/11. Staff now will use a full body lift with two assist. Staff re-education provided on 2/18/11 for proper belt tightness with the stand lift transfers of resident. 2. All residents requiring assistance with transfers have the potential to be affected. 3. All CNA's will be re-educated on the proper use of gait belts and on the proper tightness of the stand lift belt during transfers on 2/18/11. Prevent representative (existing contracted consultant company providing training in patient handling lift, transfer and repositioning) will be consulted regarding safety measures and monitors for lifts. 4. Supervisory nursing staff will monitor compliance with following the gait belt/transfer policies randomly across all shifts three days per week for two weeks and one day per week for one month. The results of the monitors will go directly to the DNS. If concerns are identified, immediate corrective action will be implemented. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action to include monitoring, will be taken dependent on the results of the initial monitors.	2/18/11 2/18/11

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 _____	01/27/2011

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

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F 323	Continued From page 34 ideopathic disorder bone and cartilage. Resident #9's "Daily Living Needs" plan of care identified the resident required assistance with transfers using one to two persons and a sit-to-stand lift. Two observations of staff transferring Resident #9 occurred on 01/25/11. At 1:20 p.m., two CNAs (#17 and #10) tranferred Resident #9 from her wheelchair to a recliner and at 3:45 p.m., two CNAs (#8 AND #9) transferred Resident #9 from a commode to a recliner in her room. The staff members utilized a sit-to-stand lift to assist Resident #9 with transferring. When the staff members raised Resident #9 to a standing position with the lift, both observations showed Resident #9's elbows elevated outwards at an approximately ninety degree angle from the sides of her body. Her elbows were aligned with her shoulders. Observation further identified the safety belt around Resident #9's chest to be loose with a gap between the belt and the resident's body. During an interview on the afternoon of 01/27/11, an administrative nursing staff member (#1) agreed the chest belt should be tightened after the resident is raised in the sit-to-stand lift to ensure a safe transfer.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 35 Based on observation, record review, review of professional literature, and staff interview, the facility failed to follow professional standards for medication administration for 1 of 1 sampled resident (Resident #8) observed receiving sliding scale insulin at a non scheduled time. Failure to follow the established time for insulin administration has the potential for the resident to experience an adverse outcome such as hypoglycemia (low blood glucose). Findings include: Taylor, Lillis, LeMone, "Fundamentals of Nursing, The Art and Science of Nursing Care," 4th ed., J.B. Lippincott Company, Pennsylvania, page 577, stated: "Frequency of Administration of the Drug: . . . If a drug is ordered to be given before or after meals, time of administration depends on the hours at which meals are served. It is a nursing responsibility to check that times for medication administration correspond to safe practice for that drug. Page 581 stated, "The five rights to help ensure accuracy when administering medications. The nurse gives the (1) right medication . . . at the (5) the right time." Saxton and Clark, "Geriatric Medication Handbook," 7th ed.,American Society of Consultant Pharmacists, Alexandria, VA, page 89, recommended Novolog, a brand name of insulin, be administered five to ten minutes before meals. Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses included dementia and diabetes mellitus. Review of the resident's physician's orders identified Lantus (a long acting insulin) 60 units every morning and 24	F 333	F 333 1. The nurse giving resident insulin on 1/25/11 was educated on the facility's practice for insulin administration on 1/28/11. 2. Any resident receiving insulin has the potential to be affected. 3. Education regarding the facility's practice on insulin administration will be given to all licensed nurses by 2/24/11. Will add time frame of administration slot to the documentation sheet for insulin administration. Residents will be interviewed for permission to give insulin in areas other than their room if they don't want to leave an activity or event. 4. Supervisory nursing staff will review insulin records one week after times of administration added to the insulin medication administration record. Supervisory nursing staff will review insulin records weekly for one month to ensure prompt administration of insulin. Forward all reports to the DNS. Implement corrective action for any concerns identified. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action including monitoring, will be taken dependent on the results of the initial monitors.	3/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 36 units in the evening, and Novolog (a fast acting insulin) sliding scale based on the blood glucose level. The sliding scale Novolog order stated to check Resident #8's blood glucose level four times a day (6:30 a.m., 11:30 a.m., 5:00 p.m., and 9:30 p.m.) and give the insulin according to the glucose level. Observation on 01/25/11 at 3:45 p.m. showed a licensed nurse (#3) administered four units of Novolog in Resident #8's abdomen. The nurse stated the resident's blood glucose level read 212 right before lunch, approximately four hours and 15 minutes ago. Per the physician's orders, a blood glucose reading of 212 indicated the resident required four units of Novolog. She stated all insulins are given after lunch and Resident #8 did not receive her insulin after lunch. During an interview on 01/27/11, an administrative nurse (#1) stated Resident #8's sliding scale insulin should have been given shortly after she started eating her meal and not four hours later. The facility staff failed to administer Resident #8's sliding scale insulin at the scheduled time and failed to check her glucose level before administering the insulin at 3:45 p.m. This practice has the potential to result in a hypoglycemic reaction if the resident's glucose level had been low at 3:45 p.m. and may interfere with the glucose check ordered for 5:00 p.m.	F 333		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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 _____	01/27/2011

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

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F 371	Continued From page 37 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, professional literature review, and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 kitchen. Failure to protect food from unsanitary water sources, has the potential to cause foodborne illness and can affect all residents who eat food stored in these areas. Findings include: The 2005 Food Code, Public Health Reasons, page 376, states, " . . . Packages that are not watertight may allow entry of water that has been exposed to unsanitary exterior surfaces of packaging, causing the food to be contaminated . . ." Review of the facility's policy titled "Food Storage" occurred on the afternoon of 01/27/11. The policy, dated 10/11/10, stated, " . . . 2. Food services staff will store all foods . . . on shelves . . . not subject to . . . contamination by condensation, leakage . . . . All packaged food . . . will be kept clean and dry at all times. . . ." An initial tour of the kitchen occurred on 01/25/11 at 6:45 a.m. Observation of the walk-in freezer	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 38 showed boxes of food stored on shelves below the unit's air compressor and a black pipe with icicles suspended from its surface. Observation showed boxes of food with ice build-up and wet areas that had frozen on their exterior surfaces. The ice build-up had formed into an approximately one to two inch high mound of ice on a closed box of frozen vanilla custard cups. Additional small ice deposits had formed in a scattered layer with wet areas on a second opened box of frozen vanilla custard cups, two packaged cream pies, and closed boxes of Plus Two and Magic Cup supplements, vanilla ice cream cups, and corn muffins. A main tour of the kitchen occurred on 01/27/11 at 10:30 a.m. with an administrative dietary staff member (#16). Observation showed the boxes of food with ice build-up on their surfaces of Plus Two supplement, vanilla custard cups, and corn muffins remained in the walk-in freezer. During an interview on 01/27/11 at 10:45 a.m., the administrative dietary staff member (#16) stated maintenance staff had repaired the walk-in freezer to address ice buildup in October 2010. Dietary staff did not implement an effective method of protecting the food stored below the air compressor from water condensation. This staff member agreed frozen food products should be protected from the potential contamination from unsanitary water sources.	F 371	F371 1. Temp Rite Services assessed the issue and retightened the freezer line connection and re-insulated the lines properly. 2. This is the only walk in freezer in the facility therefore no other can be affected 3. Monitoring of the freezer for any dripping has been added to the TELS preventative maintenance program under the direction of the Environmental Services Director 4. Director of Environmental Services will report any Dripping to QA and call Temp Rite Services immediately	2/16/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	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 _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 39 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow accepted standards of practice regarding infection control for 1 of 2 residents (Resident #4)	F 441	F441 1. Resident # 4 is having hands cleansed before coming out of the room. Staff re-educated on 1/28/11. Staff caring for resident # 4 are performing hand hygiene before leaving the room. Staff re-educated on 1/28/11. The lift used on resident # 4 is being sanitized after use. Staff re-educated on 1/28/11. Staff caring for resident # 5 was re-educated on 1/28/11 to perform hand hygiene after pericares. Staff re-educated to change linens after any potential soiling of resident's linens on 1/28/11. 2. All residents have the potential to be affected. 3. The policies on hand hygiene, equipment decontamination, linen handling and pericares were reviewed on 2/15/11. The CNA staff will be re-educated on hand hygiene practices, equipment decontamination and linen handling, and pericares by 2/18/11. 4. Supervisory nursing staff will monitor compliance with staff and resident hand hygiene practices/policies, with equipment decontamination, and with linen handling randomly three days per week for two weeks and then (cont next page) random monitoring one day per week for one month across all shifts. The results of the monitors will go directly to the DNS. If concerns are identified	2/18/11

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 _____	01/27/2011

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ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 441	Continued From page 40 in contact isolation and 2 of 9 residents (Resident #5 and #12) observed during perineal cares. Failure to follow these standards places residents in the facility, as well as staff members and visitors, at risk for facility-acquired infections. Findings include: Review of the facility policy titled "Decontaminating Equipment" occurred on 01/27/11. This policy, revised 05/23/10, stated, ". . . Policy Interpretation and Implementation . . . 1. Reusable resident care equipment will be decontaminated and/or sterilized between residents . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included chronic diarrhea, a history of vancomycin-resistant enterococci (VRE) infection in the rectal area, and a history of methicillin-resistant staphylococcus aureus (MRSA) in the nares. During the initial tour of the facility on 01/25/10 at 6:50 a.m., facility staff identified Resident #4 was in contact isolation precautions for "VRE in the stool" and "MRSA in the nares." Signage on Resident #4's door identified a need for personal protective equipment such as gowns and gloves to be worn when working with the resident. Resident #4's "Daily Living Needs" (a part of the resident's care plan) stated, ". . . MUST WASH MY HANDS PRIOR TO COMING OUT OF MY ROOM. . . . VRE --- RECTAL AREA . . . MRSA --- NARES . . ." Observation on 01/25/11 at 11:22 a.m. showed	F 441	immediate corrective action will occur. QI nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting. Further action, to include monitoring, will be taken dependent on the results of the initial monitors.	

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 _____	01/27/2011

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F 441	Continued From page 41	F 441		

an unidentified certified nursing assistant (CNA) entered Resident #4's room and transported the resident to the dining room for lunch. The CNA failed to wash Resident #4's hands prior to leaving the room.

Observation on 01/25/11 at 4:45 p.m. showed two CNAs (#8 and #9) entered Resident #4's room and transferred her from the bed to the wheelchair using a full body mechanical lift. After the transfer, a CNA (#9) took the lift out into the hallway and left it outside another resident's room. The CNA failed to sanitize the lift (shared by multiple residents) after using it to transfer Resident #4.

Observation on 01/26/11 at 7:46 a.m. showed two CNAs (#10 and #11) transferred Resident #4 to her wheelchair using a full body mechanical lift. After completing the transfer, one CNA (#10) removed her gown and gloves and left the room, failing to perform hand hygiene before leaving an isolation room. The other CNA (#11) transported Resident #4 to the dining room for breakfast and failed to wash the resident's hands prior to leaving the room.

Observation on 01/26/11 at 10:55 a.m. showed two CNAs (#10 and #14) transferred Resident #4 from the bed to the wheelchair. The resident stated, "My nose itches," and scratched in and around her nose. The CNAs transported the resident to the dining room for lunch and failed to wash the resident's hands prior to leaving the room.

Observation on 01/26/11 at 4:20 p.m. showed two CNAs (#8 and #12) transferred Resident #4 from her bed to the wheelchair using a full body

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 _____	01/27/2011

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 42	F 441		

mechanical lift. After the transfer, the CNA (#8) removed the lift from the room and left it in the hallway. The CNA failed to sanitize the lift (shared by multiple residents) after using it to transfer Resident #4.

In an interview on 01/27/11 at 10:50 a.m., a supervisory nursing staff member (#1) stated "It should be done [referring to washing Resident #4's hands]." She also stated she would expect staff to clean the lift with sanitizing wipes prior to removing the lift from an isolation room.

- Observation on 01/26/11 at 11:44 a.m. showed a CNA (#14) provided personal cares for Resident #5 as she lay in bed. The CNA donned gloves and performed perineal care for Resident #5, who was incontinent of urine and a moderate amount of stool. The CNA removed her gloves and placed a new incontinence brief on Resident #5. Without performing any hand hygiene, the CNA proceeded to reposition the resident, cover her with a bed sheet, brush her hair, and perform oral cares with a toothette (a small sponge used to clean the inside of residents' mouths).

Observation on 01/26/10 at 2:00 p.m. showed a CNA (#14) provided perineal care for Resident #5 as she lay in bed. Resident #5 was incontinent of urine and a small amount of stool. The CNA stated, "These are kind of dirty [referring to her soiled gloves]." After removing the soiled gloves, the CNA donned new gloves and placed a clean brief on Resident #5. The CNA then removed her gloves and (without performing any hand hygiene) dressed Resident #5 in a clean gown, repositioned her, covered her with a bed sheet, and combed her hair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 441	Continued From page 43 In an interview on 01/27/11 at 10:50 a.m., a supervisory nursing staff member (#1) confirmed that CNAs are expected to perform hand hygiene after providing perineal care and before performing other resident cares. - Observation on 01/27/11 at 9:15 a.m. showed two CNAs (#14 and #18) assisted Resident #12 with pericares. A CNA (#14) removed the resident's brief soiled with stool and used multiple peri-wipes to cleanse the resident's perineal area. The CNA (#14) rolled the brief and peri-wipes into a ball and placed the soiled items on Resident #12's bedspread. A CNA (#18) picked up the soiled brief, the brief opened, and the soiled peri-wipes fell onto the resident's bedspread. The CNA (#18) then placed all the soiled items into the garbage can. The CNAs failed to change Resident #12's bedspread after contamination from the soiled brief and peri-wipes. During an interview on 01/27/11 at 10:30 a.m., an administrative nurse (#1) stated the CNA should have placed the soiled brief in the garbage can immediately.	F 441		