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 _____	01/05/2017

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 01/03/17 and completed on 01/05/17, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review.	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff offered toileting in accordance with the resident's care plan for 2 of 4 sampled residents (Resident # 8 and #9) requiring assistance with incontinence cares. Failure to toilet/check and change the resident as care planned may result in skin breakdown and/or avoidable falls/injury. Findings include: Review of Resident #9's medical record, reviewed on all days of survey, identified diagnoses including Alzheimer's Disease. The resident's care plan, edited 01/02/17, identified a	F 315	Identified resident #8 & #9 had care plans reviewed for requiring assistance with incontinence cares and updated to ensure appropriate interventions were accurate. Staff education was provided to those caring for resident #8 & 9 regarding appropriate changes. Due to the potential of all residents being affected by this deficiency, all residents care planned for requiring assistance with incontinence cares had care plans reviewed and updated to ensure appropriate interventions were accurate. Education regarding the 72 hour toileting	2/6/17

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

Electronically Signed | 01/27/2017

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F 315	Continued From page 1 problem: ". . . Urinary Incontinence." Approaches to the problem included: ". . . Offer [Resident #9] the bathroom approx. [approximately] every two hours while awake and check on him at night and offer the bathroom at night. . . ." Observations and interviews identified the following: 01/03/17 at 3:30 p.m.: Two CNAs (Certified Nursing Assistants) (#1 and #3) checked and changed Resident #9 without offering toileting - as per the care plan. Observation showed the resident's brief soaked with urine and his scrotum reddened. 01/04/17 at 11:34 a.m.: When interviewed, a CNA (#5) stated staff are to check and change Resident #9 every two hours. She stated they last checked and changed the resident at approximately 8:15 a.m. 01/04/17 at 11:54 a.m.: (Approximately 3 hours and 40 minutes since staff last checked the resident) Two CNAs (#4 and #5) checked and changed Resident #9. Observation showed the resident's brief soaked with urine. 01/04/17 at 4:43 p.m.: Two CNAs (#3 and #6) checked and changed the resident. Observation showed the resident's brief wet with urine and his scrotum and the area around the meatus reddened. The facility failed to offer toileting for Resident #9 from January 03-04, 2017. During an interview on 01/04/17 at 5:20 p.m. a licensed nurse (#7) stated staff put the resident to bed at 1:15 or 1:30 p.m. (approximately 3 and 1/2 hours earlier) and stated at that time the resident was dry.	F 315	protocol bladder and bowel program was provided to nursing staff (nurses and CNA□s) to identify resident□s toileting needs. Education regarding the Care Plans policy was also provided to nursing staff (nurses and CNA□s) to ensure consistency and continuity of care. Monitoring for staff to offer toilet when checking residents for incontinence will start the week of January 23, 2017. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x8; Monthly x3; Quarterly x3	

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F 315	Continued From page 2 -Review of Resident #8's medical record, reviewed all days of the survey, identified diagnoses of dementia without behavioral disturbance, osteoporosis, type 2 diabetes mellitus and fracture of the right pubis. The resident's care plan, identified a problem: ". . . Urinary Incontinence. Approach start date 12/08/16: After initiating the 72 hour bowel and bladder program on 12/01/2016, it has been determined that [Resident #8] will benefit from a toileting schedule approximately every two hours, and as needed. . . ." Review of facility forms, dated December 8, 2016 - January 4, 2017, identified when the resident was toileted. Documentation showed that the resident was not toileted "approximately every 2 hours, and as needed" as care planned. See F323.	F 315		
F 323 SS=G	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 record review and review of facility	F 323	Identified resident #8 was assessed for	2/6/17

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F 323	Continued From page 3 policy, the facility failed to adequately assess the circumstances and causative factors contributing to the recurring falls experienced by 1 of 1 sampled residents (Resident #8) requiring extensive assistance with toileting, and failed to implement/provide appropriate interventions and/or assistance to prevent falls and harm/injury from occurring. Failure to assess and implement interventions for Resident #8 resulted in the resident experiencing avoidable falls and injury while attempting to toilet unassisted. Findings include: Review of the facility policy titled "Toileting Protocol" occurred on 01/05/17. The policy, dated 09/26/2016, stated, "Policy: To help aid residents maintain bowel and bladder continence, highest level of functioning and safety associated with toileting. . . . Data collected from the 72 hour bowel and bladder assessment is used to design an individulized toileting schedule to meet the resident's needs. This schedule is implemented and may be adjusted accordingly to resident's needs and/or changes in status. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included cerebral infarct, dementia, muscle weakness, right hip pain, glaucoma, osteoporosis, and unspecified fracture of right pubis. A quarterly Minimum Data Set (MDS), dated 09/08/16 identified a hip fracture and one fall with major injury. A quarterly MDS, dated 12/09/16, identified Resident #8 with severely impaired cognition, required extensive assist of one for toileting, transfers, and ambulation, and had two	F 323	fall risk level, items related to recurrent falls and care plan reviewed and updated to ensure appropriate interventions were accurate. Staff education was provided to those caring for resident #8 regarding appropriate changes. Due to the potential of all residents being affected by this deficiency, all residents at moderate to high risk for falls had care plans reviewed and updated to ensure appropriate interventions were accurate. Education regarding the fall policy was reviewed by nursing staff (nurses and CNA□s) to ensure understanding of fall prevention and timely intervention(s). Education regarding the policy Care Plans was also provided to nursing staff (nurses and CNA□s) to ensure consistency and continuity of care. Monitoring for implementation of fall interventions will start the week of January 22, 2017. The Director of Nursing or designee shall monitor and report to the quality committee as follows: Monitor: Weekly x8; Monthly x3; Quarterly x3	

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F 323	Continued From page 4 falls with no injury, one fall with injury, and one fall with major injury. Resident #8's current care plan identified, "Problem: Resident has a history of falling r/t [related to] dementia, medication use. . . . Approach start date 09/20/16: . . . alarms in place that monitors rising. [Resident #8] at times removes alarms per self and staff should attempt to place alarm boxes out of [Resident #8] easy reach. . . . Encourage resident to use call light and wait for staff assistance when needed . . . Provide resident an environment free of clutter. Assure the floor is free of glare, liquids, foreign objects. Approach start dated 11/28/16: Ensure styrofoam noodle is in place while [Resident #8] is laying in bed. Approach start date 11/21/16: Ensure floor mat is in place while [Resident #8] is lying in bed. . . . Problem: ADL [activities of daily living] . . . Resident required assistance with ADLs and is frequently incontinent of urine. Approach start date 11/17/16: . . . restorative therapy program that will ambulate her to and from meals . . . Approach start date 12/08/16: After initiating the 72 hour bowel and bladder program on 12/01/2016, it has been determined that [Resident #8] will benefit from a toileting schedule approximately every two hours, and as needed. . . ." Resident #8's nurses note identified the following: * 08/28/16 at 11:45 p.m.: "Res [resident] call light in the BR [bathroom] went off and answered the light, cord was pulled out from the call box, resident observed on the floor lying on her right side, no apparent injury noted, res stated 'I just want to pee and I don't know what happened.' . . . Tab alarm was in place but resident knows how	F 323		

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F 323	Continued From page 5 to took [sic] it out, noted that walker was at the side of the bed. . . . will continue to monitor res, fax sent to MD [medical doctor]." A computerized tomography (CT) completed on 09/02/16 identified "Acute comminuted fractures through the right superior pubic region." * 09/06/16 at 11:29 a.m.: "CT results indicate nondisplaced pelvic fracture . . ." * 10/28/16 at 9:52 a.m.: "Called to resident's room by staff. Resident was found lying on the floor on her right side next to her bed. Tab alarm was in place and sounding upon arrival. Resident c/o [complained of] pain to her R [right] lower rib cage. . . . Family notified and would like for resident to be monitored at this time. . . . Have ensured alarms are in place and floor is free from clutter and resident has call light available." * 11/09/16 at 11:34 p.m.: "Resident got up to BR and CNA [certified nurse assistant] found resident on the floor in BR. . . . Hematoma forming to lateral left eye. Laceration to lateral area noted. Alarm on bed. . . ." No new interventions to prevent further falls were implemented following this incident. * 11/10/16 at 10:14 a.m.: ". . . c/o pain entire left side. Call placed to MD. To send to ER [emergency room]. Family in agreement." * 11/10/16 at 2:39 p.m.: "Returned from ER. No new fractures." * 11/20/16 at 9:32 a.m.: "At 0830 [8:30 a.m.], alarm sounded . . . Resident lying next to her bed on her left hip, brief was lying beside her as well as one slipper. . . . staff unable to turn resident onto left side due to pain reported by resident. Also stated pain to left ribs. . . ." * 11/20/16 at 10:50 a.m.: "Floor pad, chair and bed alarms and tab alarm in place. 15 minute checks in place . . ."	F 323		

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F 323	Continued From page 6 * 11/21/16 at 12:46 p.m.: "Daughter requesting floor mat at all times when resident is in bed." * 11/22/16 at 2:38 p.m.: "Observed lying on left side on fall mattress. Tab alarm was on but did not went [sic] off." * 11/22/16 at 9:20 a.m.: "Bed was in lowest position. A silent alarm has been ordered to prevent resident from removing the alarm." * 11/25/16 at 11:55 a.m.: "Alarm sounded. On floor mat. Self-transferred from wheelchair and laid down on mattress. Tab alarm attached to resident." * 11/27/16 at 4:27 p.m.: ". . . found resident sitting with her butt on floor mattress and back against the bed . . . Resident's bed alarm was not connected." * 11/28/16 at 9:21 a.m.: ". . . styrofoam noodle to prevent from falling out . . ." * 11/29/16 at 9:21 a.m.: "Resident was seen by staff crawling from her bed to her mattress next to the bed. When asked what she was doing resident said she needed to use the bathroom. Resident was assisted to the BR. Will continue to monitor for continuing occurrences." Resident #8's toileting record identified she was last toileted at 9:14 p.m. on 11/28/16, over 12 hours earlier. * 11/30/16 at 12:04 a.m.: "This evening, resident was observed x 2 crawling from her bed to the mattress saying she had to go to the bathroom. Staff assisted resident to the bathroom both times as reported to this nurse by CNA who observed it." * 12/01/16 at 6:26 a.m.: "Staff report resident was crawling OOB [out of bed] onto mattress next to bed. Resident states she needed to use the BR. Resident assisted to BR then back to bed." Resident #8's toileting record identified that she	F 323		

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F 323	Continued From page 7 was last toileted at 8:13 p.m. on 11/30/16, over 10 hours earlier. * 12/07/16 at 9:38 a.m.: "Staff report observing resident crawling OOB onto her floor mat. Resident indicated she needed to use the BR. Staff provided assistance." Toileting record identified no documentation for toileting on 12/06/16, with last toileting documented at 8:22 p.m. on 12/05/16, over 33 hours earlier. * 12/16/16 at 2:18 p.m.: "Resident found by CNA crawling on hands and knees onto her bathroom floor. Neither the tab alarm or bed alarm were in place. . . . Resident's alarms were put into place and checked to make sure they were working." * 12/20/16 at 4:30 a.m.: "Resident observed sitting on the floor near the BR door, tab alarm, bed and chair alarm went off. Call light was within reach, FWW [front wheeled walker] was near the bed by the floor mattress . . . stated 'please help me, I need to use the BR.' Assisted resident x 2 . . . Educated resident to call if needs help to go to BR . . ." * 12/21/16 at 11:17 p.m.: "Resident alarm alerted staff resident sitting on edge of bed. Staff assisted resident to BR. Mattress placed next to bed on the floor for resident safety. Alarms in place on bed." The toileting record identified Resident was last toileted at 10:04 a.m. on 12/21/16, over 13 hours earlier. * 12/22/16 at 12:57 a.m.: "Resident alarm alerted staff that resident was sitting up. Staff assisted to BR without incident. Mattress replaced on floor beside bed after toileting." * 12/23/16 at 5:16 p.m.: ". . . resident standing trying to climb over foot pedals. Her alarm was wrapped around the back of her chair. . . . Will continue to monitor and test the alarms as well as speak to the CNAs."	F 323		

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F 323	Continued From page 8 * 12/31/16 at 4:51 p.m.: "Tab alarm sounded . . . upon entering the room, resident lying on back just outside bathroom door. Tab alarm was lying beside resident on pad. Silent alarm did not sound. Resident stated, 'I wanted to go to the bathroom.' . . . Post fall huddle performed with CNA staff. . . ." No new interventions to prevent further falls were implemented following this incident. Failure to toilet Resident #8 at the assessed frequency "approximately every two hours and as needed," and failure to assess the need for new interventions and consistently implement the current interventions resulted in falls/injuries.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure adequate interventions to prevent weight loss and maintain an acceptable nutritional status for 1 of 8 sampled residents (Resident #2) identified with weight loss. Failure	F 325	Due to the potential of all residents to be affected by this deficiency, facility policy for Weight Assessment and Intervention was reviewed and updated by facility Certified Dietary Manager and Dietitian.	2/6/17

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F 325	Continued From page 9 to initiate timely interventions, and re-evaluate and/or modify the interventions as needed resulted in severe weight loss for Resident #2. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, dysphagia, and nausea. The quarterly Minimum Data Set (MDS), dated 12/08/16, identified a weight loss. The current care plan stated, ". . . Problem . . . Nutritional Status . . . Resident has a history of swallowing difficulties and poor meal intake, Requires assist with oral intake . . . Approach . . . Assist resident with oral intake . . . Regular diet - No Salt Packets - Pureed - nectar liquids. . . . supplements in place at med [medication] pass and with meals . . ." Resident #2's weights showed the following: * 01/26/16: 160.3 lbs * 02/23/16: 144.9 lbs - 9.61% weight loss in 1 month * 03/22/16: 140.0 lbs * 04/22/16: 137.8 lbs - 14.04% weight loss in 3 months * 05/19/16: 134.5 lbs * 06/21/16: 133.8 lbs * 07/21/16: 120.2 lbs - 25.02% weight loss in 6 months * 08/30/16: 125.5 lbs * 09/27/16: 127.7 lbs * 10/18/16: 120.3 lbs * 11/22/16: 118.5 lbs * 12/27/16: 118.7 pounds (lbs) January 2016 to June 2016 represents a 26.5	F 325	All resident weights were reviewed. Certified Dietary Manager initiated a new document for weight review that includes current interventions and an area to record dates of documentation. This will improve timely follow-up and help to ensure interventions and documentation are performed. Resident #2□s weight was reviewed and documentation and intervention was put in place by Certified Dietary Manager on 1/03/2017, 1/13/2017, and 1/23/2017 and by Dietitian on 1/23/2017. Weekly review of residents□ (past 6 month) weights will be performed by Certified Dietary Manager or designee, using the Matrix Weight Variance Report. Information regarding residents□ weight changes will be discussed at interdisciplinary team meetings as they occur. (1st Review) 1-20-2017. To ensure plan is effective, quality monitors have the following goals: Goal: 5% or less of facility residents will have significant wt. loss in 1, 3, 6 months, if preventable. Goal: 100% of facility residents who trigger for significant wt. loss will have intervention and documentation in place. Quality Monitors will be performed weekly times 8 weeks, monthly times 2 months and quarterly thereafter for the remainder of the year, and information reported to	

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F 325	Continued From page 10 pound weight loss in 5 months (16.53 percent (%)), and June 2016 to December 2016 represents a 15.1 pound weight loss in 6 months (11.29%), i.e. a severe weight loss. Nutrition notes stated the following: * 2/26/16 at 3:06 p.m.: "Weight review shows resident had a 15 # [pounds]/9.6 [percent]= : weight loss in 1 month, will increase supplement from 2 oz [ounces]. Boost . . . daily to 2 oz. Boost . . . BID [twice a day]. Dietician to review next visit. * 03/13/16 at 2:47 p.m.: "Completed 5d /Significant Change nutrition and hydration assessments . . . ." * 06/09/16 at 2:17 p.m.: "Quaterly MDS nutrition assessment complete." * 09/09/16 at 10:30 a.m.: "Quarterly MDS nutrition assessment endging in 9-8-16." * 11/09/16 at 7:12 p.m.: "D/c'd [discontinued] 1 oz HyFIber daily r/t [related to] reports from Nursing of resident having frequent loose stools" . . . . The progress notes show no dietary interventions were implemented during the severe weight loss period in from March to December of 2016 after a severe weight loss occurred. During an interview on the afternoon of 01/04/17, an administrative staff (#8) confirmed Resident #2's severe weight loss and no explanation was provided for the lack of interventions implemented before December 2016.	F 325	the Quality Performance and Improvement Committee monthly. (1st Monitor) 1-20-2017	