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 _____	C 02/08/2024

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 The standard Medicare/Medicaid recertification survey started on 02/05/24 and concluded 02/08/24.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		3/14/24

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

Electronically Signed | 02/23/2024

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 583	Continued From page 1 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to promote privacy and confidentiality of medication administration records (MAR) on 1 of 2 Units (Badlands Unit) observed for medication administration. Failure to close the MAR may result in unauthorized viewing of resident records by other residents, unlicensed staff, and/or visitors. Findings include: Review of facility policy titled "Confidentiality of Social and Medical Information" occurred on 02/08/24. This policy, dated 10/15/17, stated, ". . . The facility should keep confidential all information contained in a resident's records, regardless of the form of storage or location of the record, . . . "Keep confidential" is defined as safeguarding the content of information including written documentation, video, audio, or other computer stored information from unauthorized disclosure . . ." Observation during medication administration on 02/07/24 showed the medication cart unattended with a resident's MAR visible on the screen during the following times: * 12:16 p.m. to 12:18 p.m. * 12:20 p.m. to 12:22 p.m. * 3:50 p.m. to 3:53 p.m.	F 583	1. The staff who administered medications on Badlands during the survey were educated on 2/23/2024. 2. All residents receiving medications during any medication pass are at risk for potential breach of residents' privacy and confidentiality of records. 3. An in-service education program will be conducted by the Director of Nursing Services and/or designee with all nursing staff addressing circumstances around leaving the medication cart and/or treatment care unattended with residents' medical information visible on the computer screen by 02/29/2024. All staff will complete HIPAA and HITECH: Essentials for Staff by 03/14/2024. 4. The Nursing Managers, or designee, will conduct a random audit of ten (10) residents weekly for four (4) consecutive weeks, then monthly thereafter for 1 year or until substantial compliance has been met. The audits will evaluate nurses during medication and/or treatment times to determine whether nursing staff are following the proper protocol to ensure that residents' medical records are kept private and confidential. On-the-spot education will be completed for non-compliance with proper privacy and confidentiality of medical records during	

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F 583	Continued From page 2	F 583	medication administration. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting until the committee determines consistent substantial compliance has been met. 5. Corrective action completion date: 03/14/2024	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		3/14/24

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F 623	Continued From page 3 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 4 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and facility policy review, the facility failed to provide the resident's representative with a completed notice of transfer for 3 of 4 sampled residents (Resident #11, #23 and #72) with hospital transfers. Failure to provide a written notice of transfer which included an appeal date does not allow the resident and/or their representative to make an informed decision	F 623	1. For residents #11, #23, and #72, the notice of transfer was updated with the correct appeal date and the reason for the transfer mailed to the representative. 2. The facility has determined that all residents who have been transferred or discharged have the potential to be	

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F 623	Continued From page 5 regarding their rights. Findings include: Review of the facility policy titled "Transfer and Discharge . . ." occurred on 02/08/24. This policy, dated 01/02/17, stated, ". . . 2. . . . f. A copy of the original notice must be given to the resident (sent to hospital with resident and other pertinent papers see letter d.), with a copy given to the resident's representative and a copy placed in the resident's medical record. . . ." A review of medical records showed the following residents were transferred to the hospital and received a "Notice of Transfer of Hospitalization/Emergency Transfer" that lacked a date by which to appeal: * Resident #11 on 01/03/24 * Resident #23 on 10/11/23 * Resident #72 on 08/11/23 and 10/07/23. Resident #72's medical record also identified the resident representative gave verbal permission for the transfers however lacked evidence the representative received a copy of the notice of transfer.	F 623	affected. 3. An in-service education program was conducted by the Director of Nursing, or designee, with all nursing staff addressing proper completion of the Notice Before Transfer/Discharge form from the facility by 02/29/2024. 4. For a period of four (4) weeks, Resident Trustee or designee, will conduct a record audit of all residents who have been transferred or discharged from the facility to ensure the record includes a copy of the transfer/discharge notice and proper completion of the form. For All residents transferred/discharged, the Notice of Transfer will be faxed to the State Ombudsman Office as needed and a copy of the successful fax transmission will be kept to prove delivery. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting until the committee determines consistent substantial compliance has been met. 5. Corrective action completion date: 03/14/2024	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		3/14/24

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F 641	Continued From page 6 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/09/23. Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 4 sampled residents (Resident #7 and #51) reviewed with alarms. Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2023, Section P: Restraints and Alarms, page P-10, stated, ". . . Identify all alarms that were used at any time (day or night) during the 7-day look-back period. . . .Code 0, not used: . . . Code 1, used less than daily: . . . Code 2, used daily: . . . Bed alarm includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing. Chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing. . . ." - Review of Resident #7's medical record occurred on all days of survey. The care plan identified a tab alarm for a fall/safety intervention, dated 09/15/23. The quarterly MDS, dated 11/25/23, identified in Section P, alarms "not used."	F 641	1. Resident #7 was reassessed on 02/16/2024 to include the use of bed alarm and chair alarms. Resident #51 was reassessed on 02/08/2024 to include the use of bed and chair alarms. 2. The facility has determined that all residents who use alarms have the potential to be affected. 3. An in-service education program with MDS Coordinator(s) and nurse managers addressing the importance of identifying the use of alarms and the effect on the resident will be conducted by 02/29/2024. The MDS Coordinator and MDS nurse will complete a Healthcare Academy Education Module reflective of Section P in the MDS for proper coding by 03/14/2024. 4. The MDS nurse, or designee, will conduct an audit of all residents that use alarms in the buildings initially, then monthly on 5 random residents for 1 year or until substantial compliance is met. These residents and their medical records will be assessed to ensure that the alarms are identified, properly evaluated, and documented in the medical record by 02/29/2024 This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting until the committee determines consistent substantial compliance has	

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F 641	Continued From page 7 Observation on 02/06/24 at 7:23 a.m. showed Resident #7 in bed, and a certified nurse aid (CNA) (#2) removed a tab alarm from the resident's clothing. Observation also showed an alarm on Resident #7's bed and wheelchair. During an interview on 02/08/24 at 8:25 a.m., an administrative nurse (#1) confirmed staff failed to code the alarms in Section P of the MDS for Resident #7. - Review of Resident #51's medical record occurred on all days of survey. The care plan identified an alarm to the bed and chair for a fall/safety intervention, dated 10/27/23. The quarterly MDS, dated 12/27/23, identified in Section P, alarms "not used." During an interview on 02/07/24 at 3:00 p.m., an administrative nurse (#1) confirmed staff failed to code the alarms in Section P of the MDS for Resident #51.	F 641	been met. 5. Corrective action completion date: 03/14/2024	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of standing orders, and staff interview, the facility failed to follow professional standards regarding physician's orders for 1 of 2 sampled residents (Resident #4) and 1 closed record (Resident #82)	F 658	1. Resident # 4 primary care physician was called on 02/07/2024, updated on resident□s blood glucose level and when to be notified regarding blood sugar level. Resident #82 has expired.	3/14/24

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F 658	Continued From page 8 reviewed for insulin orders. Failure to follow the physician's order regarding notification of high blood sugar levels has the potential to result in adverse events. Findings include: - Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included Type 2 diabetes mellitus. Observation on 02/07/24 at 11:05 a.m. showed a nurse (#3) checked Resident #4's blood sugar with a glucose meter and obtained a result of 336 milligrams per deciliter (mg/dL). Review of the Medication Administration Record (MAR) for sliding scale insulin identified ". . . Per Sliding Scale . . . Special Instructions: Call PCP [primary care provider] if Blood sugar greater than 300 [mg/dL] . . ." During an interview on 02/07/24 at 3:07 p.m., the nurse (#3) who obtained Resident #4's blood sugar and administered the sliding scale insulin stated she did not notify the provider as she did not see on the order to call if over 300 mg/dL. Review of Resident #4's blood sugar results from 09/01/23 to 02/07/24 showed six times the blood sugar results were above 300 mg/dL. The medical record lacked documentation staff notified the provider of the blood sugar results over 300 mg/dL. - Review of Resident #82's medical record occurred on 01/08/24. Review of the resident's blood sugar levels showed the following: * 01/06/24 at 7:17 a.m. blood sugar 408 mg/dL	F 658	2. The facility has determined that all residents who are diabetic and/or have blood glucose levels checked are at risk. 3. An in-service was conducted by the Director of Nursing and/or designee with all licensed nursing staff addressing and reviewing the importance of following standing orders, medical doctors orders, and proper documentation in the medical record completed by 2/29/2024. 4. The Nurse Managers, or designee will conduct a record audit on 10 random people with diabetes weekly for (4) consecutive weeks, then monthly thereafter for 1 year or until substantial compliance has been met. The audit will evaluate residents' blood glucose readings to ensure that residents' orders for blood glucose notification is being completed and documented in the medical record This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting until the committee determines consistent substantial compliance has been met. 5. Corrective action completion date: 03/14/2024	

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F 658	Continued From page 9 * 01/06/24 at 11:38 a.m. blood sugar 404 mg/dL * 01/08/24 at 7:42 a.m. blood sugar 421 mg/dL Resident #82's undated physician standing orders stated, "Diabetic Treatment . . . Blood Sugar > [greater than] 400 mg/dL notify the MD [medical doctor] by telephone." The medical record lacked physician notification of the blood sugars over 400 mg/dL.	F 658		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished	F 849		3/14/24

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F 849	Continued From page 10	F 849		

to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including

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F 849	Continued From page 11 spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to	F 849		

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 _____	C 02/08/2024

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 849	Continued From page 12 assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the	F 849		

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F 849	Continued From page 13 facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents' records contained the hospice election form for 2 of 2 sampled residents (Resident #72 and #189) receiving hospice services. Failure to obtain this document limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: - Review of Resident #72's medical record occurred on all days of survey and identified the resident elected hospice services on 12/06/23. The medical record lacked the hospice election form. - Review of Resident #189's medical record occurred on all days of survey and identified the resident elected hospice services on 01/30/24. The medical record lacked the hospice election form. During an interview on 02/08/24 at 10:33 a.m., an	F 849	1. Resident # 72 and #189 elections of hospice benefits were uploaded into their medical records on 02/07/2024. 2. The facility has determined that all residents opting to receive hospice services are at risk. 3. The Director of Nursing Services contacted CHI St Alexius Hospice on 02/09/2024 via email. The Director of Hospice and Hospice Lead Coordinator were updated regarding the issues of obtaining a copy of the hospice elections benefits form on residents receiving hospice services. CHI St Alexius Hospice Directors reported they will work on a process within the CHI Hospice Organization to ensure that hospice records are easily obtained. Medical records/Ward Clerk and Director of Nursing Services developed a checklist to be put in place to mark off records as they are scanned into the medical record to	

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F 849	Continued From page 14 administrative nurse (#1) confirmed the medical record lacked the hospice election form for Resident #72 and #189.	F 849	ensure all needed records are obtained. 4. The Director of Nursing Services or designee will conduct a record audit of all newly admitted hospice residents for (12) consecutive months or until substantial compliance has been met. The audit will evaluate the resident's records to ensure that residents' election of hospice benefits and routine hospice records are in the medical record. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting until the committee determines consistent substantial compliance has been met. 5. Corrective action completion date: 03/14/2024	