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 02/27/2019

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 An unannounced onsite complaint survey was completed on February 27, 2019.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		4/3/19

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

Electronically Signed | 03/13/2019

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F 580	Continued From page 1 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of charge nurse orientation checklist, and staff interview, the facility failed to notify the resident representative in a timely matter for 1 of 1 sampled resident (Resident #5) who experienced an injury of unknown origin. Failure to promptly notify the resident representative in a timely matter of an injury limited their ability to make informed decisions regarding medical care. Findings include: When requesting a policy regarding notification of resident representative, the facility provided a "Charge Nurse Orientation Checklist". This checklist, revised April 2018, stated, ". . . Notification of family or POA [power of attorney] of all changes. (Falls, Skin issues notify at time found) . . ."	F 580	1. Resident #5's daughter was informed of the skin issue on 2/17/19. 2. All residents in the facility may be affected by this deficiency. 3. Education will be provided by the director of nursing about the policy titled, "Notification of Changes" and document titled, "Notification Form" will be made to all nursing staff at the 3/21/19 all nursing staff meeting. 4. Monitoring of Resident #5 and all other resident with notification of changes will be done by the unit care managers starting on 27th of March 2019 and be done daily Monday to Friday for 2 weeks, weekly for 2 weeks, monthly for 3 months, and 3 times quarterly. All results will be taken to the Director of Nursing and QA committee with concerns.	

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F 580	Continued From page 2 Information received from the complainant indicated the facility staff failed to notify the resident's representative of a skin injury in a timely matter. Review of Resident #5's medical record occurred on 02/27/19. The nursing progress notes identified the following: * 02/15/19 - 1:40 a.m. "Resident has x2 [times 2] areas on buttock, one on each cheek, that are red and the top layer of skin has been abraded off. Area cleansed and protective cream applied. Will ask day nurse to call family and will fax PCP [primary care physician]. They measure 8-8 1/2 cm [centimeters] long and width is 1/2 cm to 2 1/2 cm, as the width varies in areas." * 02/16/19 - 8:00 p.m. "Weekly skin assessment done. . . . Continues to have abrasions on buttocks; bacitracin applied. . . ." * 02/17/19 - 6:00 p.m. "Resident's daughter [name] was here this afternoon. Talked to her about resident's abrasions on her buttocks. . . ." During an interview on 02/27/19 at 3:20 p.m. an administrative nurse (#1) confirmed staff failed to notify Resident #5's representative of the skin injury in a timely matter.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		4/3/19

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F 609	Continued From page 3 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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: Based on record review and review of the facility's policy, the facility failed to ensure an alleged violation involving an injury of unknown source, was reported within 24 hours to the State Survey Agency for 1 of 1 sampled resident (Resident #5) who sustained an injury of unknown source. Failure to identify an injury of unknown source and report the alleged violation to the State agency, placed Resident #5 and other residents at risk for possible neglect and/or further injury. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 02/27/19. This	F 609	1. Resident #5 had an allegation report submitted on 2/18/19 to the state health department. 2. All residents in the facility may be affected by this deficiency. 3. Education will be provided by the director of nursing about the policy titled, “Abuse, Neglect and Exploitation” to the all nursing staff meeting on 3/21/19. 4. Monitoring of Resident #5 and all other residents for notification of abuse, neglect, and exploitation will be done by the Social Worker starting on 27th of March 2019 and be done daily Monday to Friday for 2 weeks, weekly for 2 weeks, monthly for 3 months, and 3 times	

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F 609	Continued From page 4 policy, dated November 2017, stated, Reporting of Abuse, Neglect - all alleged violations will be reported to the Department of Health . . . Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source . . . are reported not later than 24 hours if the advents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency . . .)" Review of Resident #5's medical recorded occurred on 02/27/19. The nursing progress notes identified the following: * 02/15/19 - 1:40 a.m. "Resident has x2 [times 2] areas on buttock, one on each cheek, that are red and the top layer of skin has been abraded off. Area cleansed and protective cream applied. Will ask day nurse to call family and will fax PCP [primary care physician]. They measure 8-8 1/2 cm [centimeters] long and width is 1/2 cm to 2 1/2 cm, as the width varies in areas." The State Surveying Agency received an initial allegation report on 02/18/19, three days after the unknown injury to the buttocks. The facility failed to report the injury of unknown source within 24 hours to the State Survey Agency.	F 609	quarterly. All results will be taken to the Director of Nursing and QA committee with concerns.	