PRINTED: 03/05/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	R 03/01/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An on-site revisit was conducted on 03/01/12 to determine compliance with the deficiencies identified during the January 8-11, 2012 recertification survey. The revisit sample included 10 residents for focused review of the areas of non-compliance.	{F 000}	F315: 1. To address resident #4, #6, and #9 failure to consistently implement scheduled toileting times according to the My Daily Living Plan, staff will fill out time and initial new Daily Bowel and Bladder record for each resident toileted. The charge nurse will monitor these forms and report to the neighborhood supervisor.	3/7/12
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 implement scheduled toileting times for 3 of 5 sampled residents (Resident #4, #6, and #9) on a scheduled toileting plan for bladder incontinence. Failure of staff to implement scheduled toileting plans, at times consistent with the residents' determined voiding habits/patterns, placed these residents at risk for avoidable increased bladder incontinence, urinary tract infections, and also has the potential to compromise residents' individual dignity. Findings include:	F 315	2. Other residents who are susceptible to this deficient practice are those residents who are on daily bowel and bladder toileting programs. 3. The restorative nursing program policy for bowel and bladder will be revised to include specific guidelines. Staff will be educated regarding the revised policy and guidelines and will be educated on A daily bowel and bladder toileting record on all residents on a bowel and bladder program as well. All residents on bowel and bladder program will be added to the daily report sheets. The charge nurse on duty will update staff during the verbal report about anyone on this program.	

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 315	Continued From page 1 - Review of the medical record for Resident #4 occurred on 03/01/12. The current annual Minimum Data Set (MDS), dated 12/19/11, identified Resident #4 with a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition; and identified the resident as able to make self understood, able to understand others, needing extensive assistance of two or more staff members for toilet use, frequently incontinent of bladder, and on a current urinary toileting program. Resident #4's current plan of care (My Daily Living Needs) in regard to incontinence stated, "Toileting Plan: To maintain or improve my continence - Help me to the commode before and after meals, every 2-3 hours at night and as I request. I may use the bedpan if I request . . . Pull up Brief [incontinent brief] - Days [and] Regular Brief at Night . . ." Observations on 03/01/12 showed staff did not toilet Resident #4 before or after the noon meal, as identified in her plan of care. During an interview on 03/01/12 at approximately 2:15 p.m., a certified nursing assistant (CNA) (#4) stated they take Resident #4 to the bathroom when she requests. The CNA further identified Resident #4 had not requested that staff take her to the toilet before the noon meal, or after the noon meal on this date. Observation on 03/01/12 at 2:25 p.m. (10 minutes after the interview) showed the CNA (#4) assisted Resident #4 with toileting. Observation showed Resident #4's incontinent brief was wet with urine,	F 315	4. For one week nursing management personnel and charge nurse on duty will complete 62 monitors for those residents that are on a daily bowel and bladder program. For the remainder of March, nursing management & charge nurse will complete 31 monitors per week on random residents on the program. After March monitors will continue at 20 per month. If at that time consistency is proven QA committee will decide the rate of monitors to be completed. All results of monitors will be reviewed by the QA committee for follow-up as needed.	

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F 315	Continued From page 2 and the resident also urinated in the commode. - Review of the medical record for Resident #6 occurred on 03/01/12. The current quarterly MDS, dated 02/08/12, identified Resident #6 with a BIMS score of 14, indicating intact cognition; and identified the resident as having unclear speech, sometimes able to make self understood, able to understand others, needing extensive assistance of one staff member for toilet use, and frequently incontinent of bladder. Resident #6's current plan of care (My Daily Living Needs) in regard to incontinence stated, "Toileting Plan: Toilet me upon rising, before and after meals, every 2-3 hours at night, and as needed. Toilet me at 10:00 PM every evening . . . Large Brief [incontinent brief] . . ." Observations on 03/01/12 showed staff did not toilet Resident #6 before the noon meal or after the noon meal, as per his plan of care. On 03/01/12 at 12:10 p.m., after the resident had finished his noon meal, observation showed Resident #6 lying in bed, incontinent of bowel and bladder. A CNA (#5) provided pericare to Resident #6 and changed the resident's brief. The CNA made no attempt to toilet Resident #6. During an interview on 03/01/12 at 2:20 p.m., an administrative nurse (#2) stated she would expect staff to toilet residents according to their scheduled toileting plans. - Review of Resident #9's medical record occurred on 03/01/12. The current quarterly MDS, dated 01/23/12, identified Resident #9 with a BIMS of 8 indicating moderately impaired	F 315		

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F 315	Continued From page 3 cognition; and identified the resident as able to make self understood, able to understand others, needing extensive assistance of two or more staff members for toilet use, occasionally incontinent of bladder, and currently on a urinary toileting program. Resident #9's current plan of care (My Daily Living Needs), dated 02/15/12, stated, ". . . Toileting plan: To maintain or improve my continence take me to the bathroom before meals, promptly after lunch, after breakfast and supper, at bedtime and every 2-3 hours at night and as I request. Take me to the bathroom before I go to any activity. . . ." Observations on 03/01/12 showed staff did not toilet Resident #9 after the noon meal or before the group activity she attended at 2:05 p.m., as identified in her plan of care. During an interview on 03/02/12 at 2:10 p.m., a CNA (#7) stated they take Resident #9 to the bathroom per her request, and the staff last toileted the resident before lunch. During an interview of 03/01/12 at 2:30 p.m., an administrative nurse (#2) stated she expected staff to follow residents' scheduled toileting plans, and staff should have toileted Resident #9 prior to attending an activity.	F 315		