| 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 03/24/2011 |

| 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 |
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| {F 000} | INITIAL COMMENTS<br><br>An on-site revisit was conducted 03/24/11 to determine compliance with the deficiencies identified during the 01/27/11 survey. The revisit sample included 13 residents for focused review of the areas of non-compliance. | {F 000} | | |
| {F 309} SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, facility policy review, and staff interview, the facility failed to provide necessary care and services regarding feeding assistance for 1 of 1 sampled resident (Resident #1) offered food not altered to dime-size pieces as ordered and being provided water by a staff member while lying in bed. Failure to provide appropriate feeding assistance may result in choking and/or aspiration.<br><br>Findings include:<br><br>Review of the facility policy titled "Dining Assistance" occurred on 03/24/11. 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 | {F 309} | 1. F309. Resident # 1 was care planned to eat at a ninety-degree angle. He was also care planned to have food cut up into dime size pieces. Staff re-education began on 3/25/11 with monitoring continuing to ensure follow through.<br>2. All residents with a swallowing problem have the potential to be effected.<br>3. CNAs re-education began on 3/25/11and monitors continue to ensure the correct consistency of food and/or fluids are offered to the residents. The Dietary Manager will educate Staff again on consistency of foods and fluids on 4/7 in group setting. The Occupational Therapist will educate staff on proper positioning of a resident for dining and fluid intake 4/7 in formal group session. Staff were also offered CNA Education sessions with Staff development personnel for additional training. Systemic changes include: Dietary will now cut up all fruits in dime size pieces for all residents with mechanical soft ground or recommended dime size pieces.<br>4. Staff Development Nurse and Supervisory nursing staff and dietary manager or designee will monitor each meal five days a week for one week. Monitoring will then continue one meal per day rotating between meals for two months. Random monitors will then occur 3x week continually. | 4/11/11 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 3/31/11 |

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 309} | Continued From page 1<br>of bed elevated . . . be sitting up to make swallowing easier and reduce the risk of aspiration and choking. . . ."<br><br>- Observation on 03/24/11 at 11:50 a.m., showed Resident #1 sitting in the dining room with his head lying on the table. Facility staff delivered his dinner tray which contained the following food consistencies; quarter-sized pieces of cantaloupe, egg noodles, a slice of bread, ground meatloaf, and pureed corn. At 12:00 p.m., facility staff sitting at another table observed the resident with his head still lying on the table. She cued the resident to "Sit up and eat". Resident #1 began slowly eating. At 12:13 p.m., a Certified Nursing Assistant (CNA #29) sat down next to Resident #1 and began feeding him. Between bites, she cut his cantaloupe into dime-sized pieces. The "Diet Card" lying on the resident's tray identified "Regular Mechanical Soft Food with all foods cut in dime-sized pieces [and] ground meat (Speech Recommend)."<br><br>- Observation on 03/24/11 at 1:00 p.m., showed a CNA (#28) raised the head of Resident #1's bed to an approximate 30-40 degree angle, and offered him a drink of water. The resident lifted his head, took a drink of water, and laid his head back down on the pillow before swallowing.<br><br>Resident #1's medical record, reviewed March 24, 2011, identified current diagnosis of Alzheimer's dementia. The resident's quarterly Minimum Data Set (MDS), dated 09/17/10, identified problems with long term memory and moderately impaired decision making skills. His annual MDS, dated 03/15/11, identified limited assistance from one person for eating, coughing or choking during meals or when swallowing | {F 309} | At any time concerns are identified immediate corrective action/retraining and new monitoring will be implemented. The results of the Monitors will go directly to DNS and the QI nurse will submit a report to the QA committee at each scheduled meeting. | |

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| {F 309} | Continued From page 2<br>medications, and mechanically altered diet.<br><br>The current care plan/My Daily Living Needs, updated 03/18/11, identified the following:<br>* ". . . I receive mechanical soft foods and whole meats cut into dime size pieces so that I am able to chew them. . . ."<br>* "Elevate: Head of Bed; 90 degrees when eating . . ."<br>* "Eating: Assist . . ."<br>* "Other Notes: . . . elevate the head of my bed 90 Degrees . . ."<br><br>Review of education provided to certified nursing assistants on 02/17/11, stated, ". . . 9. Proper feeding positions also need to be followed: St. Lukes standard is when feeding a resident in bed the resident must be positioned at a 90 degree angle to ensure safe swallowing of food and fluids. Residents in a w/c [wheelchair] must be positioned in an upright position or sitting upright in a chair. Any changes to this protocol will be specifically care planned. . . ."<br><br>During an interview on 03/24/11 at 2:40 p.m., two management nursing staff members (#20 and #35) agreed staff should offer food consistencies consistent with the residents' care plans/diet cards and should not offer liquids and/or food while they are in a reclined position.<br><br>The facility failed to provide food that was altered into dime-sized pieces on his dinner tray and/or assist him in the dining room, and failed to raise the head of his bed to a 90 degree angle prior to offering him a drink of water. | {F 309} | | |
| {F 441} SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS | {F 441} | | |

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| {F 441} | Continued From page 3<br>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 of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by: | {F 441} | F441.<br>1. Residents #2 &13 were to have hands cleaned before leaving the room. Residents #3-12 were to have hands cleaned after toileting. Staff re-education began on 3/25 with continuing monitoring concerning washing hands of residents after toileting and those residents with MRSA or VRE before leaving their room, and hand hygiene of staff after removing gloves.<br><br>2. All residents have the potential to be affected.<br>3. As a systemic change, the policy on hand hygiene for staff was revised to include hand hygiene after toilet use for the residents on 3/30/11. Staff re-education began 3/25 on hand hygiene on staff and residents with monitoring continuing from that time. Another formal training session on infection control will be held on 4/7.<br>4. The Infection Control Nurse, will be responsible to manage the monitoring by Supervisory nursing staff and staff development nurse to monitor compliance with staff and resident hand hygiene practices and policy. Monitors will be completed with the above residents identified 1x per shift for 1 week and for 3 extra random residents 1x per shift for 1 week. If compliance continues monitors will be continued 3 residents per week per shift for 2 | 4/11/11 |

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| {F 441} | Continued From page 4<br>Based on observation, record review, and staff interview, the facility failed to follow accepted infection control practices for handwashing and glove usage for 5 of 9 sampled residents (Resident #3, #9, #11, #12 and #13) observed receiving staff assistance with toileting and 1 of 1 sampled resident (Resident #4) in contact isolation. Failure to follow proper hand hygiene has the potential to contaminate clean surfaces and clothing and spread infection to residents, visitors, and staff.<br><br>Findings include:<br><br>Review of "Care Plan Education for Certified Nursing Assistants" occurred on 03/24/11. This record, undated, stated, ". . . 13. Always remember good hand washing or hand hygiene with alcohol gel. Complete hand washing after pericares, inc [incontinent] cares, anytime you remove gloves. Also remember to wash resident hands before leaving the rooms (specifically any resident with MRSA or VRE). Always wash your hands before leaving a resident room."<br><br>- A random observation on 03/24/11 at 12:20 p.m. showed a Certified Nursing Assistant (CNA) (#33) assisted Resident #11 with toileting needs. The CNA (#33) removed the resident's stool filled brief. The resident grabbed his genitals and then gestured to the CNA to wash the stool from his hand. The CNA used a wet washcloth and wiped the stool from the resident's left hand and lowered him onto the toilet. The CNA (#33) provided pericare and Resident #11 assisted by repositioning his genitals during cleansing. The CNA (#33) applied a brief and assisted him into his wheelchair. Resident #11 wheeled himself to the dining room and ate lunch. The CNA failed to | {F 441} | months and 3x random residents week thereafter. The results of the monitoring will go directly to the DNS. If concerns are identified, immediate corrective action/retraining/re-monitoring 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. | |

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| {F 441} | Continued From page 5<br>wash Resident #11's hands after he touched his genitals the second time and before eating lunch.<br><br>- A random observation on 03/24/11 at 12:40 p.m. showed a CNA (#34) assisted Resident #12 into the bathroom. The CNA (#34) pulled down the resident's pants. The resident put her hand inside her underwear, touching her pad, and stated, "I'm wet. Am I wet?" The CNA (#34) stated, "Yes. Don't touch that." The CNA (#34) placed a new pad inside the resident's underwear following toileting. Resident #12 reached inside her underwear and repositioned the pad. The CNA (#34) assisted the resident into her wheelchair. The CNA failed to offer assistance or remind the resident to wash her hands.<br><br>- An observation of Resident #3 occurred on 03/24/11 at 9:20 a.m. A CNA (#23) assisted the resident into the bathroom. The CNA (#23) provided Resident #3 pericares following a bowel movement and assisted the resident into a wheelchair. The CNA (#23) failed to offer the resident handwashing. The CNA (#23) pushed the resident out into the hallway without washing or sanitizing her hands. The CNA (#23) left the resident in the hallway, re-entered the room, took the periwipes and ointment, opened the closet door, and put the items in the closet. The CNA (#23) applied hand sanitizer.<br><br>- An observation of Resident #9 occurred on 03/24/11 at 1:20 p.m. A CNA (#23) assisted the resident onto the toilet using a stand up lift. The CNA provided pericares following toileting and assisted the resident into her wheelchair. The CNA (#23) failed to offer handwashing to Resident #9.<br>- Observation, at 12:25 p.m. on 03/24/11, showed | {F 441} | | |

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| {F 441} | Continued From page 6<br>a CNA (#33) provided perineal cares to Resident #13 after the resident used the toilet in her bathroom. A sign in the bathroom next to the sink stated, "Attention: Please have resident wash hands with alcohol gel before leaving room." The CNA washed her hands in the sink and then transferred Resident #13 to her wheelchair and brought her out to the dining room. The CNA did not have Resident #13 wash her hands or use alcohol gel prior to leaving the room.<br><br>- Review of Resident #4's medical record occurred on 03/24/11. Diagnoses included methicillin-resistant staphylococcus aureus (MRSA) of nares and ulcer on the left heel.<br><br>A random observation on 03/24/11 at 9:40 a.m. identified Resident #4 in contact isolation. A facility staff identified Resident #4 was in contact isolation precautions for MRSA in a foot wound. 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.<br><br>Observation on 03/24/11 at 11:35 a.m. showed three CNA'S (#30, #31, and #32) gowned and gloved, then transferred Resident #4 to her wheelchair using a full body mechanical lift. After completing the transfer, the CNA's removed their gowns and gloves, washed their hands and transported the resident to the nurses station, dining room, and to the beauty salon to have her nails done. The CNA's failed to wash Resident #4's hands prior to leaving the room.<br><br>During an interview, the afternoon of 03/24/11, an administrative nursing staff member (#2) agreed staff should have residents in isolation wash their | {F 441} | | |

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| {F 441} | Continued From page 7<br>hands before leaving their rooms. | {F 441} | | |