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 03/30/2022

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
E 000	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on March 29-30th, 2022. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and complaint survey was conducted on March 29 - 30, 2022. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and will be cited at F880. The facility had no positive COVID-19 resident(s) in the facility at this time.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of facility policy, and staff interviews, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 3 sampled residents (Resident #3) with a history of falls. Failure to respond to call lights in a timely manner may result in incontinenece and falls with/without injury.	F 558	F558 Reasonable Accommodations Needs/Preferences 1. Immediate action(s) taken for the resident(s) found to have been affected include: The call light for resident # _3_ was placed within easy reach and answered within a reasonable amount of time.	5/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2022

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 03/30/2022

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 558	Continued From page 1 Findings include: The complainant alleged the facility failed to answer residents' call lights in a timely manner. Review of the facility policy titled "Call light: Accessibility and Timely Response" occurred on 03/30/22. This policy, dated April 2021, stated, ". . . all staff members who see or hear an activated call light are responsible for responding . . ." Observation on 03/29/22 at 4:07 p.m. showed Resident #3 in a recliner, with a partially raised footrest, and the call light activated. A certified nursing assistant (CNA), (#5) entered the room at 4:24 p.m. (17 minutes later) to assist the resident with toileting cares. Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, osteoarthritis, weakness, and compression fracture lumbar vertebrae. The quarterly Minimum Data Set (MDS), dated 03/11/22, identified partial/moderate supervision required for transfers . . . occasional incontinence . . . fall with injury 12/19/21 . . ." The current care plan identified, ". . . has some urinary incontinence/dribbling, . . . asks for assistance from time to time . . . history of falls while transferring to bathroom . . . at risk for falls . . . staff to offer assistance with FWW [front wheeled walker] for ambulation . . . 12/19/21 tripped over her walker while transferring from her bed to recliner . . ." During an interview on 03/29/22 at 4:40 p.m., a staff nurse (#12) stated, "We are short staffed	F 558	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Staff Development and DON provided Inservice education programs for all direct care personnel addressing policies and procedures, regulations, and facility expectations of staff to assure the accessibility of call lights in resident rooms at all times and timely response was completed on or by 5/3/2022 for all staff____. Cal-lights Accessibility and Timely Response policy was reviewed and revised. Staff educated on updated policy. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Unit manager(s) will make rounds one (1) times daily for (1) wee. Random checks will be made (2) times per week for two (2) additional weeks to ensure compliance. Random Checks will continue to be made (1) time per month for (3) months, then quarterly for (3) additional times to ensure compliance. The night shift supervisor or designee will provide checks of the same frequency and duration to ensure compliance 24/7.	

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 03/30/2022

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 558	Continued From page 2 today." She explained they did not have the required number of staff members on Unit 2 (Homestead) from 4:00-4:30 p.m. During an interview on 03/30/22 at 8:11 a.m., two administrative staff members (#2 and #3) confirmed Unit 2 (Homestead) did not have the required staff coverage on from 4:00-4:40 p.m. on 03/29/22. The administrative staff member (#3) reported she expects staff to answer call lights "within 5 to 10 minutes for safety reasons".	F 558	These random checks will be completed on resident #3 with an additional 5 residents per unit. Audits will focus on call light wait times. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: __05/03/2022_____.	
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	F 580		5/3/22

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 03/30/2022

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 580	Continued From page 3 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 (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 facility policy, and staff interview, the facility failed to notify the physician and/or resident representative of falls for 1 of 4 sampled residents (Resident #4) reviewed for falls. Failure to promptly notify the physician and/or the resident representative of a fall limits their ability to be fully informed of the resident's status. Findings include: Information received from the complainant	F 580	F580 Notify of Changes 1. Immediate action(s) taken for the resident(s) found to have been affected include: Facility immediately updated family and provider regarding resident falls that occurred in December of 2021. The facility will immediately implement appropriate measures to ensure that providers and families are updated on any change in resident status.	

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 03/30/2022

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 580	Continued From page 4 indicated the facility staff failed to notify the provider and/or resident's representative of a change in the resident's condition. Review of the facility policy titled "Falls" occurred on 03/30/22. This policy, revised 11/12/19, stated, ". . . The Physician will be updated regarding the residents fall . . . The POA [power of attorney (also referred to as resident representative)] will be updated regarding the resident's fall. . . ." Review of Resident #4's medical record occurred on all days of survey and identified the resident with severe cognitive impairment and a representative listed. Review of Resident #4's fall records, dated December 2021 through March 2022, identified the facility failed to notify the resident's representative about a fall that occurred on December 15, 2021 and failed to notify the provider and the resident's representative about falls that occurred on December 26 and 27, 2021. During an interview on 03/30/21 at 10:27 a.m., an administrative staff member (#1) confirmed the facility failed to notify Resident #4's representative and/or the provider about several falls that occurred.	F 580	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Director of Nursing Services with all licensed nursing staff addressing circumstances that require notification of the resident□s physician, legal representative or family member of change in status, falls, any incident, significant alteration in treatment, change in room or plan for transfer or discharge to another facility. Reviewed and Revised policy Falls, and Notification of Changes on 4/21/2022. Nursing staff educated on policy updates. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct a random audit of six (6) residents weekly for four (4) consecutive weeks. Random audit will be completed monthly for (3) months, and then quarterly for (3) times. These residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated and communicated to the appropriate people. This plan of correction will be monitored	

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 03/30/2022

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 580	Continued From page 5	F 580	at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: _____05/03/2022_____.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of Safety Data Sheets (SDS), and staff interview, the facility failed to ensure an environment free of accident hazards on 1 of 4 kitchenettes (Western Unit). Failure to ensure filled sanitizer buckets are kept out of a resident's reach, label all chemical containers, and store chemical and cooking items in locked drawers/cupboards placed the residents at risk for injury. Findings include: Review of the SDS for Ecolab 6114821 Apex (Trademark) Solid Sanitizing (chlorine) Tablet stated, ". . . Harmful if swallowed or in contact with skin. Causes serious eye damage . . ." Review of the SDS for cooking spray (food	F 689	1. All items found to be hazardous to residents on Western Unit were removed the day of survey. Sanitizing solution was poured out, the pan spray was empty and was thrown away, and bottle of unlabeled chemical was thrown away. A work order was given to maintenance personnel and broken cupboard locks were fixed the day of the survey with 2 additional locks placed on cupboards to provide safe storage of cooking items. 2. All residents on Western had the potential to be affected by this deficiency. 3. Staff education will be performed by Certified Dietary Manager and Director of Nursing for all facility staff prior to May 3, 2022; to ensure chemicals are labeled or thrown out if not in the original container,	5/3/22

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 03/30/2022

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 689	Continued From page 6 grade) stated, ". . . Causes mild skin irritation . . . eye irritation . . . inhaling the contents can be harmful or fatal. Inhalation may cause narcotic like effects resulting in oxygen deficiency, a risk of unconsciousness as well as central nervous system depression. Symptoms include headache, dizziness, or loss of breath. . . ." Observation on 03/29/22 at 2:21 p.m. showed Resident #5 self-propelled his wheelchair into the Western unit kitchenette, and with no staff present, rummaged through items located on a table adjacent to the steam table and attempted to open a locked cupboard. Observation and interviews on the afternoon of 03/29/22 showed the following: * A red bucket filled with approximately three quarts of liquid set inside the kitchen sink in the Western unit kitchenette. Hand-written instructions on the outside of the bucket stated to mix one chlorine tablet with seven quarts of warm water. The dietary supervisor (#7) identified the liquid contents in the sanitizer bucket as water and chlorine sanitizer. The supervisor stated, "Generally it [contents of the bucket] is dumped out [when finished after meals]." * An uncovered can of cooking spray in an unlocked cupboard. The dietary supervisor (#7) stated, "This [the can of cooking spray] should probably be in a locked cupboard." * A small clear unlabeled bottle containing blue	F 689	all sanitizers and chemicals are locked up or emptied out when not in use, appliances and cupboards are kept locked when not in use, and broken locks are reported to maintenance to get replaced immediately. 4. Education was provided to on duty Dietary employees (verbally) by the CDM on the day of survey including not leaving the sanitizing solution unattended, locking up the sanitizing solution and all chemicals if not in use, and discarding of sanitizing solution after use, placing cooking items in locked cupboards and labeling chemicals when not in original containers. Written information was posted in the Western kitchenette on 4/7/22 to lock sanitizer in cabinet , empty sanitizer when not in use and to not leave sanitizer unattended. Dietary education was performed by the CDM and posted for all dietary staff 4/8/2022 including the above and discarding and reporting of unlabeled chemicals to supervisors, not placing chemicals in unlabeled containers, and placing all chemicals in locked cabinets when not in use. 5. Dietary staff will receive education on CMS regulation F-689- 483.25 (d) at Dietary Meeting prior to May 3, 2022 containing information to ensure chemicals are labeled if not in the original container, all sanitizers and chemicals are locked up or emptied out when not in use, refrigerator and cupboards are kept locked when not in use, and broken locks are reported to maintenance to get replaced.	

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 03/30/2022

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 689	Continued From page 7 liquid located in an unlocked drawer. The dietary supervisor (#7) identified the blue liquid as possible diluted Dawn dish soap and stated staff should have labeled the spray bottle and placed it in a locked cabinet/drawer.	F 689	6. Audits to ensure sanitizing solution is not left out unattended, cupboards and appliances are locked and there are no unlabeled chemicals or cooking sprays in unlocked cupboards will be performed 5 times a week for 2 weeks, 2 times weekly for 3 weeks, 4 times monthly for 2 months and 6 times quarterly for 3 quarters. These audits will be performed by the CDM, Dietitian, or designee. All information gathered during these monitors will be shared and discussed during our monthly quality meetings, with Dietary Employees at monthly meetings, and quality assurance as needed.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		5/3/22

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 03/30/2022

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 812	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, review of professional reference, and staff interview, the facility failed to ensure appropriate concentration levels of sanitizer solution and failed to ensure cupboards/appliances remained locked in 1 of 4 kitchenettes (Western Unit). Failure to consistently test concentration levels of sanitizing solutions may result in unsanitary surfaces and a sanitizer concentration that is either too weak to sanitize or too strong and failure to ensure cupboards/appliances remained locked may result in chemical contamination or injury and has the potential for spread of foodborne illness to residents, staff, and visitors. Findings include: The "Food Code, U.S. Public Health Service, Food and Drug Administration," U.S. Department of Health and Human Services, 2013, page 499, stated, ". . . Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: 1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization; and 2. Too much sanitizer in the final rinse water could be toxic. . . ." Review of the facility policy titled "Dietary Procedure for Mixing & Testing Sanitizing Solution for Surface and Table Sanitizing" occurred on 03/30/22. This policy, dated September 2021, stated, "Dietary staff are responsible for mixing sanitizing solution, testing the sanitizing solution, and recording readings,	F 812	F812 1. The sanitizing solution was emptied out and the refrigerator was locked on the day of survey. 2. All residents and visitors on Unit 4 had the potential to be affected by this deficiency. 3. Verbal education was provided to dietary staff on the day of survey re: mixing, testing, and recording of sanitizing solution and keeping appliances and cupboards locked and reporting broken locks to maintenance. 4. All facility staff will receive education by their department supervisor re: locking of appliances and cupboards when not in use and reporting all broken locks to maintenance for repair prior to May 3, 2022. Dietary staff will receive education re: regulation F-812- 483.60 (i) and mixing of sanitizer per manufacturer recommendations , testing, and recording of sanitizer per facility policy prior to May 3, 2022. 5. Audits to ensure sanitizing solution is mixed to proper strength, tested consistently and that cupboards and appliances are locked will be performed 5 times a week for 2 weeks, 2 times weekly for 3 weeks, 4 times monthly for 2 months and 6 times quarterly for 3 quarters. These audits will be performed by the CDM, Dietitian, or designee. All information gathered during these monitors will be shared and discussed during our monthly quality meetings, with	

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 03/30/2022

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 812	Continued From page 9 each time the solution is needed and prior to using the solution. . . . Sanitizer reading should be 50-100 ppm [parts per million]. . . . If the reading is above 100 ppm, you must dilute the solution with water, and retest the solution. Record the reading on the sanitizing record provided in each kitchen." Observation and interviews on the afternoon of 03/29/22 showed the following: * A red bucket filled with approximately three quarts of liquid set inside a kitchen sink in the Western unit. Hand-written instructions on the outside of the bucket stated to mix one chlorine tablet with seven quarts of warm water. A dietary supervisor (#7) identified the liquid contents in the sanitizer bucket as water and chlorine sanitizer. When asked, the supervisor (#7) used a test strip to test the chlorine concentration in the bucket. The test strip showed a concentration of 200 ppm, and the supervisor stated, "Oh, that's too strong." The supervisor further stated, "Generally it [contents of the bucket] is dumped out [when finished after meals]." Review of the facility's document titled "Nutrition and Food Services Sanitizing Record" for March 1-29, 2022, lacked evidence of testing/test results on 42 of 87 possible entries. During an interview on 03/30/22 at 11:14 a.m., a dietary aide (#11) stated staff are required to test the chlorine concentration of each sanitizer bucket when filled prior to use at the end of each meal and record the test results. The dietary aide confirmed the March 2022 testing log lacked	F 812	Dietary Employees at monthly meetings, and quality assurance as needed.	

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 03/30/2022

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 812	Continued From page 10 several required entries. * An unlocked refrigerator and an upper cupboard with a broken safety latch/lock that contained food items. The dietary supervisor (#7) confirmed the refrigerator is to remain locked, agreed the unlocked cupboard had a broken safety latch, and stated the cupboard should be locked "so the residents can't get in."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		5/3/22

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 03/30/2022

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 880	Continued From page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 03/30/2022

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 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: TRANSMISSION BASED PRECAUTIONS 1. Based on observation, facility policy review, and staff interview, the facility failed to follow infection control practices for 2 of 2 sampled residents (Resident #1 and #2) on Transmission-based precautions (TBP). Failure to follow infection control practices related to proper procedure for personal protective equipment (PPE) usage may result in the spread of infection to residents, staff, and/or visitors. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 03/30/22. This policy, revised 11/01/21, stated, ". . . Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on isolation precautions as recommended by current CDC [Centers for Disease Control] guidelines. . . ." Review of the facility policy titled "Transmission-Based Precautions" occurred on 03/30/22. This policy, revised 03/26/21, stated, ". . . 'Transmission-based precautions' are a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively. . . .	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff entering and exiting a room on droplet precautions donned, doffed disposed of personal protective equipment (PPE), in accordance with CDC guidelines. (2) Ensuring staff have adequate knowledge of hygienic cleaning practices and the facility's cleaning/disinfecting product(s) in order to utilize them correctly for disinfection and cleaning purposes to include increase frequency of monitoring/cleaning of resident bathrooms and rooms. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on selecting, donning, doffing and disposing of PPE	

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 03/30/2022

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 880	Continued From page 13 Type and duration of Transmission-Based Precautions Recommended for Selected Infections and Conditions . . . Infection/Condition . . . Coronavirus (COVID-19) . . . Precaution . . . Droplet/Contact . . . Comments . . . Droplet/Contact with N95 mask, eye protection, gown and gloves . . . " - Observations on 03/29/22 of Resident #2 showed the following: * 10:59 a.m., door closed to room with an isolation cart by the room and a sign on the door that indicated Contact/Droplet isolation precautions. The sign stated, ". . . N95 mask for all staff . . . use gown, gloves and eye covers . . ." * 11:08 a.m., a staff nurse (#4) donned a gown, N95 mask, gloves and entered the room. The staff nurse (#4) failed to don eye protection. * 11:22 a.m., the staff nurse (#4) exited the room, her N95 face mask remained in place, her gown and gloves had been removed and she performed hand hygiene. When asked if staff were required to wear eye protection in Resident #2's room, the nurse (#4) stated yes. - Observations on 03/29/22 of Resident #1 showed the following: * 2:33 p.m., the door to the room closed with an isolation cart by the room and a sign on the door that indicated Contact/Droplet isolation precautions. The sign stated, ". . . N95 mask for all staff . . . use gown, gloves, and eye covers . . . " * 2:49 p.m., a certified nursing assistant (CNA) removed her surgical mask, placed it on top of the isolation cart, removed a used N95 face mask from a paper bag, donned the N95 mask, placed her surgical mask in the paper bag.	F 880	when entering a room on droplet precaution isolation/quarantine procedures. To verify each of these/this staff understands the procedure, the each will perform a successful return demonstration of selecting, donning, doffing and disposing of PPE for providing cares in a droplet precaution room. (2) Educate EVS and Nursing staff on hygienic cleaning technique to prevent cross contamination when cleaning resident rooms on correct dwell times and cleaning product use to achieve desired disinfection in resident rooms/bathrooms to include the need for increased monitoring and need for cleaning/disinfection of resident bathrooms/rooms. To verify these/this staff understands the training, the staff will complete a return demonstration of cleaning a room/bathroom in a hygienic manner using proper dwell times to achieve disinfection and nursing staff will identify times when they would need to provide the cleaning/disinfection. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance.	

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 03/30/2022

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 880	Continued From page 14 Without performing hand hygiene the CNA donned eye protection and a gown, removed gloves from her uniform pocket and entered the room without donning them. * 3:00 p.m., the CNA (#5) exited the room, removed the eye protection, placed them on the isolation cart, and removed the N95 mask cupping it in her palm. The CNA failed to handle the N95 mask properly or perform hand hygiene prior to reapplying the surgical mask. * Observation on 03/30/22 at 10:35 a.m., showed Resident #1's room door open and the bin for soiled isolation gowns by the open door with the cover open. During an interview on 03/30/22 at 3:20 p.m., an administrative nurse (#3) stated she expected staff to wear eye protection when entering isolation room. She expected staff to utilize appropriate donning/doffing technique for isolation rooms and isolation room doors to remain closed as indicated. ENVIRONMENT 2. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 8 sampled residents (Resident #5 and #6) and 4 supplemental residents (Resident #11, #12, #13 and #14). Failure to maintain a clean and sanitary environment has the potential for transmission of communicable diseases and infections to residents, staff and visitors. Findings include: Review of the facility policy titled "Routine	F 880	3. System Changes On or before 05/03/2022 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to select, don and utilize the necessary PPE for droplet precautions isolation/quarantine room access, in accordance with CDC guidelines. b. Failure to ensure cleaning was completed in a hygienic manner with appropriate dwell times to achieve disinfection in accordance with CDC guidelines and cleaning product manufacturer instructions. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose normal duties include entering resident rooms on the correct procedure for selecting, donning, using and doffing PPE when entering a droplet isolation/quarantine precaution room. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. Use https://youtube.com/watch?v=YYTATw9yav4 if prior site not open. b. Educate all staff whose job duties include cleaning tasks on hygienic cleaning procedures including effective contact or dwell times for disinfectants used in the housekeeping/cleaning process. Include increased frequency of	

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 03/30/2022

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 880	Continued From page 15 Cleaning and Disinfection" occurred on 03/30/22. This policy, dated January 2021, stated, ". . . It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. . . . Consistent surface cleaning and disinfection will be conducted with detailed focus on high touch areas to include, but not limited to . . . toilet seats . . . Horizontal surfaces with infrequent hand contact (window sills and hard surface flooring) in routine resident-care areas should be cleaned: a. on a regular basis b. . . . When soiling and spills occur . . ." Observations of resident rooms on 03/29/22 showed the following: * 11:03 a.m., Resident #5 and Resident #13's shared room and bathroom showed the bathroom floor contained a sticky substance and smelled of urine. Most of the floor on Resident #5's side of the room contained a sticky substance with visible dried sticky shoe track marks to the bathroom. At 2:41 p.m., the shared bathroom remained sticky and continued to smell of urine. * 11:17 a.m., Resident #6 and Resident #14's shared room showed a commode located at the foot of Resident #6's bed. The commode contained feces, urine, and perineal cleansing wipes. The floor in front of the commode contained an area of wet and dry feces/urine. Visible dried sticky shoe track marks located on most of the floor on Resident #6's side of the room extended to the exit door of the room. * 11:28 a.m., Resident #11 and Resident #12's shared bathroom showed feces smeared on the	F 880	monitoring of resident rooms and bathrooms. Include examples of when nursing staff should be expected to perform hygienic cleaning. This education will include the CDC's lesson on cleaning available at https://youtu.be/t7OH8ORr5Ig. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of all staff types to ensure correct selection, donning, use and doffing of PPE when entering and exiting droplet precaution isolation/quarantine rooms. (2) Observations of housekeeping and nursing staff engaged in cleaning activities, including increased monitoring of resident rooms/bathrooms, to ensure cleaning and disinfection is completed in a hygienic manner and cleaning products are used in accordance with manufacturer instructions to achieve disinfection.	

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 03/30/2022

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 880	Continued From page 16 front of the toilet bowl, the toilet seat, and the flooring surrounding the toilet and loose brown debris scattered on their bathroom floor. At 3:24 p.m., the shared bathroom continued to have scattered areas of dried feces inside the toilet bowel and the toilet seat and scattered loose debris remained on the bathroom floor. Observations of resident rooms on 03/30/22 showed the following: * 10:42 a.m., Resident #5 and Resident #13's shared bathroom contained dried feces in the toilet, the floor contained a sticky substance and smelled of urine. * 10:45 a.m., Resident #6's room, an area of wet and dry feces/urine located on the floor in front of the commode. During an interview on 03/29/22 at 3:07 p.m., a housekeeping staff member (#6) stated each resident's room in the unit, including the bathrooms and toilets, are cleaned daily and would be recleaned if housekeeping is notified of the need prior to the end of their shift. During interviews on 03/30/22 at 7:20 a.m. and at 3:13 p.m., an administrative staff member (#3) and an environmental staff member (#8) stated unit staff are expected to notify housekeeping if a resident's room needs recleaning. The staff members (#3 and #8) also stated, the unit staff have access to the housekeeping area after the housekeeping staff is done for the day, and the unit staff are expected to clean up soil and spills as needed as they occur.	F 880	Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 05/03/2022	