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 _____	04/10/2025

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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 04/07/25 and concluded 04/10/25.	F 000		
F 880 SS=D	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 §483.71 and following accepted national standards; §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;	F 880		5/15/25

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

Electronically Signed | 04/24/2025

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 880	Continued From page 1 (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. §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: Based on observation, review of facility policy, and staff interview the facility failed to follow	F 880	1. The facility will immediately implement an appropriate infection prevention and	

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F 880	Continued From page 2 standards of infection control for 1 of 4 sampled residents (Resident #62) observed for morning cares. Failure of staff to perform hand hygiene after removing gloves has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 04/10/25. This policy, revised 10/30/24, stated, ". . . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. . . . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . ." Observation on 04/08/25 at 10:09 a.m. showed Resident #62 resting in bed wearing oxygen per nasal cannula and his upper denture sitting on the over the bed table. Two certified nurse aides (CNAs) (#1 and #2) entered the resident's room, performed hand hygiene, donned gloves, assisted the resident to sit on the edge of the bed, placed a gait belt, and transferred the resident from the bed to the wheelchair, and onto the toilet. The CNA (#1) removed Resident #62's wet incontinence brief and changed the resident's pants. The CNAs (#1 and #2) assisted the resident to stand, applied a new brief, pulled up the resident's pants, and transferred Resident #62 to the wheelchair. The CNA (#2) removed her gloves and washed her hands. The CNA (#1) removed her gloves, and without performing hand hygiene, transferred the resident from the bathroom to bed via wheelchair while holding the resident's oxygen tubing in her hands. The CNA	F 880	intervention plan consistent with the requirements of ¿483.80 for the affected resident/unit 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 perform hand hygiene or handwashing after removing gloves after performing perineal care in accordance with CDC guidelines. The DON, staff development coordinator(SDC), IP or designee, in conjunction with applicable IDT members, will:(1) Educate all staff on correctly completing hand hygiene after removing gloves, before touching items that potentially contaminate surfaces, before applying new gloves, and prior to exiting resident rooms. To verify this/these staff understand hand hygiene and handwashing, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for performing. 2. The facility has determined that all residents have the potential to be affected. The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for hand hygiene from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facilitys compliance with the guidelines. The facility will develop action plans to address any newly identified	

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F 880	Continued From page 3 (#1) donned new gloves, removed the gait belt, oxygen cannula, and Resident #62's shirt. The CNA (#1) washed and dried the resident's face and upper body and applied a clean shirt. The CNAs (#1 and #2) assisted Resident #62 to lay on the bed. The CNA (#1) opened the resident's brief, performed perineal cares, closed the brief, and pulled up the resident's pants. The CNA (#1) removed her gloves, and without performing hand hygiene, assisted the resident to sit on the edge of the bed, applied the gait belt, raised the bed, and with CNA (#2) transferred Resident #62 from the bed to the recliner. The CNA (#1) removed the gait belt, made the resident comfortable in the recliner, assisted with a drink of water, adjusted the resident's oxygen cannula, and with a tissue, removed the dentures from the table, and placed them in a denture cup. The CNA (#1) gathered the garbage and soiled linens, exited Resident #62's room, and entered the soiled utility room. The CNA (#1) failed to perform hand hygiene after removing gloves, before touching other surfaces, and before applying new gloves, and failed to perform hand hygiene prior to exiting Resident #62's room. During an interview on 04/09/25 at 2:00 p.m., an administrative nurse (#3) confirmed she expected staff to perform hand hygiene after glove removal and before touching other surfaces, and prior to exiting resident rooms.	F 880	non-compliance. 3. All licensed and non-licensed nursing staff will be in-serviced on the facilitys policy, procedures and infection control standards for hand hygiene. Findings are reviewed with all staff. Corrective action is provided as needed. 4. 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 performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and units. Observations of non-compliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After four 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	

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F 880	Continued From page 4	F 880	committee and medical director. 5. Corrective Action Completion Date: May 15, 2025	