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

PRINTED: 09/10/2015
FORM APPROVED
OMB NO. 0938-0391

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	08/13/2015

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 For the MDS 3.0/Staffing Focused Survey started on 08/12/15 and completed on 08/13/15, the sample included 10 residents for focused review.	F 000		
F 278 SS=F	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278	As of 9/16/15, MDS for identified residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10) was corrected and resubmitted to State and Federal CMS. Due to potential of all residents being affected by the same deficiencies found, as of 9/16/15, education regarding those areas of coding found deficient (active diagnosis, pressure ulcer, admission vs. hospital return, bowel/bladder) were completed with resident care managers performing MDS'. Due to potential of all residents being affected by the same deficiencies found, monitoring for these areas of accuracy of active diagnosis, pressure ulcer, admission vs. hospital return, bowel/ bladder started the week of 9/7/15. The Director of Nursing or designee shall monitor MDS for accuracy, revise as necessary and report to the quality committee. Monitor: Weekly x4; Monthly x3; Quarterly x4	9/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/Administrator	9/21/2015

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 278	Continued From page 1 by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 10 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). Failure to complete the correct MDSs after being discharged from the facility with return anticipated (Resident #1, #5, #6, #7, #8, and #10) and failure to accurately complete portions of the MDS, Section M (Skin Conditions) (Resident #2, #4, #6, and #7), Section I (Active Diagnosis) (Resident #4, #6, #9, and #10), and Section H (Bladder and Bowel) (Resident #3 and #6), does not allow each resident's assessment to reflect the resident's current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI Manual, revised October 2014, on page 2-7 stated, ". . . Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. . . . this date is considered the 1st day of admission. Completion of an OBRA (Omnibus Budget Reconciliation Act) Admission assessment must occur in any of the following admission situations: * when the resident has never been admitted to this facility before; OR * when the resident has been in this facility previously and was discharged return not anticipated; OR * when the resident has been in this facility previously and was discharged return anticipated	F 278		

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F 278	Continued From page 2 and did not return within 30 days of discharge . . ." - Review of Resident #1's medical record occurred on August 13, 2015. Resident #1's record identified a hospital stay from June 09-17, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #5's medical record occurred on August 13, 2015. Resident #5's record identified a hospital stay from July 20-24, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #6's medical record occurred on August 13, 2015. Resident #6's record identified the following hospital stays: * January 12-17, 2015 * April 07-09, 2015 * May 13-17, 2015 The facility completed discharge assessment return anticipated MDSs and upon return from the hospital, incorrectly completed admission MDSs after each hospitalization. - Review of Resident #7's medical record occurred on August 13, 2015. Resident #7's record identified a hospital stay from July 03-06, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #8's medical record	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding admission vs. hospital return anticipated completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding admission vs. hospital return anticipated completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding admission vs. hospital return anticipated completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding admission vs. hospital return anticipated completed with resident care managers performing MDS'.	9/16/15 9/16/15 9/16/15 9/16/15

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F 278	Continued From page 3 occurred on August 13, 2015. Resident #8's record identified a hospital stay from June 27-30, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #10's medical record occurred on August 13, 2015. Resident #10's record identified a hospital stay from July 05-08, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. Resident #1, #5, #6, #7, #8, and #10 all returned to the facility within 30 days of discharge. The Long-Term Care Facility RAI Manual, revised October 2014, pages M-5 and M-6, stated, ". . . M0210: Unhealed Pressure Ulcer(s) . . . Code based on the presence of any pressure ulcer . . . in the past 7 days . . . Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300) . . . M0300: Current Number of Unhealed Pressure Ulcers at Each Stage . . . Steps for completing M0300A-G . . . 2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured that the depth of soft tissue damage cannot be observed, it is considered to be unstageable . . ." Pages M-33 through M-35 stated, ". . . M1040: Other Ulcers, Wounds and Skin Problems . . . Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding admission vs. hospital return anticipated completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding admission vs. hospital return anticipated completed with resident care managers performing MDS'.	9/16/15 9/16/15

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F 278	Continued From page 4 the above. Pressure ulcers coded in M0200 through M0900 should not be coded here . . . M1040E, Surgical wound . . . This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. . . . Surgical debridement of a pressure ulcer does not create a surgical wound. . . . M1040H, Moisture Associated Skin Damage (MASD) . . . Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration . . ." - Resident #2's medical record occurred on 08/13/15. Review of a nurse's wound progress note, dated 06/03/15, stated, ". . . Slit to coccyx, larger in size. Will start hydrogel with Mepilex patch. No maceration noted today. Necrotic tissue to [left] heel ulcer, 60% completely off and 40% open. Cont. [continue] with same dressing . . . No redness or warmth noted to heel." An annual MDS, dated 06/09/15, identified Resident #2 had one unstageable pressure ulcer due to a non-removable dressing/device and one unstageable pressure ulcer due to slough and/or eschar. The medical record lacked evidence Resident #2 had an unstageable pressure ulcer due to a non-removable dressing/device as the MDS indicated. In addition, the facility failed to identify/code the "slit to coccyx" on the resident's MDS (after further assessment, as a staged pressure ulcer or as moisture associated skin damage). - Review of Resident #6's medical record	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding pressure ulcers completed with resident care managers performing MDS'.	9/16/15

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F 278	Continued From page 5 occurred on 08/13/15. Review of a "Skin Integrity Events - Pressure Ulcer Progress" assessment, with an event date of 04/13/15, identified a Stage 3 pressure ulcer to the resident's right ischium. A progress note, dated 04/15/15, stated, "Ulcer to Rt. [right] ischium, measures 0.2 X 0.2 cm [centimeter], non-blanchable dark pink area . . ." An admission MDS (completed following hospitalization), dated 04/17/15, failed to identify Resident #6's Stage 3 pressure ulcer. - Review of Resident #4's medical record occurred on 08/13/15. Review of a nurse's progress note, dated 06/29/15, stated, ". . . Resident coccyx has an open area, cleaned and patted dry, Allevyn patch applied. Will continue to monitor until resolved." A Prospective Payment System (PPS) 30 day MDS, dated 07/08/15, identified Resident #4 had one unstageable pressure ulcer due to a non-removable dressing/device and present upon admission/reentry, one unstageable pressure ulcer due to slough and/or eschar and present upon admission/reentry, and one unstageable pressure ulcer due to deep tissue and present upon admission/reentry. The medical record lacked evidence Resident #4 had an unstageable pressure ulcer due to a non-removable dressing/device, an unstageable pressure ulcer due to deep tissue, and evidence the unstageable pressure ulcer due to slough and/or eschar was present upon admission/reentry as the MDS indicated. During an interview on 08/13/15 at 8:30 a.m. a managerial nurse (#3) confirmed Resident #4's pressure ulcer was miscoded on the 07/08/15	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding pressure ulcers completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding pressure ulcers completed with resident care managers performing MDS'.	9/16/15 9/16/15

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F 278	Continued From page 6 MDS. - Review of Resident #7's medical record occurred on 08/13/15. The admission MDS, dated 07/13/15 identified Resident #7 had a surgical wound. The medical record lacked evidence Resident #7 had a surgical wound. The Long-Term Care Facility RAI Manual, revised October 2014, page I-8 stated, "Item I2300 Urinary Tract Infection (UTI): . . . Code only if all the following are met: 1. Physician . . . diagnosis of a UTI in last 30 days. 2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g. peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria), 3. 'Significant laboratory findings' (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained) and 4. Current medication or treatment for a UTI in the last 30 days. . ." - Review of Resident #4's medical record occurred on 08/13/15 and identified she was hospitalized from June 04-09, 2015. During the hospitalization, a physician performed laboratory tests, diagnosed, and treated the resident for a UTI. A PPS 14 day MDS, dated 06/22/15, failed to identify Resident #4's UTI. - Review of Resident #6's medical record occurred on 08/13/15 and identified she was hospitalized from April 07-09, 2015. During the hospitalization, a physician performed laboratory tests, diagnosed, and treated the resident for a symptomatic UTI. An admission MDS (completed	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding surgical wounds completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding active diagnoses within last 7 days completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding active diagnoses within last 7 days completed with resident care managers performing MDS'.	9/16/15 9/16/15 9/16/15

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F 278	Continued From page 7 following hospitalization), dated 04/17/15, failed to identify Resident #6's UTI. - Review of Resident #10's medical record occurred on 08/13/15 and identified he was hospitalized from July 05-08, 2015. During the hospitalization, a physician performed laboratory tests, diagnosed, and treated the resident for a UTI. An admission MDS, dated 07/15/15, failed to identify Resident #10's UTI. The Long-Term Care Facility RAI Manual, revised October 2014, page H-2 stated, "Section H: Bladder and Bowel . . . H0100: Appliances . . . Check next to each appliance that was used at any time in the past 7 days . . . H0100A, indwelling catheter . . ." Page H-8 stated, "H0300: Urinary Continence . . . Coding Instructions . . . Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter . . . for the entire 7 days. . . ." - Review of Resident #3's medical record occurred on 08/13/15. The resident was admitted to the facility on 05/01/15 with an indwelling catheter in place. The admission MDS, dated 05/08/15, identified the resident had an indwelling catheter and was always incontinent of urine (the MDS should be coded as "9"). - Review of Resident #6's medical record occurred on 08/13/15. Review of the medical record identified a physician ordered the insertion of an indwelling catheter on 12/19/14 and discontinued the catheter on 06/19/15. An admission MDS (completed following hospitalization), dated 05/21/15, failed to identify the resident had an indwelling catheter during the time of the 7-day look-back period.	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding active diagnoses within last 7 days completed with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding appliances with resident care managers performing MDS'. As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding appliances with resident care managers performing MDS'.	9/16/15 9/16/15 9/16/15

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F 278	Continued From page 8 The Long-Term Care Facility RAI Manual, revised October 2014, page I-3 stated, "I: Active Diagnoses in the Last 7 days . . . This section identifies active diseases and infections that drive the current plan of care . . . 1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state license laws) in the last 60 days . . . 2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses . . ." - Review of Resident #9's medical record occurred on 08/12/15. Active diagnoses included type II non-insulin dependent diabetes. The current physician orders identified staff tested the resident's blood sugar twice daily and the resident received an oral antidiabetic medication twice daily. The 30-day scheduled PPS MDS, dated 07/31/15, failed to identify Resident #9's diabetes diagnosis.	F 278	As of 9/16/15, MDS was corrected and resubmitted to State and Federal CMS. As of 9/16/15, education regarding active diagnoses within last 7 days completed with resident care managers performing MDS'.	9/16/15
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		

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F 356	Continued From page 9 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to post the total and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, and the resident census in a visible/available location on 4 of 4 nursing units (Prairie, Western, Homestead, and Badlands) for the residents and visitors. In addition, the facility	F 356		

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F 356	Continued From page 10 failed to maintain the posted daily nurse staffing data sheets for a minimum of 18 months. Failure to post and maintain the daily nurse staffing data denied residents and visitors the opportunity to be informed regarding the staffing levels. Findings include: During the initial tour on the morning of 08/12/15, observation showed the daily nurse staffing information posted on a board in all four of the nurse's stations (not visible/available for residents/visitors). During an interview on 08/12/15 at 9:40 a.m. an administrative nurse (#2) confirmed the posting of staff is not visible for residents/visitors. On the afternoon of 08/12/15, review of the binder containing daily nurse staffing data sheets showed 11 months (October 2014 through August 2015) rather than the required 18 months. During an interview on 08/12/15 at 3:00 p.m. an administrative staff member (#1) confirmed the facility lacked 18 months worth of daily nurse staffing data sheets.	F 356	As of 8/19/15, a new daily staffing-census sheet was developed to reflect the items required. As of 8/19/15, education was provided to charge nurses and resident care managers regarding requirements. As of 8/19/15, all staffing-census sheets are collected and scanned to a file on the drive to ensure collection and saving of 18 months worth of data. As of 8/19/15, a clear holder outside of each nurses' station was placed to hold the daily staffing sheet. Starting the week of 8/24/15, the Director of Nursing or designee shall monitor monitor posting of, accuracy of sheets and report to the quality committee. Monitor: Weekly x4; Monthly x3; Quarterly x4	9/11/15
F 493 SS=C	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the	F 493		

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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 493	Continued From page 11 facility This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure and staff interview, the facility failed to establish and implement policies regarding the staff member (job title) responsible for completing each section of the Minimum Data Set (MDS) and how staff accomplished the Care Area Assessment (CAA) process and care planning. Failure to establish and implement policies related to all aspects of the MDS may result in inaccurate resident assessments and incomplete care plans. Findings include: Review of the facility policy titled "MDS Completion and Submission Timeframes" occurred on 08/12/15. This policy, revised 11/20/14, stated, "Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes . . . 1. The MDS Coordinator or designee shall be responsible for ensuring that resident assessments are submitted . . . in accordance with current federal and state guidelines . . . 2. See RAI (Resident Assessment Instrument) Manual for Time Frames." The policy failed to include the staff members assigned to complete each section of the MDS and how to accomplish the CAA and care planning process. During an interview on 08/12/15 at 11:15 a.m., an administrative nurse (#2) confirmed the facility lacked policies and procedures related to the staff person (job title) responsible for completing each	F 493	As of 9/11/15 policies for RAI process- MDS 3. 0 and Completion of the RAI process- MDS 3. 0 policies were developed and education was provided to appropriate IDT members.	9/11/2015

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 _____	08/13/2015

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 493	Continued From page 12 section of the MDS and how staff accomplished the CAA process and care planning.	F 493		