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 08/18/2011

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
F 000	INITIAL COMMENTS For the complaint survey, started on 08/17/11 and completed on 08/18/11, the sample included 6 residents for focused review for specific concerns related to the complaint.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on information submitted by the complainant, confidential resident interview, and staff interview, the facility failed to provide reasonable accommodations of individual needs for residents on 3 of 3 resident neighborhoods (Neighborhood 1, 2, and 3). Failure to answer call lights and provide assistance in a timely manner resulted in Resident F experiencing delayed treatment for an acute respiratory symptom and resulted in incontinence for Resident A, B, C, D and G. Findings include: Written information submitted by the complainant identified the facility's call light system did not function properly. Refer to F463 - An interview occurred with Resident F on	F 246		

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

Administrator/CEO 9/13/11

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 246	Continued From page 1 08/17/11 at 3:00 p.m. The facility identified Resident F as interviewable. When asked how quickly staff respond to call lights, the resident stated on the afternoon of 08/16/11 he/she waited one hour and fifteen minutes after putting on the call light for a nurse to bring a medication needed immediately for an acute respiratory symptom he/she was experiencing at the time. - An interview occurred with Resident A on 08/17/11 at 3:30 p.m. The facility identified Resident A as interviewable. When asked how quickly staff respond to call lights, the resident stated he/she usually waits 15-30 minutes for staff to respond to his/her call light. The resident stated he/she has waited up to an hour on several occasions, with the most recent occurrence happening the morning of the interview. Resident A stated he/she experienced multiple episodes of incontinence while waiting for staff to respond to the call light. - An interview occurred with Resident B on 08/17/11 at 12:10 p.m. The facility identified Resident B as interviewable. Resident B indicated she/he was incontinent of stool and had "shit all over." The resident said she/he put the call light on and it took "a good 45 minutes" for staff to come in and help her/him. Resident B indicated she/he is to be turned "every 2 hours or so." She/he said one staff member will come into the room and then have to leave to get another staff member. The resident said many times "they never come back." When asked how long the resident waits for the call light to be answered, the resident indicated she/he has waited up to "one and a half hours" for the call light to be answered.	F 246	F246: In regard to call lights not answered in a timely manner: St. Luke's Home certified staff will be educated on answering call lights in a timely manner. Call light response times will be addressed at Resident Council and if any issues/concerns are noted further monitoring will be initiated. The Risk Management Officer, Staff Development, Neighborhood Supervisor, and/or designee will monitor call light response times. The Call Light Response Monitors will be forwarded to the QA Committee for further evaluation and follow up if needed. Effective 9/22/11: Call lights will be monitored daily on all units and all shifts through 10/2/11. Starting 10/3/2011call lights will be monitored weekly on all units and all shifts for 4 weeks. Effective Nov. 1, 2011 will proceed to monthly monitors on all units and all shifts as currently scheduled on our Quality Assurance Calendar.	9/19/11

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F 246	Continued From page 2 - An interview occurred with Resident C on 08/17/11 at 10:00 a.m. The facility identified Resident C as interviewable. When asked how quickly staff respond to call lights, the resident stated it varies, but usually he/she has to wait "quite a while" for staff to respond to his/her call light. The resident stated he/she experienced an incontinent episode once while waiting "74 minutes" for staff to respond to the call light. Resident C stated "the only thing I have to complain about is waiting too long for staff to help." - An interview occurred with Resident D on 08/17/11 at 12:15 p.m. The facility identified Resident D as interviewable. When asked about call light response times, Resident D stated the wait is usually anywhere from 15 to 30 minutes. Resident D stated he/she has had an incontinent episode when he/she "had to wait 1/2 hour for staff to answer the call light." Resident D stated, "staff keep reminding us all the time that they are short of staff and that is why we have to wait for them." Resident D stated the facility recently put a new call light system by his/her bed because the pendant call light system hadn't been working. Resident D stated the pendant call light is "not reliable." - An interview occurred with Resident E on 08/17/11 at 12:30 p.m. The facility identified Resident E as interviewable. Resident E stated when he/she activates the call light, he/she often has to wait a long time for staff to come and help. Resident E stated "they tell me they are short of staff, and it is true."	F 246		

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F 246	Continued From page 3 - An interview occurred with Resident G on 08/17/11 at 12:45 p.m. The facility identified Resident G as interviewable. When asked how quickly staff respond to call lights, the resident stated he/she waits up to 30 minutes for staff to respond to his/her call light. The resident stated he/she had experienced incontinent episodes while waiting for staff to respond to the call light. At 4 p.m. on 08/17/11, two administrative staff members (#1 and #2) indicated they were aware that resident care is a concern. Failure to provide assistance with toileting in a timely manner resulted in incontinent episodes for these residents.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #3) with orders for therapy evaluations upon returning from the hospital. Failure to provide therapy evaluations as ordered may result in residents experiencing avoidable functional decline.	F 309		

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F 309	Continued From page 4 Findings include: - Review of Resident #3's medical record occurred on 08/17/11. Information provided by the facility identified the resident was hospitalized from 05/13/11 to 06/20/11. Physician's orders upon the resident's return to the facility on 06/20/11 included an order for a Physical Therapy (PT) and Occupational Therapy (OT) evaluation. Review of therapy notes showed an OT screen completed on 06/22/11 which identified the resident was not appropriate for skilled OT/PT services secondary to health issues, but ordered RT (restorative therapy) five times a week. Resident #3's medical record lacked evidence the resident received restorative therapy. During an interview on 08/17/11 at 2:10 p.m., an administrative nurse (#9) stated during Resident #3's care conference on 07/12/11, the resident identified he was not being seen by therapy. The staff member (#9) confirmed Resident #3 never received RT services after the therapy evaluation completed on 06/22/11, and stated the order for RT "was missed" and "did not get communicated." Nurses notes showed Resident #3 was again hospitalized from 07/14/11 to 07/15/11. Physician's orders upon the resident's return to the facility on 07/15/11 included an order for a PT and OT evaluation. Review of therapy notes showed OT completed an evaluation on 07/26/11 (11 days after ordered) and recommended Resident #3 participate in therapy two to five times a week for up to 12 weeks. On 07/27/11 (12 days after ordered) PT completed an evaluation and recommended Resident #3	F 309	F309 In regards to therapy orders: Neighborhood Supervisor will cosign orders with Restorative Therapy Coordinator to ensure compliance with physician orders. Resident chart will be reviewed randomly by Restorative Therapy Coordinator and/or designee. Chart reviews will be forwarded to the QA committee for evaluation and follow up if needed. Resident #3 had therapy initiated as soon as error was identified. In effort to prevent this from happening to other Residents, the RT Coordinator and Neighborhood Supervisors co-sign therapy orders as a double check process. The RT Coordinator and Neighborhood Supervisors revised the process and no further education is required. Effective 9/22/2011, the RT Coordinator or designee will audit 6 Resident charts per week through 10/6/2011. Effective 10/7/11, 10 Resident charts will be audited monthly.	9/18/11

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F 309	Continued From page 5 participate in therapy two to five times a week for 12 weeks. During an interview on 08/17/11 at 2:05 p.m., an administrative nurse (#9) confirmed the facility failed to complete the therapy evaluations in a timely manner after receiving the order on 07/15/11. On 08/17/11 at 3:30 p.m., Resident #3 stated it took too long for therapy to start working with him when he returned from the hospital. The resident confirmed he is now currently receiving therapy services. The facility identified Resident #3 as interviewable.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on record review and staff interview, the facility failed to identify potential safety issues, and evaluate and implement interventions for identified safety concerns for 1 of 1 report of an actual fire which occurred at the facility (June 27, 2011). Findings include:	F 323		

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F 323	Continued From page 6 The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding resident safety which states establishing a systematic approach to resident safety may include: identification of hazards, evaluation and analysis of hazards and risks, implementation of interventions to reduce risks, and modification of interventions as necessary. Review of the report of a fire in the facility occurred on 08/17/11. The report identified the fire occurred on 06/27/11 at 7:10 p.m. and stated staff had to activate multiple pull stations before the fire alarm sounded. The report did not identify when staff notified the fire department, when the fire department arrived, how long it took to extinguish the fire, if any smoke entered the building, if staff evacuated residents, how many were evacuated, where staff took evacuated residents, and/or the time it took to evacuate the residents. The report lacked an evaluation of the facility's response to the fire and/or interventions implemented based on that evaluation. An interview with a charge nurse (#4) occurred on 08/17/11 at 1:30 p.m. The nurse stated she was working in the old building on the evening of the fire. She stated a visitor informed her of a fire on the roof of an unoccupied wing of the old building. The nurse (#4) stated she directed staff to pull the fire alarm and she called the fire department. She stated, due to construction of the new building, several fire pull stations no longer functioned, but remained on the wall in the old building, along with the new pull stations which did function. Consequently, staff had to pull several stations before the fire alarm sounded. The nurse (#4) stated, when the fire department	F 323	F 323 In regards to fire report: Two fire alarm systems were in place due to the combination of old and new facility space in addition to the construction process; however, only the new alarm system was activated. The contractors failed to remove the old fire system pull stations and/or notify St. Luke's Home staff that the pull stations had not been removed. As soon as the pull station was activated, the fire department was automatically notified. The police department responded immediately and the fire department arrived within minutes. The fire was confined to a very small area in the soffit of the building under destruction and was immediately extinguished. The fire occurred on the soffit of the roof line with no smoke penetrating into the occupied building. Based on the fire plan and police instructions, staff immediately relocated residents to designated areas. The fire chief did not order evacuation. The administrator was on scene and was informed that the small fire was extinguished. The Fire Chief, Administrator, and Environmental	9/12/11

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F 323	Continued From page 7 arrived, they requested staff move residents from the Blue Wing to the Red Wing (both located in the old building) as a precautionary measure, but stated no smoke entered the building. She stated staff evacuated three residents from the Blue Wing to the Red Wing. The nurse (#4) further stated staff evacuated some residents (she did not know the exact number) from the new building to the attached assisted living building. An interview with an administrative staff member (#1) occurred on 08/17/11 at 1:45 p.m. The staff member stated she was present at the facility during the fire. The staff member (#1) stated staff evacuated 22 residents from the old building to the assisted living building and moved residents residing in the south neighborhoods in the new building to the north neighborhoods. The facility's failure to complete a thorough and accurate report of the fire and the conflicting accounts from staff members present during the event limited the facility's ability to assess and evaluate actions taken during the fire. The failure to assess and evaluate the facility's response to the fire could result in lack of interventions to protect residents in the event of another fire at the facility. 2. Based on observation, record review, and staff interview, the facility failed to ensure the environment remained free of accident hazards in 1 of 1 carpeted dining room (Neighborhood 3 dining room). Findings include: Upon entering the facility on 08/17/11 at 8:30	F 323	Services Supervisor remained on scene to reset the fire system and ensure all fire systems were functioning properly. St. Luke's Home staff was educated on the correct fire pull stations. The following morning, the old fire pull stations were covered up and the building contractors were notified again that they must remove the old pull stations. Currently the building where the fire took place is no longer in existence. As part of the construction process, the old building was intentionally destroyed and moved off the premises. St. Luke's Home Fire Plan was in place and facility staff implemented this plan during the fire. See attachment A for post disaster fire evaluation form. The facility Fire Plan has been updated to include a post- fire evaluation. To ensure safety and Resident protection, the form will be used to evaluate the facility response to a fire or other disaster. Effective 9/22/11, QA evaluation for fire events will occur if/when a fire occurs. Fire Drills will continue to be done on a monthly basis and the post-drill evaluation will be done at the end of the drill. This will continue to be an ongoing monthly process. The drills will be conducted and monitored by the Maintenance Department and the Safety Committee. St. Luke's Home has contacted professional carpet installers to replace	

9/18/11

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F 323	Continued From page 8 a.m., observation identified patched carpet over an area several feet long in the Neighborhood 3 dining room/front entrance area. Observation identified the patch did not perfectly match the opening and showed a spot approximately four inches long where the patch was peeling from the floor. Observation showed residents seated at tables near the patched carpet. Observation in the Neighborhood 3 dining room occurred on 08/17/11 at 2:30 p.m. with an environmental staff member (#3). Measurements taken during the observation identified the patched area to be 18 feet long and 2 feet wide. Observations in the dining room also identified duct tape covering an area 7 inches long by 4 inches wide on the floor near a window on the south wall. When the surveyor applied pressure to the duct tape it collapsed into a hole in the floor. Observation showed Resident #4 seated in a chair approximately two feet from the hole in the floor, with a wheeled walker next to her. The staff member (#3) stated the hole resulted when an office area was converted into the dining room, and stated the hole was for an electrical outlet. She stated when the equipment was moved the outlet cover could not be located. Review of Resident #4's medical record occurred on 08/17/11. The record identified diagnoses including osteoporosis, macular degeneration, and glaucoma. A quarterly Minimum Data Set, dated 06/13/11, identified Resident #4 required extensive assistance with transfers and walking in the room and corridor, and identified no falls since the prior assessment. Resident #4's current care plan stated, "I have fallen in the past and am at risk for falling. I have osteoporosis which	F 323	section of the carpet that was cited. In regards to the 4X7 inch hole, a temporary 4X7 inch sturdy wooden block was properly placed since this building is set to be demolished. Maintenance work orders requiring priority attention will be printed on colored paper. St. Luke's Home Staff will be educated regarding priority work orders. Environmental Services Director will notify Administrator and/or designee if the priority work order cannot be completed within the specified time frame. Completed priority work orders will be forwarded to the Safety Committee and then to the QA committee for review and follow up as needed. Multidisciplinary Safety Rounds are going to be implemented effective Oct.1, 2011. The rounds will take place 3 times weekly during our Multidisciplinary report meetings. Safety checklists from Workforce Safety & Insurance (which are specific to all areas) will be used. Any safety issues identified on the rounds will be corrected in a timely manner. The data will be forwarded to the Safety Committee for review monthly and follow up as necessary.	

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F 323	Continued From page 9 increases my risk of injury if I fall." On the afternoon of 08/18/11, the facility provided a "Maintenance & Work Order," dated 08/16/11 at 6:55 a.m. The order stated, "PRIORITY!! [underlined three times] . . . Unit III dining room . . . By the Big windows is a floor outlet with duct tape over it, but it 'broke down.' Could this hole be filled in so no one/resident especially, accidently trips on it . . ." Under the heading "To be completed by Maintenance" the form stated, "Work completed on: 8/18/11. Type of repairs made: Put a piece [sic] of 1/2 painted particle board over the whole [sic]." Failure to maintain the Neighborhood 3 dining room carpet in safe condition and promptly repair the uncovered outlet could result in residents experiencing injuries when ambulating in the dining room.	F 323		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, resident and staff interview, and interviews with representatives from the company who installed the call system, the facility failed to maintain a functioning call system in the new building affecting 62 of 84 current residents.	F 463		

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F 463	Continued From page 10 Findings include: In a letter received from the complainant information indicated the call system did not work properly. Observation on 08/17/11 at 11:55 a.m. revealed the following seven room numbers scrolled across a signboard affixed to the ceiling on Unit (Neighborhood) 1: 101, 112, 117, 126, 133, 141, 142. One hour later, those same room numbers continued to scroll across the signboard. Approximately two and a half hours later, four of those rooms (101, 112, 117, 141) continued to scroll across the signboard. At 12:45 p.m. on 08/17/11, two different nursing staff members (unknown), when asked about the call system, indicated it has not been working correctly. One nursing staff member, when asked, checked on the resident in room 133. The resident sat in the dining room and the staff member checked the call pendant around the resident's neck. The staff member indicated she checked with the resident and the resident did not require any assistance. The staff member attempted to reset the pendant. Observation in room 133 found no call light turned on in either the room or the bathroom and the light in the corridor indicating a call light on was not illuminated. Observation of the signboard found this room number continued to scroll across the screen. During interview at 4 p.m. on 08/17/11 with two administrative staff (#1 and #2), these staff members confirmed the call system is not	F 463	F463 In regards to the function of the Call Light System: Call lights for room 101, 112, 117, and 141, and 142 are now working properly. The call light company sent out a technician and an engineer to St. Luke's Home on 8/23/2011. Call light company personnel gathered all of the pendants, reprogrammed, and verified that they were functioning before redistributing them. St. Luke's Home continues to monitor the call light system and is collaborating with the call light system company to provide quality services. Any further issues and concerns will be evaluated by the Environmental Services Director and will be reported to the QA committee for review and follow up as needed. See Page 12	9/18/11

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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 463	Continued From page 11 working properly. They indicated a technician from the company who installed the system was in the building earlier in the day looking into the problem. These staff members did not indicate if the problem had been resolved. They directed the survey team to speak with representatives from the call light company. During interviews with representatives (#6 and #7) from the call light company on 08/18/11 at 9:30 a.m. and 11:30 a.m., the representatives were not able to explain a definite problem with the call system. However, they did indicate the problem has been ongoing for the last 8-9 days. These people confirmed the problem continued at the time of the survey and at no time during the interview did they indicate the problem had been resolved. They indicated it was a priority for them to fix the call system at St. Lukes Home. - An interview occurred with Resident D on 08/17/11 at 12:15 p.m. Resident D stated the facility recently put a new call light system by her bed because the pendant call light system hadn't been working. Resident D stated the pendant call light is "not reliable." - An interview with a staff member (#8) occurred on 08/17/11 at 12:45 p.m. The staff member stated "the call lights haven't always been working right" and the facility is "putting a new call light system in." The staff member stated the "pendent lights are hard to re-set and there are currently two pendant call lights that are not re-setting."	F 463	F463 In regards to the function of the Call Light System: Call lights for room 101,112, 117, and 141, and 142 are now working properly. The call light company sent out a technician and an engineer to St. Luke's Home on 8/23/2011. Call light company personnel gathered all of the pendants, reprogrammed, and verified that they were functioning before redistributing them. St. Luke's Home continues to monitor the call light system and is collaborating with the call light system company to provide quality services. Any further issues and concerns will be evaluated by the Environmental Services Director and will be reported to the QA committee for review and follow up as needed. Effective 9/22/2011, daily call light functional checks will be implemented by the Neighborhood Supervisors and/or designee through 10/6/11. After 10/6/2011, the call light functional tests will be completed weekly by the Neighborhood Supervisors and/or designee. Nonfunctional lights will be corrected will be serviced in a timely manner. Call light functional checks will be reviewed at the monthly Safety Committee.	9/18/11