STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	R-C 10/05/2011

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 on-site revisit, conducted on 10/05/11, to determine compliance with the deficiencies identified during the 08/18/11 complaint survey, the sample included 18 residents for focused reviews of the areas of noncompliance.	{F 000}	F246: 1. In regard to residents affected by failure to answer call lights properly and in a timely manner: Call system has been extensively revised by Advance Wireless technicians, Director of Nursing Services, and Staff Development Coordinator on site. This extensive review revealed that the call system is fully functional at this time. Effective 10/6/11 to 04/21/12 daily exception reports have been conducted and analyzed to identify call lights over the extended wait time on unit 3. The analyzed reports will be reviewed at Report meeting three times per week. Effective 10/14/11 to 04/21/12 members of the interdisciplinary health care team have been interviewing residents who were identified to have extended wait times. Residents of units 1, 2, and 3 may potentially be affected by failure to answer call lights properly and in a timely manner. The same process stated above will be used to identify failure to answer call lights properly and in a timely manner. Corrective measures and systemic changes include:	
{F 246} SS=D	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 review of resident council meeting minutes, confidential resident interview, and staff interview, the facility failed to provide reasonable accommodations of individual needs for residents on 1 of 1 resident neighborhoods (Neighborhood 3). Failure to answer call lights and provide assistance in a timely manner resulted Resident A, B, and C experiencing incontinent episodes. Findings include: Review of resident council meeting minutes occurred on 10/05/11. The minutes, dated "September 1, 2011 & [and] September 28, 2011," stated, ". . .Monitoring Call lights . . . Unit III, some complained still takes 1/2 hour for their call light to be answered. . . ."	{F 246}		11/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Boulden	Administrator	10/18/11

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 - An interview with Resident C occurred on 10/05/11 at 9:35 a.m. The facility identified the resident as interviewable. Resident C stated he/she has a certain time each day he/she prefers to get up. The resident stated this morning he/she put on the call light at that time. Resident C stated a staff member came in the room and shut off the call light, stating she would be right back to assist him/her. Resident C stated, after waiting approximately an hour, he/she rang the call light again. The staff member then arrived to assist the resident out of bed, approximately one hour later than the resident's preferred time to get up for the day. Resident C stated he/she has experienced incontinent episodes due to waiting an extended time for staff to respond to his/her call light. - An interview occurred with Resident A on 10/05/11 at 1:15 p.m. The facility identified Resident A as interviewable. When asked how quickly staff respond to call lights, the resident stated he/she waits 15-30 minutes for staff to respond to his/her call light. 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 10/05/11 at 9:35 a.m. The facility identified Resident B as interviewable. When asked how quickly staff respond to call lights, the resident stated he/she usually waits 30 minutes for staff to respond to his/her call light. The resident also stated sometimes staff will answer his/her call light, shut the call light off, say they will "be right back," and then will return 30 minutes later to assist him/her, or won't return at all.	{F 246}	1. Reprograming call light software escalation times from eight minutes extended wait time to five minutes extended wait time effective 10/19/11. 2. A review and relabeling of the acronyms that appear on the unit's display monitors took place 10/12/11. As a result of this review acronyms will be changed effective 10/19/11 from: - *PA Room 114* to *Room 114 pendant* - *Room 114 bath* to *Room 114 Bathroom* - *Bed Room 114* to *Room 114 Bed*, etc. 3. Effective 10/21/11 bed call light cords and buttons will be replaced with a malleable cord and an easier activation red push button, that will be easier to be identified. 4. A mandatory All-Staff Training will be conducted 10/21/11 to include: proper procedure for answering call lights (accountability for answering call lights in a timely manner, proper procedure for answering call lights "Do not turn call lights off and leave the room without assistance, resident rights and dignity, etc.) new escalation time frames in regard to extended wait times, acronym changes, etc. Further education in regards to proper procedure to answer call lights (refer to item #4) will be provided in the monthly Departmental Meetings Effective 10/21/11 to 04/21/12.	

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{F 246}	Continued From page 2 During an interview on 10/05/11 at 2:40 p.m. an administrative nurse (#1) stated his expectation is that staff do not shut off a resident's call light without providing assistance at that time.	{F 246}	5. Effective 10/21/11 to 04/21/12 residents located in units 1, 2, and 3 will be explained, and shown, how to use the bed call light system. Issues and concerns in regard call light system will be review at resident council and education will be provided as deemed necessary. 5. Effective 10/14/11 to 04/21/12 issues and concerns regarding the call light system will be addressed at the monthly personnel Departmental Meetings. Education will be provided to facility staff as deemed necessary. Effective 10/14/11 to 04/21/12 data gathered from: residents interviews, daily exception reports (extended wait time), and education and training will be submitted to Quality Assurance Committee for the evaluation of its effectiveness. Further follow up will be implemented as deemed necessary.	