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 _____	12/04/2014

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 standard Medicare/Medicaid recertification survey started on December 1, 2014 and completed on December 4, 2014, the sample included four (4) residents for complete review, eleven (11) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/16/14 Based on observation, record review, facility policy review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 supplemental resident (Resident #15) observed with medications left at the bedside. Failure to determine if SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Self-Administration of Medications" occurred on 12/03/14. This policy, revised 02/2014, stated, ". .	F 176	Facility failed to assess the safety of self-administration of medication for 1 of 1 sampled resident (Resident #15) who was observed with medications left at bed side. Resident #15 has severely impaired cognition and is not safe to self-administer medication. Licensed nurses will be re-educated on 1-5-14 on facility "Self-administration Policy" and "Medication Administration Policy" to include "not leaving medications at bedside" for residents who have not been assessed safe to self-administer medications. All residents residing in the facility have the potential to be affected. Nursing staff will be re-educated on 1-5-14 on facility "Self-administration Policy" and "Medication Administration Policy" to include "not leaving medications at bedside" for residents who have not been assessed safe to self-administer medications. Agency and facility nursing staff will be educated on above policies and protocol upon hire and annually. DNS or designee will audit 4 resident rooms weekly for medications left at bedside starting 1-8-15 X 1 month for compliance; then monthly X 6 months; then quarterly. Areas of concern will be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Hoebel | TITLE: CEO | (X6) DATE: 12/31/14

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 176	Continued From page 1 . Residents in our facility who wish to self-administer their medication may do so, if it is determined that they are capable of doing so . . . 3. If the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications . . ." Review of Resident #15's medical record occurred on 12/04/14. Diagnoses included dementia. The annual Minimum Data Set (MDS), dated 09/21/14, identified Resident #15 with severely impaired cognition. Resident #15's medical record lacked a SAM assessment. Observation on the morning of 12/01/14 identified a medication cup containing seven medications at Resident #15's bedside. During the observation, Resident #15 reported she takes the medications when she needs them. Observation on 12/01/14 at 4:35 p.m., identified the same medication cup with seven medications at Resident #15's bedside. Observation on 12/02/14 at 08:15 a.m. identified that same medication cup with seven medications at Resident #15's bedside. During an interview on 12/02/14 at 8:16 a.m., an administrative nurse (#5) stated Resident #15 is unable to self-administer medications, and staff should not leave medications at Resident #15's bedside. This nurse removed the medications and identified the medications as from an evening medication pass on 11/30/14.	F 176	addressed immediately and reviewed in Quality Assurance meeting monthly. Completion Date:	1-8-15
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274	Facility failed to complete a significant change in status assessment for 1 of 15 sampled residents (Resident	

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F 274	Continued From page 2 A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete significant change in status assessments (SCSA) for 1 of 15 sampled residents (Resident #10) within 14 days after a significant change occurred in the resident's physical condition. Failure to complete a SCSA in response to the resident's decline limited the facility's ability to identify and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual," Version 3.0, October 2013, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: . . . 2. Impacts more than one area of the	F 274	#10 who had a significant decline in bed mobility, transfers, walking in his room, toilet use, and personal hygiene. Resident #10 has been scheduled for a significant change MDS on 1-6-2015. All resident's who experience a significant decline or improvement in their health status has the potential to be affected. Interdisciplinary Team (IDT)were re-educated on 12-30-14 regarding the Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual", Version 3.0, October 2013, pages 2-20 and 2-23 regarding.. A 'significant change' is a decline or improvement in a resident's status that: Impact more than one area of the residents health status and requires interdisciplinary review and/or revision of the care plan. A significant change assessment is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments. A significant change assessment is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline. Interdisciplinary Team will discuss resident's on each unit during morning meeting 5 days per week to identify those resident's who are being observed for a significant change in their health status. DNS or designee will review with the IDT daily (5 days per week) residents	

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F 274	Continued From page 3 resident's health status; and 3. Requires interdisciplinary review and /or revision of the care plan. . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline . . ." Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia. Resident #10's quarterly Minimum Data Set (MDS), dated 8/07/14, identified the resident required supervision for bed mobility, and walking in his room, and limited assist for transfer, toilet use, and personal hygiene. The quarterly MDS, dated 11/06/14, indicated a decline in these areas with extensive assistance for bed mobility, transfer, walking in his room, toilet use, and personal hygiene. The record lacked evidence staff completed a SCSA following Resident #10's decline in functional status. During an interview on 12/03/14, an administrative nurse (#4) was unaware a significant change MDS should have been completed on 11/06/14 instead of a quarterly MDS.	F 274	who are having a significant change in their health status to assure compliance in identifying and scheduling significant change assessments. This will be done weekly starting 1-8-14 X 1 month for compliance; then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15
F 278 SS=F	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278	Facility failed to ensure the Minimum Date Sets (MDSs) accurately reflected the residents' status for 13 of 15	

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F 278	Continued From page 4 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 by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 13 of 15 sampled residents (Resident #1, #2, #3, #4, #6, #7, #8, #9, #11, #12, #13, #14,	F 278	sampled residents (Resident #1, #2, #3, #4 #6, #7, #8, #9, #11, #12, #13, #14, and #15) in Section M1200D of the MDS. MDSs will be corrected and resubmitted by 1-8-15 for above resident's identified. Residents residing in the facility have the potential to be affected. Resident Care Managers were re-educated on coding MDS Section M1200D for nutrition and hydration on 12-4-15 by the surveyors. Section M1200D on the most recent MDS assessment for each resident residing in facility as of 12-12-14 was reviewed for accuracy. Significant correction assessments will be completed and re-submitted to Medicare/Medicaid by 1-8-15 for those residents whose Section M1200D was coded incorrectly. Dietary manager was educated regarding coding the MDS for nutrition and hydration intervention to manage skin problems (Section M1200D) as stated in The Long-Term Care Facility RAI User's Manual, October 2014 on 12-10-14. Dietary Manager will code Section M1200D of the MDS effective 12-15-14. DNS or designee will audit Section M1200D of four (4) MDS assessments weekly X 1 month starting 1-8-15 for compliance, then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting Monthly. Completion Date:	1-8-15

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F 278	Continued From page 5 and #15) coded on the MDS for nutrition and hydration intervention to manage skin problems. Failure to accurately assess and code the MDS may affect the level of care provided to residents and the accurate development of the comprehensive care plan. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, stated the following: *Section M1200D (Nutrition or Hydration Intervention to Manage Skin Problems), pages M-38 and M-39, stated, "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation . . . and obtain dietary consultation as needed,' . . ." Review of the medical records for Resident #1, #2, #3, #4, #6, #7, #8, #9, #11, #12, #13, #14, and #15 occurred on all days of survey. - Review of Resident #1's quarterly MDS, dated 09/04/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #1's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 09/05/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition.	F 278		

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F 278	Continued From page 6 - Review of Resident #2's quarterly MDS, dated 11/25/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #2's MDS identified not pressure ulcers or wounds. The most current "Quarterly Nutrition Assessment," dated 11/26/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #3's quarterly MDS, dated 09/16/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #3's MDS identified no pressure ulcers or wounds. The most current "Quarterly Nutrition Assessment," dated 09/17/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #4's significant change MDS, dated 09/08/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #4's MDS identified no pressure ulcers, wounds, or skin problems identified on the MDS. - Review of Resident #6's quarterly MDS, dated 10/07/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #6's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 10/09/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #7's annual MDS, dated	F 278		

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F 278	Continued From page 7 09/18/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #7's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 09/06/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #8's quarterly MDS, dated 09/12/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #8's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 09/15/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #9's annual MDS, dated 10/18/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #9's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 10/12/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #11's quarterly MDS, dated 09/18/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #11's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 09/24/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition.	F 278		

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F 278	Continued From page 8 - Review of Resident #12's quarterly MDS, dated 10/06/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #12's MDS identified moisture associated skin damage. The "Quarterly Nutrition Assessment," dated 10/07/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #13's quarterly MDS, dated 09/20/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #13's MDS identified an unstageable pressure ulcer. The "Quarterly Nutrition Assessment," dated 09/24/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. -Review of Resident #14's quarterly MDS, dated 09/28/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #14's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 09/30/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition. - Review of Resident #15's annual MDS, dated 09/21/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. Resident #15's MDS identified no pressure ulcers, wounds, or skin problems. The "Quarterly Nutrition Assessment," dated 09/06/14, failed to identify any skin concerns or specific nutritional interventions related to skin condition.	F 278		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/16/14 Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 3 of 15 sampled residents (Resident #1, #2, and #3). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident.	F 280	Facility failed to revise the comprehensive care plan to reflect the residents' current status of 3 of 15 sampled residents (Resident #1, #2, and #3). Resident #1's care plan was updated on 12-31-14 to reflect that she is able to self-administer Carafate 1 gram four times a day. Resident #2's care plan was updated on 12-31-14 to reflect "no straws". Resident #3's care plan was updated on 12-31-14 to reflect sit to stand lift with two staff assist and CAM boot was dis-continued from care plan. Residents that reside in the facility have the potential to be affected. Nursing staff will be re-educated on 1-5-15 regarding facility "Care Plan Policy" and updating of care plan. Resident Care Managers will review and update resident care plans quarterly and PRN (in conjunction with the MDS schedule) with any changes in a resident's status to ensure continuity of care for each resident on their unit. DNS or designee will audit 4 care plans weekly X 1 month for compliance starting 1-8-15, then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality Assurance meeting monthly. Date of Completion:	1-8-15

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F 280	Continued From page 10 Findings include: Review of the facility policy titled "Care Plans - Comprehensive" occurred on 12/03/14. This policy, dated February 2014, stated, ". . . Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included gastroesophageal reflux disease. Medications included Carafate 1 gram four times a day. Special Instructions: May self-administer. Resident #7's current care plan failed to address the resident's ability to self-administer the medication. During an interview on 12/02/14 at 12:20 p.m., Resident #1 indicated a nurse (#8) did not administer the ordered Carafate until 11:30 a.m. Resident #1 takes the medication at 11:00 a.m. and wondered why the nurse (#8) did not leave the three other doses with her during the 6:00 a.m. dose administration. The resident would then self-administer the 11:00 a.m., 4:30 p.m., and the 9:00 p.m. doses in her room. Interview on 12/02/14 at 12:40 a.m., a nurse (#8) verified he offered the Carafate at 11:30 a.m., and Resident #8 refused the dose due to the late time. During an interview on 12/02/14 at 4:30 p.m., a nurse manager (#3) verified staff completed a self-administration of medication (SAM) evaluation and identified Resident #1 appropriate for self-administration of the Carafate. The nurse manager (#3) indicated the resident's care plan	F 280		

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F 280	Continued From page 11 did not include the self-administration of Carafate. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dysphagia (trouble swallowing). Review of the Quarterly Nutrition Assessment, dated 11/26/14, stated, ". . . To be upright at 90 degrees while eating-Small bites or sips-No straws (per OT [Occupational Therapy] recommendations). . . ." Resident #2's care plan failed to address the "No straws" recommendation. Observation on 12/01/14 at 4:00 p.m., showed two Styrofoam cups, both with lids and one with a straw on Resident #2's bedside table. During an interview on the morning of 12/03/14, a nurse manager (#3) verified Resident #2's care plan did not include the "no straws" recommendation. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a recent leg fracture, cerebral vascular accident, and muscular dystrophy. Review of the current "My Daily Living Needs" care plan identified two staff and a Hoyer (total body mechanical lift) for transfers and a CAM (controlled ankle movement) boot to the right leg except during baths or showers. Observation on 12/02/14 at 8:00 a.m. showed two certified nursing aides (CNA) (#12 and #13) transferred Resident #3 from his bed to his wheelchair using a sit-to-stand lift. The two CNAs did not apply a CAM boot to Resident #3's right leg. During an interview at 12:40 p.m. a CNA (#12) stated staff always use a sit-to-stand lift for Resident #3's transfers.	F 280		

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	355063	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 12 During an interview on the morning of 12/04/14, a nurse manager (#3) stated the physician ordered non-weight bearing (NWB) for two weeks after the 08/02/14 fall/fracture and discontinued the CAM boot the end of September. Staff should have used the Hoyer when the resident was NWB. Resident #3 changed to the sit-to-stand lift and two staff assist on 10/23/14. She agreed the care plan did not reflect these changes.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: FOLLOWING PHYSICIANS' ORDERS 1. Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed physicians' orders for 2 of 2 sampled residents (Resident #1 and #7). Failure of staff to follow physicians' orders resulted in Resident #1 receiving an as needed (PRN) medication at the wrong time and Resident #7 not having a urinary analysis (UA) completed. Findings include: Review of the facility's policy titled "Administering Medication" occurred on 12/04/14. This policy, dated, February 2014, stated, ". . . 3. Medications must be administered in accordance with the orders, including any required time frame. . . ."	F 281	1. Facility failed to ensure staff followed physicians' orders for 2 of 2 sampled residents (Resident #1 and #7). Licensed Nurses will be re-educated on facility policy "Administering Medication" and facility protocol for reviewing and following consultant physician's orders on 1-5-15. 2. Facility failed to document administration of standing order medications on the medication administration record (MAR) for 3 of 4 sampled residents (Resident #4, #7, and #8) who received as needed (prn) medications. Licensed Nurses will be re-educated on 1-5-15 regarding: a) Documentation of administration of PRN medications on MAR. b) Implementation and transcription of routine standing orders on the MAR when administered per physicians protocol. Residents residing in facility have the potential to be affected. Licensed Nurses will be re-educated on 1-5-14 regarding: Administering Medication Policy; Documentation of administration of PRN medications on MAR; Implementation and transcription of routine standing	

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F 281	Continued From page 13 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included osteoporosis and pain. The November 2014 PRN Medication Administration History form identified a dose of tramadol 50 milligrams PRN once a day at bedtime for pain administered on 11/23/14 at 10:49 a.m. During an interview on the morning of 12/04/14, a nurse manager (#3) verified staff did not administer the tramadol during the correct ordered time frame. - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, schizophrenia, and history of urinary tract infections. Resident #7's progress notes identified the following: * 03/17/14 3:35 p.m. - "Resident seen by [physician's name] via telemed [telemedicine]. Plan for UA [urinalysis] with Micro [microscopic]. F/U [follow-up] in 1 month. Awaiting on orders." A consulting physician's progress note dated 03/17/14, stated, ". . . The patient continues to have yelling episodes and signs of restlessness and anxiety, which according to the staff not any worse from last visit. They did note though in the last week or 2 she has been noticeably tearful so during this visit we are going to rule out a urinary tract infection (UTI) as a possible cause so we will get a urinalysis (UA) with micro. . . ." Resident #7's medical record lacked evidence a UA was obtained as ordered by the consulting physician.	F 281	orders on the MAR when administered per physicians protocol; and reviewing and following consultant physician orders. Resident Care Managers will review nursing progress notes and MAR of residents on their unit for documentation of PRN medication use. Resident Care Managers will review the following in IDT (5 days per week): physician orders and consultant physician progress notes. DNS or designee will audit MAR for transcription and documentation of PRN medication use and audit consultant physician progress notes for implementation of any new orders on 4 residents weekly X 1 month for compliance, then monthly X 6 months, then quarterly starting 1-8-15. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Date of Completion:	1-8-15

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F 281	Continued From page 14 During an interview on the morning of 12/03/14 an administrative nurse (#5) stated staff failed to follow the consultant physician's order and did not obtain the UA as ordered. DOCUMENTATION 2. Based on record review and staff interview, the facility failed to document administration of standing order medications on the medication administration record (MAR) for 3 of 4 sampled residents (Resident #4, #7, and #8) who received as needed (prn) medications. Failure to document medications on MAR may result in duplication of medication and inhibits tracking the frequency of use for prn medications. Findings include: Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included dementia. Resident #4's "Resident Progress Notes" identified the following: *07/09/14 at 5:38 a.m. - ". . . suppository given . . . *07/24/14 at 5:55 a.m. - ". . . dulcolax suppository per S.O. [standing order] . . . ." *07/26/14 at 4:11 a.m. - "Resident was given fleet enema . . . " Review of Resident #4's July 2014 prn MAR lacked documentation that Resident #4 received the above prn constipation medications. - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, and constipation.	F 281		

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F 281	Continued From page 15 Resident #7's progress notes stated the following: 08/18/14 5:23 a.m. - ". . . suppository given per facility protocol." 09/05/14 5:23 a.m. - ". . . suppository per facility protocol." 09/06/14 2:59 a.m. - "Fleet administered . . ." 10/18/14 4:07 a.m. - ". . . suppository per facility protocol." 11/14/14 4:34 a.m. - ". . . Dulcolax supp. [suppository] given per facility protocol. . . ." Review of Resident #7's prn MAR's from 08/2014 to 11/2014 lacked documentation that Resident #7 received the above prn medications. During an interview on 12/02/14 at 5:00 p.m. an administrative nurse (#5) confirmed Resident #7's prn MAR and physician's orders lacked documentation of the prn medications administered. This nurse reported staff are expected to write an order for prn medications when administered per physicians protocol and document the medication on the prn MAR. - Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease and dementia. Resident #8's nursing progress notes stated the following: 07/22/14 6:20 a.m. - ". . . Suppository given per facility protocol." 07/28/14 6:08 a.m. - ". . . Suppository given per facility protocol." 09/07/14 6:31 p.m.- "Ducolax supp given . . . ." Review of Resident #8's prn MAR's from 07/2014 and 09/2014 lacked documentation that Resident	F 281		

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F 281	Continued From page 16 #7 received the above prn constipation medications. During an interview on the morning of 12/03/14, an administrative nurse (#5) confirmed Resident #8's prn MAR and physician orders lacked documentation of the prn medications administered.	F 281	Rel tc e Doil on 1-13-15 Resident #4, #7, #8 Doc regarding Bowel elimination Was reviewed.	
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, review of physician's standing orders, and staff interview, staff failed to follow the facility's bowel protocol to promote regular bowel elimination for 3 of 4 sampled residents (Resident #4, #7, and #8) receiving as needed (prn) bowel medications per physician's standing orders. Failure to follow the bowel protocol may have contributed to residents experiencing constipation, discomfort due to delayed bowel elimination, and manual extraction of stool. Findings include: Review of "Physician Standing Orders 2014" occurred on 12/03/14. The Standing Orders	F 309	Staff failed to follow facilities bowel protocol to promote regular bowel elimination for 3 of 4 sampled residents (Resident #4, #7, and #8 receiving as needed (prn) bowel medication per physician's standing orders. Licensed nurses will be re-educated on facility bowel protocol and implementation protocol of physician's standing orders on 1-5-15. Residents residing in facility have the potential to be affected. Bowel Management Protocol was updated. Licensed nurses will be re-educated on facility bowel management protocol and implementation of protocol for physician's standing orders on 1-5-14. Bowel Protocol Form was initiated on each unit to track bowel movements and bowel medications given daily. Night shift charge nurses on each unit will turn form in to DNS for review at the end of their shift. DNS or designee will audit 4 residents bowel records each week X 1 month for compliance, then monthly X 6 months, then quarterly starting 1-8-15. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15

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F 309	Continued From page 17 stated, ". . . The nurse may implement approved orders without contacting the Physician, unless otherwise indicated. For all standing orders, the physician will be notified if the Resident is not improved within 48 hours, or for any significant clinical deterioration. Medications: Bowel Management protocol Day 3 without a BM [bowel management] - Administer: MOM [Milk of Magnesia] 1 oz. [ounce] PO [by mouth]. If no results administer: Dulcolax 10 mg [milligrams] Suppository per rectum. Day 4 without a BM - Administer Fleets enema per rectum. If no results after following protocol, notify Physician for further orders. . . ." - Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included dementia. Resident #4's "Resident Progress Notes" identified the following: *07/09/14 at 5:38 a.m. - ". . . suppository given for no BM x [times] 4th day." *07/20/14 at 8:58 a.m. - "Resident yelling out "get it out" while on toilet. CNA [certified nursing assistant] updated this nurse. Resident had large amount of hard stool present at rectum, lubricant applied and stool removed manually. After large firm ball of stool removed resident had liquid stool and soft stool defecation. Resident stated that she felt better." *07/24/14 at 5:55 a.m. - "resident given dulcolax suppository per S.O. [standing order] d/t [due to] no BM x 4th day." *07/26/14 at 4:11 a.m. - "Resident was given fleet enema due to no BM x 5 days, was effective. Had a small BM after administration." Review of Resident #4's bowel movement record for July 2014 identified the following: *July 4 - small bowel movement;	F 309		

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F 309	Continued From page 18 *July 5, 6, 7, 8 - no bowel movement (4th day) *July 9 - large, dry hard bowel movement (Dulcolax suppository given on July 9th - 5th day). Staff failed to follow bowel protocol. *July 11, 12, 13, 14, 15 - No bowel movement (5th day) MOM given on July 11 (2nd day), July 14, (4th day) and July 15 (5th day). Resident #4 had a medium, dry hard stool on July 16 (7th day) Staff failed to follow bowel protocol. *July 16 - medium dry hard stool *July 17, 18, 19 - no bowel movement (3rd day) *July 20 - large dry hard stool (Resident Progress Note identified nursing staff member manually extracted large hard stool). *July 21, 22, 23, 24, 25 - no bowel movement (5th day) *July 26 - small, soft formed stool (6th day). Nurses notes identified staff administered a Dulcolax suppository on July 23 (3rd day) and MOM on July 25 (5th day), and Fleets enema on July 26, (6th day). Staff failed to follow bowel protocol. The August 2014 bowel movement record identified the following: *August 5 - large dry, hard bowel movement *August 6, 7, 8 - no bowel movement (3rd day) *August 9 - medium, hard dry stool after a Dulcolax suppository (4th day). Staff failed to follow bowel protocol. *August 10, 11, 12 - no bowel movement (3rd day) *August 13 - large dry hard stool (4th day). Staff failed to follow bowel protocol. Review of the medical record identified no evidence staff notified the physician of Resident #4's constipation and need for manual extraction	F 309		

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F 309	Continued From page 19 of stool and no evidence of dietary interventions regarding constipation. Staff failed to follow the facility's bowel protocol regarding prn medications. During interview on 12/04/14 at 8:45 a.m., an administrative nurse (#2) confirmed staff should follow the standing orders regarding the Bowel Protocol and notify the physician if the interventions are ineffective. - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, and constipation. Resident #7's constipation medications included senna-s one tablet per day prn (as needed). Resident #7's care plan stated, ". . . history of constipation . . . dietary intervention is in place for constipation . . ." Resident #7's progress notes stated the following: * 08/18/14 5:23 a.m. - "Day 4 no BM, suppository given per facility protocol." * 09/05/14 5:23 a.m. - "Day 4 no BM, resident given suppository per facility protocol." * 09/06/14 2:59 a.m. - "Fleet administered as there was no results from suppository." * 10/18/14 4:07 a.m. - Day 4 no BM resident received suppository per facility protocol." * 11/14/14 4:34 a.m. - "No BM x [times] 4 days, 1 Dulcolax supp. [suppository] given per facility protocol. Will monitor for results." During an interview on 12/02/14 at 5:00 p.m. an administrative nurse (#5) stated staff are expected to administer MOM if no BM and then a dulcolax suppository on day three. Staff should administer Resident #7's prn senna as ordered. This nurse confirmed staff failed to follow the	F 309		

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F 309	Continued From page 20 physician's bowel protocol. - Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease and dementia. Resident #8's progress notes stated the following: * 07/22/14 6:20 a.m. - "Day 4 with no BM. Suppository given per facility protocol." * 07/28/14 6:08 a.m. - "Four days with no BM. Suppository given per facility protocol." * 09/07/14 6:31 p.m.- "Ducolax supp [suppository] given due to no BM [times] four days, will monitor for results." During an interview on the morning of 12/03/14 an administrative nurse (#5) stated staff failed to follow the bowel protocol.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	Facility failed to verify placement of a gastrostomy tube according to policy for 1 of 1 sampled resident (Resident #4) observed receiving medications through a gastrostomy tube. Licensed nurses will be re-educated on facility policy "Confirming Placement of Feeding Tubes" on 1-5-15. Residents who have a feeding tube have the potential to be affected. Confirming Placement of Feeding Tubes Policy was added to nursing orientation packet for new hires and added to the nursing orientation checklist. Director of Staff Development will review policy upon hire and annually with licensed nurses. DNS or designee will audit 1 nurse weekly X 1 month for compliance of checking placement of feeding tube	

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F 322	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to verify placement of a gastrostomy tube according to policy for 1 of 1 sampled resident (Resident #4) observed receiving medications through a gastrostomy tube. Failure to verify placement has the potential to result in complications. Findings include: Review of the policy "Confirming Placement of Feeding Tubes" occurred on 12/03/14. This policy, dated 05/24/12, stated, " . . . 4. Attach fifty (50) to sixty (60) cc [cubic centimeter] syringe with ten (10) cc of air to the end of the tube. . . . 6. Place stethoscope 2-3 inches below the xyphoid process. 7. Forcefully inject ten (10) cc of air into tube while listening to the abdomen with stethoscope for a "whooshing" sound. 8. Verification of placement of tube is complete when "whooshing" sound is heard. . . ." - Observation of a staff nurse (#6) preparing to administer medications and a water flush of Resident #4's gastrostomy tube occurred on 12/01/14 at 3:40 p.m. The nurse pulled back on the plunger of the syringe attached to the gastrostomy tube, with no residual obtained. The nurse (#6) failed to verify placement according to facility policy prior to administering medications to Resident #4 via gastrostomy tube.	F 322	prior to administering medications, then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15

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F 322	Continued From page 22 During interview, on 12/03/14, at 10:50 a.m., an administrative nurse (#2) stated staff should verify placement of the gastrostomy tube prior to giving medications and flushes by injecting air and listening with a stethoscope.	F 322		1-13-15 Del TC C Dcm
F 323 SS=D	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: Based on observation, record review, review of facility policy and procedure, review of operating instructions for the whirlpool tub/chair, and staff interview, facility staff failed to appropriately use assistive devices during bathing and transfers for 3 of 3 sampled residents (Resident #3, #9, and #11). Failure to perform safe transfers including use of appropriate safety devices resulted in avoidable falls for Resident #3, #9, and #11. Finding include: Review of the facility's policy titled "Safe Lifting and Movement of Residents" occurred on 12/03/14. This policy, dated February 2014, stated, ". . . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident' needs for transfer assistance on an ongoing basis. Staff will document resident	F 323	Facility failed to appropriately use assistive devices during bathing and transfers of 3 of 3 sampled residents (Resident #3, #9, and #11). Nursing staff will be re-educated on 1-5-15 regarding: 1). Following resident care plans, and wound reassessed and changed as needed. 2). "Safe Lifting and Movement of Residents" Policy 3). Review of Care Plan to determine what preventative measures were in place at time of fall so appropriate corrective action can be implemented for fall prevention. 4). Review of operating instructions for use of "Integrity Bath" (whirlpool tub) and chair. 5). Completion of Witness Statement for all witnessed falls. 6). Updated Fall investigation. Residents residing in the facility have the potential to be affected. Nursing staff will be re-educated on 1-5-15 regarding: 1). Following resident care plans. 2). "Safe Lifting and Movement of Residents" Policy 3). Review of Care Plan to determine what preventative measures were in place at time of fall so appropriate corrective action can be implemented for fall prevention. 4). Review of operating instructions for use of "Integrity Bath" (whirlpool tub) and chair.	(3, 9, 11)

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	355063	A. BUILDING _____ B. WING _____	12/04/2014

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ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 323	Continued From page 23 transferring and lifting needs in the care plan . . . 6. Staff will be observed . . . periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a recent fracture of the right lower leg. The "My Daily Living Needs" care plans, dated 08/02/14 and 11/10/14, identified Resident #3 transferred with a Hoyer (total body lift) and two staff assist. "Comments: PWB R Leg [partial weight bearing right leg]." Review of Resident #3's progress notes identified: * 08/02/14 - A fall resulted in "a spiral fracture of the . . . right fibula up near the knee joint. Treatment is to be a knee immobilizer . . . To be non-weight bearing for the next two weeks on the right leg. . . ." * 08/18/14 - ". . . returned from appointment with a CAM [controlled ankle movement] boot and orders for partial weight bearing with transfers. . . ." * 08/19/14 - "Resident observed to be sitting on ground in front of chair. Chair was in upright position. Two CNAs [certified nursing aides] had been attempting to transfer resident with a stand-aid and in attempting to attach loops of sling to lift had to raise chair to maximum height and pad on seat had slid off. No injuries noted. . . ." On 10/16/14 physical therapy recommended, "Resident to complete transfers with use of stand-aid and assist x [times] 2." During an interview on 12/03/14 at 12:15 p.m., a	F 323	5). Completion of Witness Statement for all witnessed falls. 6). Updated Fall investigation. Fall investigation form was updated to include whether strap was in place while resident was in tub chair and number of staff needed to assist with transfers. Director of Staff Development or designee will review in nursing orientation (upon hire and annually) facility policy and procedures for: "Safe Lifting and Movement of Resident's",Resident Care Plans, Safe Operation and use of whirl pool tub and chair, Fall investigations and witness statements. DNS or designee will observe 1 resident transfer on each unit (four total) weekly to ensure safety measures are followed X 1 month starting on 1-8-15, then monthly X 6 months, then quarterly for compliance. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15

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F 323	Continued From page 24	F 323		

nurse manager (#3) indicated prior to 10/16/14 nursing or therapy staff had not assessed Resident #3 safe to transfer with a Sit-to-Stand lift.

The CNAs transferred the resident with the Sit-to-Stand lift and not the assessed and care planned Hoyer lift which resulted in Resident #3's fall.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Dementia with behaviors. Resident #9's "My Daily Living Needs" care plan, dated 09/19/14, identified the resident required assist of one to shower and assist of 2 for transfers using a total body lift. In addition, the care plan identified the resident with a history of combative behaviors with cares. The current Minimum Data Set (MDS), dated 10/18/14, identified short and long term memory loss, extensive assist of two or more staff for transfers and total assist of 2 or more staff for bathing. No care plan changes occurred after the 10/18/14 MDS assessment.

Resident #9's progress note stated:
* 11/02/14 10:53 a.m. - "Resident observed on the floor in front of shower chair. CNA states she was applying the sling when the resident slid from shower chair. 4 cm [centimeter] [by] 1 cm skin tear to left forearm. 2 cm [by] 1 cm skin tear to left wrist. Cleaned with NS [normal saline] steri strips applied wrapped with kling. Neuro checks wnl. [within normal limits] able to move extremities. No bruising noted message left with daughter. . . ."

The Accident/Incident Report, dated 11/02/14, stated, " . . . CNA called CN [charge nurse] to

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F 323	Continued From page 25 resident room. CNA stated she was trying to apply sling to transfer from shower chair to wheelchair. Resident slid out of shower chair. . . ." The Report stated Resident #9 became combative when the CNA tried to place the Hoyer sling behind the resident and Resident #9 then slid out of the chair onto the floor. The report included corrective action of "1.) proper application of sling 2.) make sure shower chair is dry, to prevent slipping 3.) use Broda chair for showers. . . ." The corrective action failed to address the need for two or more staff to assist with transfers and bathing. During interviews on 12/02/14 at 2:15 p.m. and 12/03/14 at 10:35 a.m., an administrative nurse (#5) stated he would expect two staff members to place the sling behind the resident for transfer in and out of the shower chair. This nurse further stated he would expect staff to use the shower chair strap to prevent the resident from falling. Review of the operating instructions for the "Integrity Bath"(whirlpool tub) occurred on 12/04/14. The instructions, dated 02/18/13, stated, ". . . Move the Individual Out Of The Integrity Bath: . . . Pull up on the Main Chair Release Lever and roll the individual forward until the chair is fully on to the carrier and automatically latched into place. Before disengaging the carrier from the tub, make sure the chair is securely latched into place by pushing the chair back towards the tub. If properly latched into place, the chair will not allow itself to be pushed off of the carrier rails onto the tub rails. (The gravity latch is engaged) . . . "	F 323		

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F 323	Continued From page 26 - Review of Resident #11's medical record occurred on all days of survey. Diagnoses include gait abnormality, muscle weakness, and pain in limb. The quarterly MDS, dated 09/18/14, identified Resident #11 cognitively intact and independent with ambulation. Review of Resident #11's progress notes identified: * 08/21/2014 at 10:15 a.m., "CN [charge nurse] called into W.P. [whirl pool] because resident had a fall. CNA WP aid stated that resident did not wait for her and pushed back really hard on chair and fell in front of the w.p. tub. VS [vital signs] taken . . . Family called and MD [medical doctor] called. Then received order to notify administer [sic] & [and] administer of nursing. Director & Director of nursing were notified promptly per MD order." * 08/23/2014 at 11:12 a.m., "Res [resident] has light bruising to legs bilat [bilateral] from fall. No c/o [complaints of] pain noted. Res states feeling 'Good'. " During an observation on 12/04/14 at 9:45 a.m., a CNA (#18) demonstrated how the tub chair in the whirlpool tub is to be operated. During this interview, the CNA stated, "you have to push (the chair) all the way to the front so the chair locks." She also stated, "when I train someone to give a bath I always tell them to put the belt [safety] on and be sure the chair is locked." During this demonstration, an administrative nurse (#4) stated, "I don't know if Resident #11 had the belt on." During an interview on the morning of 12/04/14,	F 323		

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F 323	Continued From page 27 an administrative nurse (#1)reviewed the incident/fall report dated 08/21/14. The report included a statement Resident #11 gave the staff at the time of the fall, "I pushed back on the chair really hard and fell on my butt." The CNA assisting Resident #11 with the bath that day, reported, "[resident's name] was ready to stand and she pushed back and the chair slid back." The report identified the nurse "reviewed safety with CNA and resident at the time." The report lacked interviews with staff present at the time of the fall to determine if the chair's safety latch was locked and if Resident #11 had the safety belt in place. During an interview the morning of 12/04/14, an administrative nurse (#1) stated the interdisciplinary team reviewed the incident. This staff member, when asked to provide a policy or procedure for giving a whirlpool bath, provided a copy of the manufacturer's operating instructions for the tub chair. The facility failed to conduct a thorough investigation of the events of the fall. The facility failed to ensure safe operating procedures were followed and staff were trained to operate the equipment safely.	F 323	Per TC E Don. date to change 12-5-14	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure residents were free of significant	F 333	Facility failed to ensure residents were free of significant med errors for 2 of 15 residents (Resident #15 and #19). Resident # 15 - Physician was contacted and licensed nurses were reminded verbally and a reminder was posted on each unit by DNS on ~~12-3-14~~ that KB medications can not be left at bedside. Licensed nurse must to stay with resident until all medications have been taken. Resident #19 Physician was contacted regarding med error and insulin order was clarified to read that insulin is to be	12-5-14

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F 333	Continued From page 28 medication errors for 2 of 15 sampled residents (Resident #15 and #19). Failure to ensure Resident #15 actually took her evening medications may result in adverse health consequences, and failure to administer insulin before reviewing Resident 19's food intake has the potential to adversely affect the resident's blood sugar resulting in hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Findings include: Review of Resident #15's medical record occurred on 12/04/14. Diagnoses included dementia. The annual Minimum Data Set (MDS), dated 09/21/14, identified Resident #15 with severely impaired cognition. Resident #15's medical record lacked a Self Administration of Medication assessment. Observation on the morning of 12/01/14 identified a medication cup containing seven medications at Resident #15's bedside. During the observation, Resident #15 reported she takes the medications when she needs them. Observation on 12/01/14 at 4:35 p.m., identified the same medication cup with seven medications at Resident #15's bedside. Observation on 12/02/14 at 08:15 a.m. identified that same medication cup with seven medications at Resident #15's bedside. During an interview on 12/02/14 at 8:16 a.m., an administrative nurse (#5) stated Resident #15 is unable to self-administer medications, and staff should not leave medications at Resident #15's bedside. This nurse removed the medications	F 333	given after resident eats instead of at meal times. Licensed nurse was re-educated on facility Insulin Administration policy at time of medication error by DNS. Resident's who receive medications have the potential to be affected. Licensed Nurses will be re-educated on Insulin Administration, Medication Administration, and Self-Administration policies on 1-5-14. Licensed Nurses will be re-educated on facility Insulin Administration, Medication Administration, and Self-Administration policies on 1-5-14. Medication Administration Policy will be reviewed at new hire orientation and annually starting 1-8-15. DNS or designee will observe 4 nurses per week starting 1-8-15 during insulin administration X 1 month for compliance. Then monthly X 6 months, then quarterly. DNS or designee will check 4 resident rooms weekly on each unit for medications left at bedside starting 1-8-15 X 1 month, then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15

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F 333	Continued From page 29 and identified the medications as from an evening medication pass on 11/30/14. Review of Resident #15's MAR identified the following oral medications as either PM (evening) or HS (bedtime) medications: Keflex (antibiotic); Aricept (dementia medication); Lipitor (medication for high cholesterol); Lopressor (antihypertensive); Potassium Chloride (mineral); Seroquel (antipsychotic medication); Coumadin (anticoagulant medication); PreserVision Lutein (vitamin/mineral eye medication); and Tylenol Arthritis (pain medication). The medication cup may have included seven of the 9 medications listed above. - Review of the facility's policy titled "Insulin Administration" occurred on 12/03/14. This policy, dated February 2014, stated, ". . . 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. . . ." Observation on 12/02/14 at 7:50 a.m. showed a nurse (#8) administered 13 units of Novolog insulin to Resident #19 before the resident left his room to go to the dining room for breakfast. Review of Resident 19's Physician Order Report, dated 11/04 - 12/04, 2014, identified "Novolog Flexpen . . . 13 UNITS . . . Special Instructions: (AT BREAKFAST) (HOLD IF EATING LESS THAN 50%) . . . Once A Day; 08:30 AM." During an interview on 12/02/14 at 4:30 p.m., a nurse manager (#3) agreed staff did not follow the physician's order to administer Resident #19's	F 333		

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F 333	Continued From page 30 Novolog insulin after verifying the resident had eaten at least 50% of his breakfast.	F 333	Not TCC Reg #15's pharm Review Dan 1-13-15 was signed + Reviewed by physician.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report of medication recommendations for 1 of 15 sampled residents (Resident #15). Failure to ensure the physician reviewed the consulting pharmacist recommendations has the potential to affect the resident's highest practicable level of functioning. Findings include: Review of the facility policy titled "Medication Regimen Review" occurred on 12/04/14. This undated policy, stated, " . . . G. Recommendations are acted upon and documented by the facility staff and/or the prescriber. 1) Physician accepts and acts upon suggestion or rejects and provides an explanation	F 428	Facility failed to ensure the attending physician reviewed and acted upon the consulting pharmacist's report of medication recommendations for 1 of 15 sampled residents (Resident #15). Facility sends consulting pharmacists report of medication recommendations directly to physicians for review and signature starting in December. Licensed nurses will be re-educated o 1-5-15 that consultant pharmacist recommendations have to be reviewed and signed by the resident's physician and not a physician's assistant (PA) or nurse practitioner (NP). In the event the pharmacist recommendation comes back unsigned or signed by a PA or NP, charge nurse must contact physician and send it back for physician to review and sign. All resident's residing in the facility have the potential to be affected. Licensed nurses will be re-educated on 1-5-15 regarding consultant pharmacist's report for medication recommendations must be reviewed and signed by resident's physician and not a PA or NP. In the event the pharmacist recommendation comes back unsigned or signed by a PA or NP charge nurse must contact physician and send it back for physician review and signature. Resident Care Managers will track physician response to pharmacists report of medication recommendations. If physician does not respond within 7 days,	

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F 428	Continued From page 31 for disagreeing. . . ." - Review of Resident #15's medical record occurred on 12/04/14. Pharmacy reviews with recommendations, completed on 04/07/14 and 09/09/14, lacked evidence of physician review/recognition of the pharmacist's findings. During an interview on the morning of 12/04/14, an administrative nurse (#5) confirmed the above identified pharmacy review lacked evidence of a physician review.	F 428	physician will be contacted for follow up weekly until response is received starting 1-8-15. DNS or designee will audit 4 pharmacist recommendations for physician response and signature monthly X 12 months for compliance. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-14
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	Facility staff failed to store medications under proper temperature control in 1 of 4 medication refrigerators (Unit 4 - Western). No residents were identified. Licensed staff will be re-educated regarding facility policy "Medication Refrigerators" on 1-5-15. Resident's residing in the facility that have medications stored in medication refrigerators on their unit have the potential to be affected. Licensed staff will be re-educated regarding facility policy "Medication Refrigerators" on 1-5-15. Recommended temperature range was highlighted on medication refrigerators posted on refrigerators in each medication room to draw staff's attention. DNS or designee will check medication refrigerator temperatures 5 days per week on each unit X 1 month starting 1-8-14 for compliance. Then monthly X 6 months, then quarterly. Completion Date:	1-8-15

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F 431	Continued From page 32 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to store medications under proper temperature control in 1 of 4 medication refrigerators (Unit 4 Western). Failure to maintain the refrigerator temperature within an acceptable range has the potential to affect the potency and efficacy of the medications. Findings Include: Review of the facility policy titled "Medication Refrigerators" occurred on 12/04/14. This policy, dated 2014, stated, " . . . Medication refrigerators, located in each medication room, will be maintained at the appropriate temperature. 1. A thermometer is kept in each refrigerator at all times to monitor the temperature. 2. Temperature of the refrigerator will be checked and recorded on the refrigerator monitoring form daily . . . 3. In the event of a temperature variation outside the acceptable range of 35-46 [degrees Fahrenheit] the Charge nurse will record and then adjust the refrigerator temperature. The Charge Nurse will re-check and record the temperature again prior	F 431		

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F 431	Continued From page 33 to end of shift. . . ." Diabetes Care by the American Diabetes Association, Inc., January 2004, Vol. 27, Supplement 1, stated, ". . . Insulin Administration. . . Storage. . . Extreme temperatures ([less than] 35 [degrees Fahrenheit]) should be avoided to prevent loss of potency, clumping, frosting, or precipitation. Specific storage guidelines provided by the manufacturer should be followed. . . ." Observation of the the Unit 4 Western medication refrigerator occurred on 12/04/14 at 8:30 a.m. with an administrative nurse (#4). The refrigerator thermometer identified the temperature at 30 degrees. The administrative nurse (#4) verified this temperature. Review of the refrigerator temperature log identified the temperature range of 35 to 46 degrees. This log showed the following temperatures: 11/24/14 - 31 degrees - no re-check documented 11/25/14 - no documentation 11/26/14 - 30 degrees - no re-check documented 11/27/14 - 15 degrees - re-check 30 degrees 11/29/14 - 30 degrees re-check 32 degrees 11/30/14 - no documentation 12/01/14 - 32 degrees - no re-check documented 12/02/14 - 35 degrees 12/03/14 - 30 degrees no re-check documented The medication refrigerator contained the following medications: Novolog insulin pens - five boxes Lantus insulin pens - one box Levemir insulin pens - one box Vitamin B-12 - one vial	F 431		

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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 431	Continued From page 34 During an interview on 12/04/14 at 8:35 a.m., an administrative nurse (#5) confirmed the medication refrigerator was below the recommended range.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	Facility failed to follow standard infection control practices for 1 of 2 sampled residents (Resident #5) observed during a dressing change and 4 of 8 sampled residents (Resident #4, #7, #9, and #10) observed during personal cares. Licensed nurses will be re-educated on 1-5-15 on "Wound Care Dressing Change" policy and "Hand Washing/Hand Hygiene" policy. Residents residing in the facility have the potential to be affected. Nursing staff will be re-educated on 1-5-15 on "Wound Care Dressing Change" policy and "Hand Washing/Hand Hygiene" policy. During nursing orientation and annually policies regarding "Wound Care Dressing Change" and "Hand Washing/ Hand Hygiene" will be reviewed and demonstrated starting 1-8-15. DNS or designee will audit 8 nursing staff each week (two on each unit) for hand washing / hand hygiene during Peri-care and dressing change starting 1-8-15 for compliance X 1 month, then monthly X 6 months, then quarterly. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15

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F 441	Continued From page 35 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 1 of 2 sampled residents (Resident #5) observed during a dressing change and 4 of 8 sampled residents (Resident #4, #7, #9, and #10) observed during personal cares. Failure to follow infection control practices related to glove usage with dressing changes and hand hygiene during personal cares has the potential to spread infection within the facility. Findings include: HAND HYGIENE - DRESSING CHANGES Review of the policy "Wound Care Dressing Change" occurred on 12/04/14. This policy, dated August 2011, stated, ". . . 8. Put on clean gloves. Loosen tape and remove soiled dressing. 9. Pull glove over dressing and discard into plastic or biohazard bag. 10. Wash and dry your hands thoroughly. . . ." - Observation on 12/02/14 at 8:00 a.m. showed a nurse (#6) changed a dressing to Resident #5's left foot (skin graft area from toe amputation, pressure ulcer area on the heel, as well as small areas on the top of the foot). After removing the dressing, the nurse (#6) failed to remove gloves, perform hand hygiene, and don new gloves prior to cleaning the wounds with saline soaked gauze.	F 441		

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F 441	Continued From page 36 During interview the morning of 12/04/14, an administrative nurse (#2) confirmed staff should remove gloves and perform hand hygiene after removing a dressing. HAND HYGIENE - PERSONAL CARES Review of the policy "Handwashing/Hand Hygiene" occurred on 12/04/14. This policy, dated January 2012, stated, "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . . . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. . . . 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . n. Before and after assisting a resident with toileting (hand washing with soap and water); . . ." - Observation on 12/01/14 at 4:05 p.m. showed a CNA (#7) donned gloves and provided Resident #4 (who was in her bed) with perineal cares after the resident had a large, soft, incontinent bowel movement (BM). After completing perineal cares, applying ointment to Resident #4's buttocks, and applying a new brief, the CNA (#7) removed her gloves. Without performing hand hygiene and while waiting for another CNA to return with the Hoyer lift pad, the CNA (#7) rearranged bed linens and straightened items on the bedside table. When another CNA (#10) returned to the room with the Hoyer lift pad, CNA (#7) placed the pad under the resident in bed, assisted to transfer Resident #4 from the bed to the wheelchair, and positioned the resident's feet on the foot pedals.	F 441		

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F 441	Continued From page 37 The CNA (#7) then brought the garbage from the room to the dirty utility room in the hallway and washed her hands. - Observation on 12/02/14 at 7:50 a.m. showed two CNA's (#16 and #17) donned gloves and assisted Resident #9 with perineal care after an incontinent BM. After completing perineal care, CNA (#16) removed one glove from his double gloved right hand, applied cream to Resident #9's buttocks and removed both gloves. The two CNA's (#16 and #17) put the lift sling under the resident and transferred the Resident #9 into the wheelchair. The CNA (#16) combed the resident's hair, put on the resident's glasses, jacket, and shoes. Both CNA's (#16 and #17) left Resident #9's room without performing hand hygiene. - Observation on 12/02/14 a.m. at 7:10 a.m. showed two CNA's (#16 and #17) assisted Resident #7 off of the toilet. The CNA (#16) provided perineal care and both CNA's assisted the resident into the wheelchair. Both CNA's left Resident #7's room without performing hand hygiene. - Observation on 12/03/14 at 6:55 a.m., showed a CNA (#15) assisted Resident #10 with morning cares. The CNA donned gloves, ambulated the resident into the bathroom, cued the resident to use the toilet, guided the resident over to the sink, gave him a washcloth to wash his face, his toothbrush for oral cares, and helped the resident change his incontinent product and pants. After assisting and cueing Resident #10 during morning cares, the CNA removed his gloves and failed to perform hand hygiene before leaving the room.	F 441		

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F 441	Continued From page 38 During an interview on 12/04/14 at 9:55 a.m. an administrative nurse (#5) stated staff are expected to perform hand hygiene after perineal care before completing other tasks and exiting a resident's room. This nurse further stated staff should not double glove.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition in 1 of 4 resident care units (Unit 3 Prairie). Failure to ensure the suction machine remained functional in case of an emergency situation placed residents at risk for choking and aspiration. Findings include: Observation of the suction machine storage on Unit 3 Prairie occurred on 12/04/14 at 8:52 a.m. with two nursing staff members (#4 and #14). Observation showed a suction machine without a canister, connecting tubing, filter tubing and suction cannula. The nurse (#14) obtained a suction cannula and connecting tubing from a nearby emergency cart and connected it to suction machine motor. The nurse failed to obtain a canister and filter tubing. The nurse (#14) obtained a glass of water and attempted to suction the water. The surveyor stopped the	F 456	Facility failed to ensure emergency equipment remained in safe operating condition in 1 of 4 resident care units (Unit 3 - Prairie). Licensed nurses will be re-educated on proper set-up and use of suction machine on 1-5-15. No residents were identified, however residents who may require suctioning have the potential to be affected. Director of Staff Development or designee will review set-up and use of suction machine upon hire and annually starting 1-8-15. Supplies needed for suctioning are now packaged in a zip lock bag for easy access on each unit as of 1-5-15. DNS or designee will audit 4 licensed nurses weekly X 1 month on the set-up and use of suction machine for compliance, then monthly X 6 months and quarterly thereafter starting 1-8-15. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly. Completion Date:	1-8-15

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F 456	Continued From page 39 nurse as suctioning the water may have harmed the suction machine. The nursing staff member (#14) failed to properly connect the suction canister, filter tubing, and connecting tubing to the suction machine. During an interview on 12/04/14 at 9:00 a.m. with two nursing staff members (#4 and #14) both identified lack of training on use of the suction machine.	F 456		