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 _____	12/20/2012

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 17, 2012, and completed on December 20, 2012, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included 15 additional residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Resident #1's nursing and behavior documentation will be reviewed for any statements/concerns that may indicate an abuse/neglect allegation no later than end of day Resident #6's chart will be reviewed and an amended to note the absence of the left great toe nail and an amended incident report will be completed no later than end of day 1/18/13. MD and family will be notified, if not completed no later than All resident had the potential to be affected by this violation	1/18/13 1/18/13.

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

D Jenna Skokan — Administrator — 1-18-13

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.

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 _____	12/20/2012

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 17, 2012, and completed on December 20, 2012, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included 15 additional residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Resident #1's nursing and behavior documentation will be reviewed for any statements/concerns that may indicate an abuse/neglect allegation no later than end of day 1/18/13 Resident #6's chart will be reviewed and an amended to note the absence of the left great toe nail and an amended incident report will be completed no later than end of day 1/18/13. MD and family will be notified, if not completed no later than 1/18/13. All resident had the potential to be affected by this violation	

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

Donna Hoebel — CEO — 1-31-2013

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.

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 _____	12/20/2012

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to ensure all alleged and potential violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency) for 1 of 1 sampled residents who reported injury and/or pain (Resident #1) and 1 of 1 sampled resident with an injury of unknown origin (Resident #6). Findings include: Review of facility policy, titled "Abuse/Neglect Policy & Procedure" occurred on 12/19/12. This undated policy stated, "Policy Statement: Each resident has the right to be free from abuse. . . . Residents must not be subjected to abuse by anyone including, but not limited to, St. Luke's Home staff, other residents, consultants or volunteers, staff from other agencies serving the resident, family members. . . . 3. Implementation:	F 225	•Social Service Staff discuss Resident Abuse and Neglect in depth at new employee orientation. (Ongoing) •New Employee's required to read and sign detailed information regarding resident right, abuse and neglect at time of hire acknowledging receipt of information. (Ongoing) •Resident Rights and Abuse to be standing topic at Quarterly Mandatory All Staff Education until February 1, 2014. First meeting was held 1/22/2013. •Resident Rights and Abuse to be discussed at time of resident admission with resident and family and form signed acknowledging receipt of information. (Ongoing) Responsible person is Social Services. •Residents Rights/Abuse/Neglect and Reporting of Abuse/Neglect to be standing topic at the Dept. of Nursing CNA and Charge Nurse Meetings. In addition, include untoward resident conditions, i.e. loss of toenail that requires completion of variance report no later than 1/24/13 and ongoing. This will be part of the next six monthly meetings and thereafter semi-annually. Social Services will be responsible. •Dakota Travel Nurse Staff to receive Resident's Rights and Abuse education prior to initial shift at St. Luke's Home. (Ongoing). Director of Quality Assurance.	

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 _____	12/20/2012

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 225	Continued From page 2 *St Luke's Home will investigate alleged violations and report the results of the investigation to the proper authorities. *Residents will be protected from harm during an investigation. St. Luke's Home will not allow retaliation against anyone for reporting an incident of abuse, neglect, . . . The facility will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. *All alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown source and misappropriation of resident property will be reported immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including the State survey and certification agency). In addition, the results off (sic) all investigations will be reported to the administrator or his designated representative and to other officials in accordance with State Law (including the State survey and certification agency) within five working days of the incident . . . *St. Luke's home will report all alleged instances of mistreatment, neglect, or abuse including injuries of unknown source . . . Reports will concern instances where a nurse aide or other individual used by the facility is suspected or an allegation is made of mistreatment, neglect or abuse including injury of unknown source . . . Mistreatment includes abuse, neglect, and misappropriation of resident property. Injuries of Unknown Source: . . . will be regarded in the same regulatory light as mistreatment, neglect and abuse and will be reported if there is reasonable cause to believe or suspect that a nurse aide or other individual used by the facility	F 225	•Social Services Department to develop a log to monitor all allegations of resident abuse/neglect, including date identified, action taken, reported date. This started 1/18/13 and will be ongoing. Social Services responsible. •Collaborate with Dakota Travel Nurse to coordinate and monitor that all DTN staff who practice at St. Luke's Home have received Mandatory Resident Abuse/Neglect Education .provided upon hire and annually by DTN and prior to initial shift on unit (ongoing). •Monthly CNA/Charge Nurse/CMA meeting minutes to reflect Resident Abuse/Neglect and Reporting standing agenda. Date of compliance for F-225 will be no later	02/08/2013

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 _____	12/20/2012

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 225	Continued From page 3 has inflicted an injury upon a resident. If there is no reasonable cause to believe or suspect that a nurse aide or another individual used by the facility has inflicted an injury upon a resident, the facility will not report the occurrence to the State Survey and certification agency. However, the facility will establish a reasonable manner of determining whether or not injuries such as skin tears, bruises, abrasions and other untoward events that occur in the facility are abusive or neglectful in nature or whether these occurrences are simply happenstance. Please Note: The facility is not relieved of its responsibility to investigate, regardless of the circumstances, to complete the appropriate documentation, and implement corrective actions as necessary. If, in the course of the investigation, the facility decided that abuse or neglect was a factor, the facility will thoroughly document this fact and report the incident at that time. For injuries of unknown source, which the facility did report to the State survey and certification agency, the facility must be prepared to provide survey staff with the rationale for their decision including their inability to identify staff involvement. . . . All allegations will be reported to the Department immediately by telephone (during business hours) followed by the report of the investigation and the results within five working days. . . ." - Review of Resident #1's medical record occurred on all days of survey. Resident #1's Minimum Data Sets dated 12/04/12, 09/12/12 and 06/22/12 identified the resident as cognitively intact. During an interview on 12/18/12 at 7:50 a.m.,	F 225		

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 _____	12/20/2012

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 225	Continued From page 4 Resident #1 stated "99 percent" of the staff treat her well, but on one occasion a staff member was rough with her and caused shoulder pain and a bruise. Resident #1 did not remember the exact date the event occurred, but thought it was "a while back," and "in the summer." The resident stated she told the bath aide about the incident and the bath aide reported it to the charge nurse. During an interview on 12/18/12 at 3:30 p.m., a supervisory nursing staff member (#12) stated, "Resident #1 reported being grabbed [by a staff member]. I reported [the allegation of abuse] to the unit supervisor." During interviews on 12/18/12 at 4:30 p.m. and on 12/20/12 at 11:00 a.m., a unit supervisor (#9) confirmed the charge nurse reported the incident to her and she investigated it. I was gone a day or two. The charge nurse left a message on my recorder." She further stated, "The resident reported a staff member was rough with her, grabbing her by the arm. She reported having soreness. I followed up. She stated she did not document her investigation and did not remember the exact date of the incident. An interview with two administrative staff members (#3 and #7) occurred on 12/19/12 at 4:00 p.m. When asked about the incident regarding Resident #1 both staff members stated they were not aware of the alleged incident. Failure to investigate and report Resident #1 incident as a potential incident of abuse or neglect limited the facility's ability to consider corrective action if necessary and placed all facility residents at risk of potential abuse and	F 225		

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 _____	12/20/2012

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 225	Continued From page 5 neglect. - Review of Resident #6's medical record occurred on December 17-20, 2012. The facility admitted the resident in November 2008. Current diagnoses included pain and osteoarthritis. The resident's annual MDS, dated 11/20/12, identified the resident sometimes makes herself understood and sometimes is able to understand others, had short term memory problems, required extensive assistance of one person for bed mobility, transfers, locomotion on and off the unit, dressing, and walking did not occur. Observation, on 12/19/12 at 8:40 a.m., showed a certified nursing assistant (CNA) (#13) assisting Resident #6. The CNA removed the resident's left slipper revealing a dry gauze bandage on the tip of the left great toe. The CNA (#13) summoned the licensed nurse (#14) who removed the dry gauze bandage which showed the left great toe nail absent. The toe appeared dry without drainage and the resident did not express pain. Resident #6's Nurse's Notes, dated 12/10/12, identified a CNA notified a licensed nurse regarding the absence of Resident #6's left great toe nail and the nurse's observation of the toe. During interview, on 12/19/12 at 4:00 p.m., a supervisory nursing staff member (#2) reported being unaware of the absence of Resident #6's left great toe nail. This staff member reported she was unaware of the completion of any accident or incident report being completed or physician notification. On 12/20/12 at 9:30 a.m., a supervisory nursing	F 225		

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 _____	12/20/2012

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 225	Continued From page 6 staff member (#2) confirmed the facility failed to complete an accident or incident report regarding the unknown mechanism of removal of Resident #6's left great toe nail. Failure to report and investigate the absence of Resident #6's left great toe nail as an injury of unknown origin limited the facility's ability to ensure the safety of Resident #6 and placed all residents at risk of injury.	F 225		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of Resident Council Meeting Minutes, and group, resident, family, and staff interview, the facility failed to ensure prompt meal service/palatable foods for 4 of 13 sampled residents (Resident #1, #5, #11, and #13) and 13 supplemental residents (Resident #17, #18, #19, #21, #22, #23, #24, #25, #26, #27, #28, #29, and #30) on 2 of 3 units (Units 1 and 2). Failure of the facility to act upon the grievances of the residents resulted in continued delay of meal service in the dining room and unpalatable food. Findings include:	F 244		

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 _____	12/20/2012

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 244	Continued From page 7 Review of the facility policy titled "Serving Resident Meals" occurred on 12/20/12. This policy, dated 06/19/2012, stated, ". . . POLICY: Resident will be provided with . . . palatable, attractive meals that meet the Resident's daily nutritional and special dietary needs. Food will be served in a pleasant and tasteful manner. PROCEDURE: . . . 3. Nursing and Dietary staff passing trays and plates also aid in setting up meals for the residents that need help opening containers, cutting meat, buttering bread. 4. Nursing department is responsible for having residents ready for meals, positioning residents, feeding of residents and taking trays to the rooms if needed." Review of the facility policy titled "Frequency of Meals" occurred on 12/20/12. This policy, not dated, stated, "Meal Times: Breakfast.....7:00 am-8:30 am or until all residents have been served. Dinner.....meals should arrive to each location at these approximate times Unit 1: 11:45 am to 12:00 am [sic]. Unit 2: 12:00 pm to 12:15 pm - served from the steam table. Unit 3: 12:00 pm to 12:15 pm. Supper.....meals should arrive at these locations at these approximate times Unit 1: 5:15 pm to 5:30 pm. Unit 2: 5:30 pm to 5:45 pm - served from the steam table. Unit 3: 5:30 pm to 5:45 pm." Twelve residents (identified by the facility as being interviewable) attended the group interview on 12/17/12 at 1:30 p.m. The residents voiced concerns regarding the facility failing to serve meals in a timely manner, resulting in "very cold" food. The "Resident Council Minutes" stated the	F 244	Multiple residents were affected by the violation. A dietary steam table trial was in place on Unit 2 at time of survey. Action Plan was in place r/t dining experience and addressed at Staff meetings, including Nursing and Dietary staff meetings. All Residents had the potential to be affected by this violation. •Dietary Steam Table initiated on Unit 1 on 1/14/13 for meal delivery. •Dietary Steam Table continues on Unit 2 for delivery of meals (in place). •Nutrition and Food Services will add 1 employee on Unit 1 and Unit 2 at Lunch and Supper meals to assist in passing meals to residents (for a total of 2 staff to pass from the Nutrition and Food Service Department on Unit 1 and Unit 2) and one staff member serving the meal on each unit effective 1/16/13. •Meal Times on each Resident Care Unit start at a designated time, no longer an open timeframe effective no later than •Revise seating chart to ensure adequate CNA staff able to provide resident assistance/cueing are available i n the dining room at time of meal service •One CNA staff on Unit 1 and Unit 2 to begin work at 0500 unless employee when possible •No Nursing Dept. Employee breaks during mealtime effective immediately. •Provide additional assistance at meal time, i.e. Activities, RT, and Leadership to assist with passing trays allowing CNA staff to begin assisting/cueing residents no later than. •Residents will be brought to the dining room once meal service commences. Residents may remain in TV lounge or in their room while awaiting meal. •Educate to new process at Mandatory All-Staff Meeting Mandatory Nursing Department Meeting. Also, staff education at Dietary Department meeting .	

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 _____	12/20/2012

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 244	Continued From page 8 following: * "May 10, 2012, . . . Dietary Agenda: 1. Food Temperatures: Some residents stated on Unit 1 [and] 2 that occasionally some items could be hotter . . . and on Unit 3 they stated that they feel their food is not always hot . . . 2. Unit 2 felt meal service was rather slow . . ." * "July 12, 2012, . . . Dietary Agenda: 1. Reviewed the food temperatures. 2. Reviewed food service time." * "September 13, 2012, . . . Dietary Agenda: 1. Review food temperatures - residents were reminded to send foods to the kitchen to be heated if they are not palatable. 2. Review serving times of the meals - still taking a while to get trays. Concerns: . . . Action: . . . using steam tables in the unit . . . This will help with . . . food temperatures and will allow the residents to receive their food faster at meal times. . . ." * "November 29, 2012, . . . Concerns: . . . 2. Trays not being served right away when they arrive and causing cold food at times. Action: will have dietary staff help out with meal pass and serving on units from steam table will help correct this issue. . . ." - During interview at 9:15 a.m. on 12/18/12, Resident D stated the meals are "never on time" and residents have to wait in the dining room. The resident stated not everyone at the same table is served at the same time and "some are finished with their meals" while others "wait and have nothing." - During interview at 7:15 a.m. on 12/19/12, Resident B stated "last evening, only three [residents] got their meals on time" and the "rest had to sit at the table and wait." Resident B states	F 244	•Food Temperatures monitors to be performed 3X/week at various meal times on each unit X 1 month followed by 3X/week at various meal times and various units to continue thereafter effective no later than 1/23/13. Dietary Manager or designee responsible. Quality monitor to be initiated that includes time resident was at table, time meal arrived, etc. Director of Quality Assurance responsible. •Focused resident satisfaction survey tool to be developed and completed monthly by Social Services with interviewable residents addressing meal service. Social Services will be responsible. Date of compliance for F-tag 244	1-25-2013 02/08/13

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 _____	12/20/2012

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 244	Continued From page 9 that she likes to eat with her room-mate as they go to the dining room at the same time and sit at the same table. Resident B stated "we don't get our trays together" and "one person eats while the other one sits and waits." Resident B further stated, "we are so used to cold food, cold eggs, cold toast." - During interview at 7:30 a.m. on 12/19/12, Resident C stated he had to "wait until after 6:00 [p.m.] last evening to get something to eat." Resident C stated evening meals used to be served "by 5:30 p.m." but now "meals are always late" (approximate scheduled meal time is 5:15 p.m. - 5:30 p.m.). - During an interview on the afternoon of 12/20/12, a family member (A) identified the facility wants all the residents in the dining room for a meal by noon, but then the residents "wait and wait" for their food. The family member added, "Meals [are] always so late." - Observation of the breakfast meal in the Unit I dining room on 12/18/12 identified the following: * At 7:45 a.m., observation showed Resident #21 seated at a dining room table in her wheelchair waiting for her breakfast. The resident received her breakfast meal at 8:55 a.m. (one hour and ten minutes later). - Observation of the breakfast meal in the Unit I dining room on 12/19/12 identified the following: * At 7:00 a.m., observation showed Resident #1 sitting in her wheelchair in her room, watching tv, with her bedside table in front of her. Resident #1, dressed and groomed, stated she is waiting for her breakfast. At 7:30 a.m., a certified nurse aide	F 244		

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 _____	12/20/2012

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 244	Continued From page 10 (CNA #16) answered Resident #1's call light. The resident stated she would like to have breakfast and the CNA told her she would check with the kitchen. Staff delivered Resident #1's breakfast tray at 8:05 a.m. * At 7:30 a.m. observation showed seven residents sitting in the Prairie dining room and seven residents sitting in the Badlands dining room waiting for breakfast (Breakfast meal time: 7:00 - 8:30 a.m.) At 7:50 a.m., a cart of meal trays arrived and a staff member began distributing the trays. In the Badlands dining room, trays were distributed to 3 of the 7 residents waiting for breakfast. The dining room staff called the kitchen to report missing meal trays from the cart. At three different tables, some residents ate their breakfast meal, while their table-mates waited for their trays. At 8:25 a.m., the remaining breakfast meals arrived from the kitchen. *At 7:55 a.m., Resident #26 received her meal tray, and her spouse, Resident #13, received his meal tray at 8:25 a.m. (30 minutes later, although they both arrived at the table at the same time). * At 9:20 a.m., breakfast meal trays arrived for service to Resident #22, #23, #24, and #25 at 9:20 a.m. (50 minutes after scheduled end of breakfast). - Observation of the breakfast meal in the Unit 2 dining room on 12/18/12 identified the following: * At 7:30 a.m., observation showed Resident #5, #17, #27, #28, and Resident #29 sitting in the dining room. The residents received their breakfast trays at the following times: Resident #5 and #17 at 8:20 a.m., Resident #27 at 8:39 a.m., Resident #28 at 8:18 a.m., and Resident #29 at 8:52 a.m.	F 244		

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 _____	12/20/2012

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 244	Continued From page 11 - Observation of the breakfast meal in the Unit 2 dining room on 12/19/12 identified the following: * At 7:15 a.m., an unidentified staff member transported Resident #11 to the dining room table. At 7:50 a.m., an unidentified staff member served Resident #11 her breakfast tray. * At 7:18 a.m., an unidentified CNA transported Resident #18 to the dining room table. At 7:40 a.m., an unidentified staff member prepared two breakfast trays and placed them in the service window. A second unidentified staff member served Resident #18 his breakfast tray. * At 7:21 a.m., an unidentified CNA transported Resident #19 to the dining room table. The resident dozed off and on while waiting for her breakfast tray to be served. At 8:13 a.m., an unidentified CNA served Resident #19 her breakfast tray (52 minutes after entering the dining room). * At 7:25 a.m., observations showed Resident #5, #17, #27, and #28 in the dining room. The staff members started delivering residents' breakfast trays to their tables at 7:44 a.m. * At 8:23 a.m., a CNA (#17) stated Resident #30 remained in bed as they were waiting for available staff to assist them to get her up for breakfast. At 8:42 a.m., a CNA (#17) asked an unidentified CNA to assist her to get Resident #30 up from bed with the full-body mechanical lift. Staff brought Resident #30 to the dining room at 9:03 a.m. The resident stated she had been awake in her room and ready for the day, but was waiting for staff to get her up and bring her to the dining room. Resident #30 received her breakfast tray and verbalized she was hungry from waiting so long.	F 244		

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 _____	12/20/2012

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 244	Continued From page 12 During an interview on 12/20/12 at 10:15 a.m., an administrative nurse (#3) confirmed residents have voiced concerns regarding the timeliness of meal service/palatability of foods. She also agreed the facility failed to deliver meals in a timely manner and failed to assist residents as needed.	F 244		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/11/11. Based on record review, review of the Long Term Care Facility Resident Assessment Instrument User's Manual, and staff interview, the facility failed to complete significant change in status assessments (SCSA) for 3 of 13 sampled residents (Resident #9, #12, and #13). Failure to complete a SCSA on a timely basis limited the	F 274		

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 _____	12/20/2012

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 274	Continued From page 13 facility staff's ability to accurately assess each resident's status, identify, and implement appropriate care plan approaches. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 3.0, occurred on 12/20/12. This manual, revised July 2011, pages 2-22 and 2-23 states ". . . A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." - Review of Resident #9's medical record occurred on December 17-20, 2012. The facility admitted the resident in January 2012. Diagnoses included stroke with left side weakness in March 2012 and left hip fracture after a fall in December 2012. The resident's significant change and quarterly Minimum Data Sets (MDSs), dated 03/30/12 and 06/19/12 respectively, identified the resident required extensive assistance of one person for ADLs of bed mobility, transfers, walk in room and corridor, locomotion on and off unit, and dressing. A quarterly MDS, dated 09/19/12, identified Resident #9 required no assistance for bed mobility and required supervision and setup help of one person for transfers, walk in room and	F 274	Resident #9 had a comprehensive ARD on 1/08/2013 Care Plan reviewed and updated. Resident #12 had a comprehensive ARD 02/06/2013, care plan will be reviewed and updated. Resident #13 had a significant change ARD on 12/23/2013 care plan reviewed and updated All residents who have a significant change in status had the potential to be affected by this violation *Implementation of ADL charting on every resident, every day. *Review ADL charting monthly for changes in ADLs. MDS Coordinator or designee will be responsible *Review residents with potential for significant change in IDT and schedule SCSA MDSs if needed. MDS Coordinator or designee will be responsible *Documentation will be kept of monthly ADLs starting 02-01-13 and remain ongoing *Review ADL charting monthly for changes in ADLs. starting when a completed month is available *Monthly monitoring will be tracked starting 02/01/2013 MDS coordinator or designee is responsible. Date of compliance for F-Tag 274	02/08/2013

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 _____	12/20/2012

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 274	Continued From page 14 corridor, locomotion on and off unit, and dressing. Resident #9 showed improvement in seven areas of functional status, however the facility failed to complete a significant change in status MDS. - Review of Resident #12's medical record occurred December 19-20, 2012. Resident #12's admission MDS, dated 03/15/12, identified she required extensive assistance of one person for bed mobility, transfers, walking in her room, locomotion on the unit, dressing, toilet use, and hygiene; walking in the corridor did not occur; and dependent on one staff member for locomotion off the unit. A quarterly MDS, dated 06/04/12, identified Resident #12 as independent for bed mobility, transfers, walking in room and in corridor, locomotion on and off the unit, dressing, toilet use, and hygiene. Resident #12 showed improvement in nine areas of functional status, however the facility failed to complete a significant change in status MDS. - Review of Resident #13's medical record occurred on December 17-20, 2012. The facility admitted the resident in December of 2011. Diagnoses included chronic obstructive pulmonary disease, pulmonary fibrosis, and congestive heart failure. Resident #13's admission MDS, dated 01/04/12, identified the resident required extensive assistance of 1 person for toileting and locomotion on and off the unit. A quarterly MDS, dated 03/23/12, identified Resident #13 as independent for toileting and	F 274		

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 _____	12/20/2012

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 274	Continued From page 15 locomotion on and off the unit. The medical record showed Resident #13 showed improvement in three areas of functional status, however staff did not complete a significant change in status MDS.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	Resident #3 Amendment added to CAA to reflect missing information/incorrect information 01/18/2013 Resident #4 assessments ARD 08/26/2012 and 11/25/2012 were modified on 01/18/2013. Resident #10 assessment ARD 11/12/2012 modified on 02/01/2013. Resident #17 Assessment ARD 10/01/2012 was modified on 01/18/2013. *Educate CNA at next staff meeting, and individually as needed regarding section G ADL coding. *CAA contributors (social services, director of activities, director of dietary and MDS coordinator) will meet to discuss findings prior to completion of CAA. Contributors will meet weekly when comprehensive assessments are due, more often as needed. *Nurse Managers will complete check list for each scheduled assessment due to ensure documented changes are currently implemented and to ensure resident's current status is reflected on plan of care. Educate CNAs regarding section G ADL coding *CNA team leader will document additional education completed on as needed basis beginning in February to monitor its effectiveness. Which will be reviewed at Monthly CNA meetings beginning at February *Minutes of CAA meeting will be kept. *MDS Coordinator will review Nurse Manger's check list to ensure it completed and correct start date- MDS Coordinator or designee responsible. Date of compliance for F-Tag 278	02/08/2013

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 _____	12/20/2012

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 278	Continued From page 16 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/11/11. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) and accompanying Care Area Assessment (CAA) Summary, when applicable, accurately reflected the residents' status for 3 of 13 sampled residents; (Resident #3's CAA documentation incorrectly identified psychotropic drug usage); (Resident #4's incorrectly coded swallowing status); (Resident #10's coded incorrectly for toileting program); and one supplemental resident (Resident #17's coded incorrectly for amount of assistance needed for eating). Failure to accurately complete portions of the MDS and CAA for residents does not allow each resident's assessment to reflect the resident's accurate needs. Finding include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, April 2012, page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page G-5 states, ". . . Activities of Daily Living (ADL) Assistance [includes eating] . . . Coding Instructions for G0110, Column 1, ADL-Self Performance Code 0, independent: if resident completed activity with no help or oversight every time during the 7-day look-back period. . . .	F 278		

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 _____	12/20/2012

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 278	Continued From page 17 Coding Instructions for G0110, Column 2, ADL Support Code 0, no setup or physical help from staff: if resident completed activity with no help or oversight. . . ." Page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ." Page K-1-2 states "Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modification or other interventions . . . and therefore represents a functional problem for the resident. . . . Code even if the symptom occurred only once in the 7-day look-back period." Page 4-1 states, "Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment . . . which must accurately reflect the resident's status and needs . . . the updated RAI consists of three basic components: 1) the MDS Version 3.0, 2) the CAA process, and 3) the RAI Utilization Guidelines. . . ." Page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * The Medicare Prospective Payment System * Medicaid reimbursement programs	F 278		

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 _____	12/20/2012

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 278	Continued From page 18 * quality monitoring activities . . . * the data-driven survey and certification process * the quality measures used for public reporting . . ." - Review of Resident #4's medical record occurred December 17-20, 2012. The facility identified diagnoses of dementia with behavioral disturbances, depression, and old lacunar CVA (cerebrovascular accident). An annual MDS, dated 08/26/12, identified he had no swallowing disorders. The CAA for this MDS stated, ". . .He was noted to have a loss of liquids from mouth, holding food in mouth and coughing/choking at meals this assessment period." A note from the Speech-Language Pathologist (SLP) confirmed the accuracy of the CAA. This note, dated 08/20/12, stated, "Observed res. [resident] during breakfast. Res. trialed pureed x [times]12 w/ [with] no s/sx [signs and symptoms] of aspiration. Trialed honey by spoon x 3 w/ holding of liquid [and] [increased] difficulty w/ swallowing. Trialed pudding thick liquids x 3, no s/sx of aspiration. Res. did need cues to chew [and] swallow. Spoke w/ staff [and] res. having difficulty w/ honey by spoon, coughing episodes. Res. does become fatigued during meals, encouraged small bites and drinks presented during feedings. St [staff] to monitor meals." Documentation from the SLP showed the resident experienced the following MDS disorders related to swallowing: holding food in mouth; coughing or choking during an observed meal; and difficulty swallowing. The CAA identified Resident #4 experienced the MDS swallowing disorder of loss of liquids from mouth. Facility	F 278		

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 _____	12/20/2012

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 278	Continued From page 19 staff identified "None of the above" for swallowing disorders on the MDS, which supporting documentation showed as incorrect coding. - Review of Resident #3's medical record occurred December 17-20, 2012. The facility completed a significant change of assessment MDS for Resident #3 on 11/30/12. The CAA, not dated, but identified for this MDS stated, ". . . has a diagnoses of dementia/Alzheimer's type with/out [sic] behaviors . . . She is on . . . seroquel [sic] 25 milligrams [mg] po [by mouth] daily . . . Family has agreed and would like [Resident #3] to be followed by the telemed psychiatrist at his assigned visit in the month of August. . . ." The record showed the following in contrast to the significant change CAA: On 08/28/12, the physician changed the diagnosis to dementia with behavioral disturbances. On 09/24/12, the physician increased the Seroquel to 25 mg twice a day and on 10/29/12, increased it to 50 mg twice daily. The record lacked evidence the facility arranged an appointment for Resident #3 with the psychiatrist in August. The CAA lacked the appropriate diagnoses, drug dosage, and identified the resident would see the psychiatrist in August. Failure of the facility to have accurate information in the CAA has the potential to affect the care planning process for Resident #3. During an interview on the afternoon of 10/20/12, administrative staff members (#2, #3, and #4) confirmed errors in the MDS and/or CAA for	F 278		

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 _____	12/20/2012

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 278	Continued From page 20 Resident #3 and #4. An administrative staff member (#2) identified Resident #3 did not have an appointment with the psychiatrist in August nor since, and due to the change in Resident #3's condition the facility would not pursue an appointment with the psychiatrist at this time. - Review of Resident #10's medical record occurred on all days of survey. The admission Minimum Data Set, dated 05/25/12, identified Resident #10 as on a urinary toileting program/trial. A quarterly MDS, dated 08/13/12, identified Resident #10 as frequently incontinent of urine and on a urinary toileting program. The quarterly bowel and bladder assessment, dated 08/14/12, stated, ". . . Resident is currently on a bowel and bladder program which she seems to be declining on. Due to her diagnosis of senile dementia and urinary incontinence, res [resident] is not likely to improve with her continence. Will d/c (discontinue) her bowel and bladder program at this time." A quarterly MDS, dated 11/12/12, identified Resident #10 as on a toileting program. The quarterly bowel and bladder assessment, dated 11/13/12, stated "Res has become almost fully incontinent during this assessment period, of both bowel and bladder. she is frequently incontinent of both bowel and bladder [with] no discernable pattern. Res has no physical cause of increased incontinence . . . and is likely showing progression of dementia. Will d/c toileting program at this time." The quarterly bowel and bladder assessments from 08/14/12 and 11/13/12 identify discontinuation of a toileting program, however	F 278		

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 _____	12/20/2012

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 278	Continued From page 21 the quarterly MDS assessments identify Resident #10 as on a toileting program. - Review of Resident #17's medical record occurred on December 19-20, 2012. Diagnoses included Alzheimer's disease, depression, and history of a cerebrovascular accident. The resident's Minimum Data Sets (MDSs) identified the following regarding the level of assistance Resident #17 required for eating: * 04/01/12 Quarterly - setup help and supervision * 07/01/12 Quarterly - setup help and supervision * 10/01/12 Annual - independent The Care Area Assessment (CAA), dated 10/01/12, corresponding with the annual MDS stated, ". . . Nutritional Status: . . . Her meal intake is less than 50% at most meals and her fluid intake ranges from 30-35% of the approx. [approximately] 1800 ml [milliliters] offered daily with meals . . . She does feed herself with supervision and set up at meals by staff. . . ." During an interview on 12/20/12 at 7:06 a.m., an administrative nurse (#9) stated Resident #17 required staff supervision verifying the MDS coded on 10/01/12 was not accurate.	F 278		
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.	F 309		

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 _____	12/20/2012

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 309	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review, facility standing orders, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #11) receiving insulin. Failure to notify the physician in a timely manner of a pattern of low or high blood sugars has the potential to result in poorly controlled diabetes and does not allow the resident to attain or maintain the highest practicable level of physical well-being. Findings include: Review of Resident #11's physician's "Standing Orders" occurred on 12/20/12. These orders, dated 01/12/12, stated, ". . . TREATMENTS: 1. Insulin Reaction before unconsciousness BS [blood sugar] parameter [Blank] [Check] Glucose gel 15 grams (PO) [orally] - repeat in 15 min. [minutes] if no response and notify physician. 2. Insulin reaction and resident not responsive BS Parameter [Blank] or physician preference [Blank] [Check] Glucagon 1 mg [milligram] (IM) [intra-muscular] and notify physician [Check] Check blood sugar PRN [as needed] as indicated. . . ." Review of nurse's notes identified the following: * "09/14/12 at 6:00 a.m., Res [resident] BS 62. Give 2 oz [ounces] OJ [orange juice] and 2 oz applesauce (approx.) [approximately]. Will recheck." Review of a fax sent to Resident #11's physician	F 309	•Resident #11's medical record to be evaluated for any additional episodes of hypoglycemia and associated interventions no later than 1/18/13. Resident #11's chart was reviewed on 1/18/13. A fax was sent on 1/9 regarding a low blood sugar. Orders in the MAR do state not to call the "on call" unless the blood sugar continues to be <50 after one hour of treatment. Resident #11's blood sugar came up from 49 to 153 following 35 minutes. All Residents who have scheduled blood glucose monitoring have the potential to be affected by this violation. •Residents who have current orders for scheduled blood glucose monitoring will be identified no later than •Primary Physician of all Residents who have been identified to have scheduled blood glucose monitoring will be sent a Fax requesting clarification of low and high parameters in which the provider would be notified. Fax requesting parameters to be sent to primary MD's Request clarifications to be faxed back to St. Luke's Home no later than 1/25/13. •Resident Specific high and low blood sugars call parameters to be placed on the Resident MAR, added to the Resident Report Sheets and included in the Physician Orders no later than 1/25/2-13 •Educate Charge Nurses to continue use of Physician Standing orders for immediate treatment of hypoglycemia at Mandatory Nursing Department Meeting •Educate Charge Nurses to include addition of resident specific call parameters at Mandatory Nursing Department Meeting.	

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 _____	12/20/2012

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 309	Continued From page 23 on 09/14/12 at 6:20 a.m. stated, "Reason for Assessment: [Low] BS . . . 6:00 a.m. BS [check] Res. BS was 62. Res. alert. Give 2 oz OJ and 2 oz Applesauce. 6:20 a.m. Res. BS was 135. . . . Physician's Response: Noted 09/19/12." The facility received a response from the physician 5 days after transmitting the original fax. The facility failed to reattempt to contact the physician prior to receiving the 09/19/12 fax. Review of nurse's notes identified the following: * "10/12/12 at 8:30 p.m., Res. was very drowsy and cold and sweating profusely. BS [check] at 7:30 p.m. 72. But as res. was not alert and responding well gave her 15 grams of glucose gel. At 7:45 p.m. BS [check] 52. Res. became more drowsy and not responding. So, Glucagon 1 mg IM administered. Slowly res. started to arouse. Helped res. to bed and covered her up good as she was cold and clamy [sic]. Stayed with res. until I [sic] 8:00 p.m. BS [check] at 8:00 p.m. 115. Res. alert and responding. Will continue to monitor." The facility failed to notify the physician regarding Resident #11's "no response" after administering the Glucose gel which required staff to administer IM Glugagon. Review of a fax sent to Resident #11's physician on 10/12/12 at 9:45 p.m. stated, ". . . Reason for Assessment: Hypoglycemia. Res. was very cold, clamy [sic] drowsy and sweating profusely. BS [check] 72. Gave 15 gms [grams] glucose gel [at] 7:30 but her BS went down to 52 after 15 minutes and res. became unresponsive. So Glucagon 1 mg IM administered per SO [standing order]. After 15 mins. BS [check] 115 and res. started to	F 309	•Educate Charge Nurses to include contacting the Physician via telephone for any change in resident condition that requires time sensitive intervention or communication, including but not limited to blood sugars outside parameters at Mandatory Nursing Department Meeting on 1/24/13. •Quality tool developed to monitor diabetic residents with scheduled blood sugar monitoring. Complete 10 random record reviews monthly for residents who receive blood sugar checks X6 months. Implement no later than 2/4/13. Director of Quality Assurance or designee responsible. •Results of quality monitor to be reported at monthly quality meeting. Compliance date for F-tag 309	2/08/2013

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 _____	12/20/2012

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 309	Continued From page 24 arouse. At 9:30 p.m. BS [check] 210 - Res alert and responding. Will continue to monitor. . . . Physician response: Noted [Undated]." Review of nurse's notes identified the following: * "10/12/12 at 11:30 p.m., Res. looks aroused and answers question [sic] well. Res. ate Yogurt 3 ounces. BS [check] at 9:30 p.m. 210. Will continue to monitor. * 10/12/12 [sic] at 1:00 a.m., Res. asleep. Arouses with external stimulus. Will monitor. * 10/12/12 [sic] at 4:00 a.m., Res asleep. Arouses when called by name. Alert and responding to answers well [sic]. . . . BS [check] 360. * 10/15/12 at 1:30 p.m., Fax received regarding increased blood sugar [470] at lunch. Give 8 units now. Recheck in 2 hours. Give 4 more if BS > 350." The facility failed to notify the physician of Resident #11's high blood glucose reading on 10/15/12. During an interview on 12/18/12 at 12:50 p.m., when asked for a copy of Resident #11's blood sugar parameters, a nursing staff member (#6) stated, "I would look for them on the MAR [medication administration record]. " When she failed to locate them on the MAR, she stated, "I would look for them on the physician's orders then." When she failed to locate them on the physician's orders, she phoned a managerial nursing staff member (#9) for direction. The managerial nursing staff member (#9) stated, "The physician would be contacted if blood sugars were below 60 or above 400. " When asked for the source of the parameters, she stated, "They are just based on the nurse's judgment at the time."	F 309		

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 _____	12/20/2012

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 309	Continued From page 25 During an interview on 12/20/12 at 10:15 a.m., an administrative nurse (#3) confirmed establishing blood sugar parameters as they relate to physician notification should not be left to the nurse's judgment. Failure of the facility to obtain physician ordered parameters for blood glucose levels placed residents at risk.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: 1. Based on record review; review of facility policy; and group, family, and staff interviews, the facility failed to provide the necessary services to maintain good hygiene for 10 of 13 sampled residents (Resident #2, #3, #4, #5, #6, #8, #9, #10, #11, and #13), 3 of 4 supplemental residents (Resident #17, #18, and #19), and 1 of 3 closed records (Resident #20) who required assistance bathing. Failure to provide bathing assistance limits residents' ability to maintain their personal hygiene, skin integrity, and dignity. Findings include: Review of the facility policy titled "Bath - Whirlpool" occurred on 12/20/12. This policy stated, ". . . Purpose 1. To thoroughly cleanse resident body through use of whirlpool action. 2.	F 312	A total of 14 residents were identified to be affected by assistance with bathing. Restructuring within the Dept. of Nursing moved the focus of bathing from a designated "whirlpool" aide to an individual CNA responsibility within the past 90 days, necessitating staff education, revision of forms and a culture change. Action Plan was in place relating to bathing at the time of the survey. Bathing addressed with CNA Staff at meetings on January 8 and January 10, 2013. A total of 4 residents were affected by failure to provide residents with cueing and assistance during meals. Resident #6 Revised her care plan that resident requires extensive to total assist with meals. Also placed at a table that has staff available to assist. Resident #11: Was moved to a table staffed at all meals to assist residents with feeding and cueing. Resident #17: Care plan changed from resident requiring cueing only to limited to total assistance.- Resident #18: Was moved to a table that is staffed at all times to assist in cueing and feeding residents. Failure to provide residents with cueing and assistance during meals was addressed at CNA staff meeting on January 8 and January 10, 2013.	

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 _____	12/20/2012

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 312	Continued From page 26 To stimulate muscles and circulation. 3. To assist in pain relief and cleansing of skin wounds. . . . Procedure 1. CNA assigned to resident is to . . . take to whirlpool at scheduled bath time. . . ." During the group interview on 12/17/12 at 1:30 p.m., two residents (#13 and #20) and a confidential family member (#1) voiced concerns regarding the facility failing to bathe residents as care planned/scheduled. - Review of Resident #2's medical record occurred on all days of survey. The facility identified the resident as interviewable. Resident #2's quarterly Minimum Data Set (MDS), dated 11/30/12, identified intact cognition, no behaviors or acute changes in mental status, and total assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #2's whirlpool on Sundays and Thursdays. During interview on 12/18/12 at 1:25 p.m., Resident #2 reported he is scheduled for baths two times a week, but frequently waits "ten days" or more between baths. Resident #2's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 9-14 (6 days), November 16-22 (7 days), and no documented bath November 24-December 19 (26 days). - Review of Resident #3's medical record occurred on all days of survey. The resident's significant change MDS, dated 11/30/12, identified extensive assistance of one person for	F 312	All Residents had the potential to be affected by this violation (bathing). Residents who require cueing and assistance at meals had the potential to be identified by this violation (cueing and assistance during meals). Additional residents at risk will be identified by staff observation or by speech and MD order. Bathing •Reviewed deficiencies at January 2013 CNA Staff Meetings. •Discuss at Mandatory All Staff Meeting on 1/22/13 and Mandatory Department of Nursing Meeting on •Required CNA Documentation moved to the CNA Care Book within the past 90 days. •Bath/Shower schedule by Resident/Day updated and placed in CNA Care Book within past 90 days. •CNA Worklists updated within the past 90 days to reflect residents bath/shower day. •Whirlpool/Shower Charting added to the Vital Signs and Bowel and Bladder Flowsheet within the past 90 days. •Change border to red on the Vital Signs and Bowel and Bladder flow sheet to highlight Residents Bath/Shower Day no later than •Discuss with Staff that failure to provide ADL's can result in corrective action not limited to termination and reporting to the State of ND as Neglect no later than • Address Resident ADL's in Monthly Updates Newsletter (ongoing). •Education regarding the importance of documentation of bath/shower to be completed at Mandatory Nursing Department Meeting •Broda shower chair obtained and education completed at December, 2012 CNA and Charge Nurse Meetings. •All CNA Staff oriented to whirlpool/showers within the past 90 days and ongoing during new employee orientation.	

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 _____	12/20/2012

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 312	Continued From page 27 bathing. Resident #3's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 4-17 (13 days), November 17-30 (13 days), and December 10-18 (8 days). - Review of Resident #4's medical record occurred on all days of survey. The resident's quarterly MDS, dated 11/25/12, identified the resident as dependent on one person for bathing. Resident #4's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 18-December 2 (14 days), and December 2-15 (13 days). - Review of Resident #5's medical record occurred on all days of survey. Resident #5's annual MDS, dated 12/05/12, identified extensive assistance of one person for bathing. Resident #5's "Whirlpool/Shower Charting" for November and December 2012 identified no bath December 5-17 (13 days). - Review of Resident #6's medical record occurred on all days of survey. Resident #6's annual MDS, dated 11/20/12, identified extensive assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #6's whirlpool on Wednesdays and shower on Fridays. Resident #6's "Whirlpool/Shower Charting" for November and December 2012 identified no bath/shower November 1-8 (7 days), Nov 9-16 (7	F 312	•Standards of Care Updated to Include addition of Bath/Shower. Education to be completed at 1/24/13 Mandatory Nursing Staff meeting. Cueing and Assistance at Meals •Meal Times on each Resident Care Unit start at a designated time, no longer an open time frame. •Revise seating chart to ensure adequate CNA staff able to provide resident assistance/cueing are available in the dining room at time of meal service •One CNA staff on Unit 1 and Unit 2 to begin work at 0500 when possible. •No Nursing Dept. Employee breaks during mealtime effective immediately. •Provide additional assistance at meal time, i.e. Activities, RT, and Leadership to assist with passing trays allowing CNA staff to begin assisting/cueing •Residents will be brought to the dining room once meal service commences. Residents may remain in TV lounge or in their room while awaiting meal •Educate to new process Mandatory Nursing Department Meeting on 1/24/13. Education of Dietary Staff on delivery, setup and cueing of resident meals 12/28/12 and 1/21/13	

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 _____	12/20/2012

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 312	Continued From page 28 days), Nov 17-29 (12 days), and November 30-December 14 (15 days). - Review of Resident #8's medical record occurred on all days of survey. Resident #8's quarterly MDS, dated 11/26/12, identified total assistance of one person for bathing. Resident #8's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 15-23 (9 days) and December 3-14 (12 days). - Review of Resident #9's medical record occurred on all days of survey. Resident #9's quarterly MDS, dated 7/19/12, identified extensive assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #9's whirlpool on Mondays and Thursdays. Resident #9's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 1-13 (13 days), 15-25 (10 days), and December 4-19 (15 days). - Review of Resident #10's medical record occurred on all days of survey. Resident #10's quarterly MDS, dated 11/12/12, identified extensive assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #10's shower on Sundays and whirlpool on Thursdays. Resident #10's "Whirlpool/Shower Charting" for November and December 2012 identified no	F 312	•Whirlpool/Shower Quality Tool to be added to front of CNA Care Book by Unit reflecting required Showers/Baths on a daily basis. CNA staff to be educated to completion of form at Mandatory Nursing Department Meeting on 1/24/13. Implement quality tool no later than 2/1/13 •CNA staff to verbally report completion of baths/showers to charge nurse at completion of shift. Education to be completed at Mandatory Nursing Department Meeting on 1/24/13 •Unit Charge Nurse or Designeeresponsible for monitoring completion of the written Quality tool and documentation of Bath/Shower on the Vital Signs and Bowel and Bladder Sheet every shift prior to the CNA Shift ending. Education to be completed at Mandatory Nursing Department Meeting 1/24/13 and implement 1/25/13. •CNA Team Leader or designee to collect and place new Quality Monitoring Tools on a Weekly Basis. CNA Team Leader to maintain file with hard copies •CNA Team Leader or designee to monitor completion of Whirlpool/Shower Quality Tool and Required Whirlpool/Shower documentation in the CNA Care Book on M/W/F until 100% compliance is noted X4 weeks. •Initiate corrective action if necessary for failure to comply with provision of Resident ADL's. (ongoing). •Quality monitor developed to monitor meal process (see attachment) Initiate monitor. Complete random audits per month per unit at various meal times/total 30 per month for 3 months at which time we will evaluate for effectiveness and random there after. Director of QualityAssurance or designee responsible. Report data at Quality Assurance meeting x one year. Date of compliance for F-tag 312	2/08/2013

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 _____	12/20/2012

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 312	Continued From page 29 bath/shower November 1-14 (14 days), November 16-28 (13 days), and November 29-December 12 (14 days). - Review of Resident #11's medical record occurred on December 18-20, 2012. The quarterly MDS, dated 10/01/12, identified severe cognitive impairment and extensive assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #11's whirlpool on Wednesdays and shower on Sundays. Resident #11's "Whirlpool/Shower Charting" for November and December 2012 identified no bath/shower November 4-24 (21 days), and December 6-20 (15 days). - Review of Resident #13's medical record occurred on December 19-20, 2012. The facility identified Resident #13 as interviewable. Resident #13's annual MDS, dated 12/06/12, identified intact cognition, no behaviors or acute changes in mental status, and limited assistance of one person for bathing. During interview at 9:15 a.m. on 12/18/12, Resident #13 stated he is scheduled for a bath two times a week, but recently went "almost two weeks" between baths. The whirlpool/shower schedule showed staff scheduled Resident #13's whirlpool on Wednesdays and Fridays (day shift). During interview on 12/19/12 at 9:00 a.m., Resident #13's family member (Family Member	F 312		

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 _____	12/20/2012

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 312	Continued From page 30 #2) stated a staff member came into the room "between 9:30-10:00 [p.m.] last evening to give him a bath." The family member stated, "He was already in bed for the evening, they never go by a schedule." Resident #13's "Whirlpool/Shower Charting" for November and December 2012 identified the November charting sheet as "missing," and no bath between December 1-10 (10 days). - Review of Resident #17's medical record occurred on December 19-20, 2012. Resident #17's annual MDS, dated 10/01/12, identified total assistance of one person for bathing. Resident #17's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 7-16 (10 days), November 20-December 2 (13 days), and December 4-16 (13 days). - Review of Resident #18's medical record occurred on December 19-20, 2012. The quarterly MDS, dated 12/03/12, identified severe cognitive impairment and extensive assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #18's whirlpool on Mondays and Fridays. Resident #18's "Whirlpool/Shower Charting" for November and December 2012 identified no bath November 4-11 (8 days), November 13-22 (10 days), and December 1-13 (13 days). - Review of Resident #19's medical record	F 312		

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 _____	12/20/2012

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 312	Continued From page 31 occurred on December 19-20, 2012. The quarterly MDS, dated 09/25/12, identified severe cognitive impairment and extensive assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #19's whirlpool on Thursdays and shower on Sundays. Resident #19's "Whirlpool/Shower Charting" for November 2012 identified no bath/shower November 1-10 (10 days), and November 12-21 (10 days). - Review of Resident #20's medical record occurred on December 19-20, 2012. The quarterly MDS, dated 12/07/12, identified intact cognition and limited assistance of one person for bathing. The whirlpool/shower schedule showed staff scheduled Resident #20's whirlpool on Thursdays and shower on Sundays. Resident #20's "Whirlpool/Shower Charting" for December 2012 identified no bath/shower December 10-15, and the resident "showered per self" on the 16th. During an interview on 12/20/12 at 9:00 a.m., a managerial nursing staff member (#4) stated the residents are "typically bathed/showered weekly." She confirmed staff should bathe residents according to their care plan/schedule. 2. Based on observation, record review, and staff interview, the facility failed to ensure residents received the necessary services to maintain good	F 312		

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 _____	12/20/2012

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 312	Continued From page 32 nutrition for 2 of 6 sampled residents (Resident #6 and #11) and 2 supplemental residents (Resident #17 and #18) who required staff assistance (including cueing) with eating. Failure to provide residents with cueing and assistance during meals may result in decreased intake and weight loss. Findings include: - Review of Resident #17's medical record occurred on December 19-20, 2012. Diagnoses included Alzheimer's disease, dementia with behaviors, depression, history of a cerebrovascular accident, esophagitis, kyphosis, and scoliosis. The annual MDS, dated 10/01/12, identified short and long term memory problems and a mechanically altered diet. The Care Area Assessment (CAA) summary, corresponding with the 10/01/12 MDS, stated, ". . . She is on a regular mechanical soft diet with ground meats. Her meal intake is less than 50% at most meals and her fluid intake ranges from 30-35% of the approx. 1800 ml [milliliters] offered daily with meals, she is at moderate risk of dehydration per the dietician hydration assessment. She has experienced gradual wt. [weight] loss in the past, but wt. is now stable the past 6 months. Her current wt is 87# [pounds] and family have [sic] does not want her to have a feeding tube. She receives supplements at med [medication] pass TID [three times daily] for poor meal intakes with a risk of further wt. loss. She does feed herself with supervision and set up at meals by staff. HyFiber suppl. [supplement] is provided TID for constipation. The Dietician and Dietary Manager will routinely review her meal record, fluid intake and weights. . . ."	F 312		

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 _____	12/20/2012

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 312	Continued From page 33 The current care plan stated, ". . . . I fall asleep at meals and need cueing when eating . . . I have poor meal intake, which causes me to lose weight and I am at moderate risk of dehydration . . . At times I refuse meals. . . ." Observations of Resident #17 during meals identified the following: * 12/18/12 during breakfast - At 7:30 a.m., staff brought the resident into the dining room. She leaned to the left in her Broda chair with her head down and eyes closed. Staff brought her breakfast to the table at 8:20 a.m., and Resident #17 continued to sleep. At 9:00 a.m., the resident woke up, consumed half a glass of chocolate milk, and had no further intake. * 12/18/12 during the noon meal - At 12:30 p.m., the resident leaned to the right in her Broda chair, unable to reach her food and drinks. At 12:40 p.m., an unidentified CNA handed the resident a glass of chocolate milk which she spilled on her clothing (staff gave her more chocolate milk). The unidentified CNA handed the resident her egg salad sandwich which she held in her hand and took a few bites. While she ate the sandwich filling fell from her mouth and hands and onto the floor and her clothing. The resident ate a few bites of her egg salad sandwich and drank half a glass of chocolate milk. * 12/19/12 during breakfast - At 7:25 a.m., the resident was in the dining room in her Broda chair, leaning to the right and sleeping. Staff delivered the resident's breakfast tray at 7:42 a.m., but she continued sleeping until 8:30 a.m. At this time, a CNA (#17) handed her a glass of chocolate milk without a straw. The resident extended her neck back in order to drink from the	F 312		

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 _____	12/20/2012

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 312	Continued From page 34 glass, and milk spilled on the resident's clothing. The resident fell asleep holding her glass of milk and did not eat any of her meal (hot cereal, toast, and a banana). * 12/19/12 during the noon meal - At 1:00 p.m., Resident #17 leaned to the left and slept in her Broda chair while her sherbet, chocolate milk, and grilled cheese sandwich remained untouched. * 12/20/12 during breakfast - At 9:05 a.m. the resident leaned to the left and slept in her Broda chair. Her food and drinks remained untouched. During the above observations, staff failed to ensure Resident #17's food and drinks were within her reach, encourage her to eat, and provide her with continued assistance during her meals. During interviews on the morning of 12/20/12, a dietary staff member (#5) and an administrative nurse (#9) stated they expected staff to provide encouragement and assistance to Resident #17 during meals. They identified staff should place her food and fluids within reach so she can eat independently if she chooses. - Review of Resident #11's medical record occurred on December 18-20, 2012. The quarterly MDS, dated 10/01/12, identified severe cognitive impairment and a mechanically altered diet. The CAA [Care Area Assessment] Summary, dated 04/05/12, stated, ". . . She eats independently after tray set up. She eats in her neighborhood DR [dining room] R/T [related to] dementia and risk of needing help and/or supervision as often dozes off. Her meal intake is above 50-7% [sic] at most meals. . . ."	F 312		

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 _____	12/20/2012

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 312	Continued From page 35 The current physician orders stated, ". . . regular diet, mechanical soft with ground meats . . . nectar thick liquids. . . ." The current care plan stated, ". . . Problem: . . . I have swallowing difficulties at meals . . . I have a mechanically altered diet with nectar liquids per speech therapy. . . ." The current daily living needs plan stated, "Eating: Self . . . Assist PRN [as needed]." Observations on 12/19/12 showed the following: * 7:15 a.m., Resident #11 sat in her wheelchair in the dining room, asleep. * 7:50 a.m., an unidentified staff member delivered her breakfast tray. She made no effort to wake/cue the resident prior to returning to the kitchenette. * 7:55 a.m., an unidentified CNA walked past a resident seated near Resident #11. Using a raised tone of voice, the CNA instructed the other resident to "Wake up and start eating." Resident #11 startled, and stared at the food on her tray. * 8:00 a.m., Resident #11 began eating, taking a few bites. Staff made no effort to cue the resident to continue eating. Resident #11 consumed half of her food and one third of her beverages. - Review of Resident #18's medical record occurred on December 19-20, 2012. The quarterly MDS, dated 12/03/12, identified severe cognitive impairment, limited assistance of one person for eating, and a mechanically altered diet. The current physician orders stated, ". . . regular diet, mechanical soft, whole meats cut in small	F 312		

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 _____	12/20/2012

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 312	Continued From page 36 pieces. . . ." The current care plan stated, ". . . Problem: I have a history of swallowing problems . . . I often need assistance eating but at times I can eat independently. . . . Goal(s): I would like to continue to eat over 75% at most of my meals. . . . Approach(s): See my daily living needs plan . . ." The current daily living needs plan stated, "Eating: Assist 1." Observations on 12/19/12 showed the following: * 7:45 a.m., Resident #18 sitting in his wheelchair in the dining room, asleep. An unidentified staff member delivered his breakfast tray. She made no effort to wake/cue the resident prior to returning to the kitchenette. * 7:55 a.m., An unidentified CNA walked past Resident #18, saw him sleeping in the dining room, and using a raised tone of voice, instructed the resident to "Wake up and start eating." Resident #18 startled, saw his tray sitting on the table, and began eating. During an interview on 12/20/12 at 10:15 a.m., an administrative nurse (#3) confirmed staff should assess the resident's alertness level prior to delivering meal trays and should provide cueing throughout the meal for those residents at risk for poor intake. - Review of Resident #6's medical record occurred on December 17-20, 2012. The resident's annual MDS, dated 11/20/12, identified extensive assistance of one person for eating. Resident #6's Nutrition CAA, dated 11/27/12, stated ". . . has shown a 5# [pound] wt. [weight]	F 312		

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 _____	12/20/2012

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 312	Continued From page 37 loss in the past 6 months. She is at a moderate risk of dehydration . . . receives total assist with eating. . . ." The resident's current care plan, dated 11/30/12, stated, "NUTR [Nutrition], Problem(s) . . . I need assistance with eating . . . Goal(s), I will receive the help I need at meals from staff. . . . Approach(s) . . . I need extensive to total assistance at meals . . ." Observation of the Unit I dining room, on 12/18/12 at 7:55 a.m., showed Resident #6 seated in a wheelchair at a dining room table with a covered glass of thickened water in front of her. The resident remained seated at the table and the water remained covered until 9:00 a.m. when a CNA (#15) wheeled her from the table back to her room to assist her with the breakfast meal (one hour and five minutes later).	F 312		
F 323 SS=G	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 record review, resident interview, and staff interview, the facility failed to ensure a safe environment for 1 of 1 sampled resident (Resident #2) who experienced a fracture during wheelchair transport. Failure to ensure the resident's foot remained on the wheelchair foot	F 323	Resident #2 has remained in a standard wheelchair. Resident's immobilizer has been dc'd. Resident was evaluated during week of 1/14/13 to determine whether he could return to his electric wheelchair. Resident was not felt to be safe in Electric Wheelchair at this time. Resident has his own wheelchair and will not require use of a transfer wheelchair. Resident's wheelchair continues to be equipped with leg straps to secure his legs to foot rest. Residents who require the use of a transfer wheelchair had the potential to be affected by this violation.	1-14-13

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 _____	12/20/2012

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 323	Continued From page 38 pedal resulted in a fracture of Resident #2's right distal femur. Findings include: During the initial facility tour, on 12/17/12 at 9:00 a.m., a supervisory nursing staff member (#2) reported Resident #2 experienced a fracture of the right leg "three-four months ago" when his right foot "fell off" a wheelchair foot pedal. The staff member reported he continued to be non-weight bearing on the right leg. Review of Resident #2's medical record occurred on December 17-20, 2012. The facility admitted the resident in August 2010. Current diagnoses included right distal femur fracture on 05/29/12, osteoarthritis, pain, paraplegia, and osteoporosis. The resident's quarterly Minimum Data Set (MDS), dated 11/30/12, identified the resident as cognitively intact and walking did not occur. The facility identified the resident as interviewable. Resident #2's quarterly and significant change MDSs, dated 05/25/12 and 03/11/12, respectively, identified the resident demonstrated functional limitation in range of motion of both lower extremities. The resident's CNA care plan, dated 05/29/12, stated "Mobility . . . Self . . . electric wheelchair . . ." and "Transfers . . . May use stand lift for all transfers. If I am having difficulty may use hoyer lift. . . ." The CNA care plan and the nursing care plan prior to and after the fracture did not identify Resident #2's loss of function in his lower extremities or interventions and safety measures during transfers and transportation.	F 323	•Transport Wheelchairs will be marked for ease of identification as a transport chair by maintenance department staff . •Transport chairs to be evaluated using a standardized checklist by maintenance department to ensure proper working order. •Transport chairs to be equipped with a double Velcro strap that cannot be removed to prevent feet from dropping off the pedals. •All St. Luke's owned wheelchairs to be evaluated using a standardized checklist by maintenance department. •Maintenance Department staff to maintain log of all St. Luke's owned wheelchairs, including date evaluated and confirming that wheelchair is in proper working order (ongoing). Director of Maintinance or designee. •Wheelchair safety tips and information to be included in new employee orientation no later than •Educate all staff at the Mandatory All-Staff Meeting on 1/22/13 to Wheelchair safety tips and information including Lock Out/Tag Out. •Post Wheelchair Safety Tips and information Poster on all Resident Care Units and strategically throughout facility no later than •Lock Out/Tag Out Forms to be placed on All Resident Care Units no later than •Maintenance Department staff to maintain log of all St. Luke's owned wheelchairs, including date evaluated and confirming that wheelchair is in proper working order including presence and proper function of Velcro strap on all transport chairs (ongoing). •Transport chairs to be evaluated using a standardized checklist by maintenance department to ensure proper working order no later than 1/25/13 and biannually thereafter. Director of Mantinance or designee. •All St. Luke's owned wheelchairs to be evaluated using a standardized checklist by maintenance department no later than 2/28/13 and biannually thereafter. Director of Maintinance responsible. Compliance date for F-323	1/25/13. 2/08/13

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 _____	12/20/2012

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 323	Continued From page 39 Resident #2's Nurse's Notes stated: *05/29/12, 2:00 p.m. - "Res. [Resident's] Rt. [right] foot fell off of foot pedal of w/c [wheelchair] during transfer to appt [appointment]. C/o [Complains of] (R) [right] knee pain c/o [sic]. [Nurse practitioner (NP)] aware et [and] states to monitor (R) knee. Res. requests to be transferred to bed per hoyer lift [full body lift] et done so per his request. Has bruise to (Rt) knee. No new swelling as noted by [name] supervisor. Today's faxes observed et filed as noted to monitor by [NP]." . . . 7:00 p.m. - "Res. c/o left toe pain & [and] Rt. knee pain. Scheduled pain meds. [medications] given. Toe bandaid in place." 10:00 p.m. - "Res. c/o Rt. knee pain & requesting pain medication. PRN [as needed] p.o. [by mouth] pain med given. . . ." *05/30/12, 5:30 p.m. - "Res. c/o Rt. knee pain & scheduled pain meds. given. Res. refused to use stand lift this a.m. [morning] & staff used hoyer lift transfer due to knee pain." 11:45 a.m. - "Res. request x-ray of (R) knee due to pain from incident yesterday. Order received per telephone to send to [clinic] for x-ray and [physician] will see on rounds tonight. . . . Knee has reddened area [with] sl. [slight] warmth to area. Remains swollen et painful [with] movement. Receiving pain meds PRN. . . ." 3:15 p.m. - "Res. to be direct admit to hospital per [physician] due to fx [fracture] (R) knee. . . ." Resident #2's physician ordered pain medications on 05/29/12 included Tylenol with Codeine (opioid pain reliever) 300/30 milligrams (mg), one tablet every four hours as necessary for pain relief, Tramadol (opioid pain reliever) 50 mg, one tablet	F 323		

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 _____	12/20/2012

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 323	Continued From page 40 every eight hours, and Fentanyl patch (opioid pain reliever) 12 micrograms per hour, every 72 hours. Resident #2's medical record included an acute care facility history and physical, dated 05/30/12, which stated ". . . He has been confined to a wheelchair for years because of lower extremity paraplegia of unknown etiology. . . ." The medical record also included a physician progress note, dated 10/29/12, which stated ". . . He will also need to see an orthopedic surgeon about a possible replacement of the right total knee prosthesis based on an orthopedic's [sic] surgeon review of the x-rays after he had the fracture. . . ." Resident #2's medical record also included an x-ray report of the right knee, dated 05/30/12, which stated ". . . Mildly displaced fracture of the distal right femur immediately cephalad [above] to the femoral component of the TKA [total knee arthroplasty (replacement)]. Angular deformity with the apex directed anteriorly [forward]. . . ." At the surveyor's request to review the facility's incident report for Resident #2's fracture on 05/29/12, a supervisory nursing staff member (#9), provided a "summary" of the incident. This "summary," dated 06/05/12, stated ". . . One of the CNA's [certified nursing assistants] started to take the resident down to the front office where the bus comes to pick up clients, when she was going down the hall the resident's right foot slid off of the right foot pedal on the wheelchair. Since the resident is a paraplegic and cannot physically move his lower extremities he was unable to lift his foot back up on the foot pedal. His right foot then was twisted while it went under the	F 323		

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 _____	12/20/2012

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 323	Continued From page 41 wheelchair. At that time the CNA asked if the resident was all right, he replied 'I think so.' Still in the hall to the office, the CNA stopped by the therapy room and applied a band to help [sic] the legs from falling off the pedals while transferring. She did notice that the wheelchair pedals did not match and the right foot rest on the pedal was loose but still functioning. . . ." The remainder of the "summary" confirms the nurse's notes on May 29-30, 2012. During interview, on 12/18/12 at 1:25 p.m., Resident #2 reported his right foot fell off the right foot pedal of the wheelchair and his right foot "dragged" under the wheelchair as the facility staff member continued to push the wheelchair. Observation throughout the survey identified Resident #2 in a wheelchair with his legs elevated, wearing a right leg immobilizer. Observation of the resident in bed showed a lack of active function in the resident's lower extremities. Resident #2 did request pain medications after observed transfers and positioning of the right leg. Resident #2 has a history of limited lower extremity function. The resident's care plans lacked interventions regarding preventive or protective measures for facility staff regarding his lower extremities during transfers or transportation. The facility staff used a standard wheelchair with a loose foot pedal for transportation on 05/29/12. The CNA applied a band to the wheelchair foot pedal to hold Resident #2's leg in place after the incident. The incident "summary" provided by the facility lacked information regarding corrective action, including	F 323		

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 _____	12/20/2012

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 323	Continued From page 42 staff education, wheelchair maintenance checks, or reviews of other residents for potential similar situations. Failure to ensure the environment remained free of safety hazards for Resident #2, including interventions for his limited lower extremity function and the loose wheelchair pedal, resulted in the resident's right leg fracture. Information provided by the facility failed to identify additional investigation, preventive or staff education measures regarding similar situations.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #6) at risk for dehydration and on thickened liquids received liquids during daily cares. Failure to offer fluids increased Resident #6's risk of dehydration. Findings include: Review of the facility policy and procedure, "Hydration Policy," occurred on 12/20/12. This policy, revised 06/19/12, stated, "POLICY: To develop a plan of care to promote proper hydration status by providing residents with sufficient fluids. Residents will be assessed,	F 327	Resident #6 was affected by this violation. Resident's Care Plan reflects moderate risk for dehydration. Care Plan change to reflect extensive to total assistance at meals. Educated staff to offer her fluids as well as remove cover on all liquids. A pink label was affixed to her water glass at meals and her bedside to to alert staff to encourage fluids. Pink water glass signage placed resident name plate to indicate risk of Hydration. Also her risk of hydration is indicated on nurses log. Residents who are identified at moderate to high risk for dehydration are at risk for this violation. In addition, based on resident medical condition, all residents have potential to be affected by this violation.	

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 _____	12/20/2012

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 327	Continued From page 43 identified, and provided with sufficient fluid intake to maintain proper hydration and health. PROCEDURE: . . . 4. Each residents [sic] minimal fluid needs are attempted to be met through the provision of fluid at meals, bedside, snacks, and the nutrition center. 5. Nursing and Dietary staff will provide and encourage intake at bedside, snack and meal fluids, on a daily and routine basis as part of daily care. 6. Certain . . . medical conditions may put residents at higher risk and should be care planned appropriately. . . . HYDRATION PROTOCOL . . . MODERATE RISK: . . . Hydration risk is noted on the log sheets for staff awareness. A hot pink encourage fluids sticker is placed on the liquids at bedside. . . . Between meal fluids are encouraged at snack passes. . . ." Review of Resident #6's medical record occurred on December 17-20, 2012. Current diagnoses included nutritional deficiency, history of mouth cancer, and mouth pain. The resident's annual Minimum Data Set (MDS), dated 11/20/12, identified moderately impaired cognition, extensive assistance of one person for eating, a loss of liquids or solids from her mouth when eating or drinking, coughing or choking during meals or when swallowing medications, and a mechanically altered diet. Resident #6's Annual Assessment, dated 11/27/12, stated, "Resident's decline is stable and continues to have untreated areas of cancer to her lip/mouth." The Nutrition Care Area	F 327	•Fluids provided at meals (ongoing). •Initiation of formal intake and output for all residents identified as high risk for dehydration.. •Intake and Output forms to be placed in those Resident's care plan folder in room. •Fluid Measurements for Intake to be attached to front of Resident Care plan folder in room to alert staff of Resident Intake and Output. •Intake and Output section by shift added to the CNA documentation on the Bowel and Bladder and Vital Signs Sheet. Implement. •Pink Cup sign to be added to each resident name plate on outside of room alerting staff that resident is at moderate to high risk for dehydration no later than. •Mandatory education to include Hydration and the Vulnerable Adult and S/S of Dehydration at the Mandatory All Staff Meeting on 1/22/13 and at Mandatory Nursing Department Meeting including intake and output form, etc. on 24/13. •Residents at Moderate or High Risk of Dehydration highlighted in yellow on the Dining Room Quality Monitor Tool. •Residents at Moderate or High Risk for dehydration identified on Report Sheets (ongoing). •Residents requiring Intake and Output to be identified on the report sheets. •Resident Hydration Tool developed to monitor fluid intake outside of dining room, i.e. in resident room. •Pink stickers to be placed on all resident's water in dining room indicating that resident is moderate or high risk for dehydration. •Meal intake record updated to identify residents at moderate or high risk of dehydration no later than •Resident Standards of Care policy updated to reflect provision of fluids at all scheduled meals if applicable, when completing scheduled cares, i.e. toileting, turning, etc. and prn according to resident care plan.	

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 _____	12/20/2012

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 327	Continued From page 44 Assessment (CAA), dated 11/27/12, stated, ". . . receives a regular diet with pureed foods and honey thick liquids per speech therapy recommendations. . . . has shown a 5# [pound] wt. [weight] loss in the past 6 months. She is at moderate risk of dehydration . . . She has an enc. [encourage] fluid sticker on her bedside fluids and hydration risk is noted on the nursing log sheets to make staff aware of the need to enc. her fluids throughout the day. . . . receives total assist with eating. . . ." Resident #6's Dietary Assessment, dated 11/19/12, identified 1440 cubic centimeters (cc) of fluid offered daily. Resident #6's current care plan, dated 11/30/12, stated, "Category, NUTR [Nutrition], Problem(s), I have swallowing difficulties and can't chew foods, related to not wearing my dentures (I don't want to wear them) . . . I need assistance with eating. . . . Goals, I will receive [sic] the help I need at meals from staff. . . . Approach(s) . . . I need extensive to total assistance at meals. . . . I have a pink encourage fluid sticker on my liquids at bedside and also hydration risk noted on the nursing log sheets as a reminders [sic] for staff to offer/encourage liquids throughout the day. . . ." The certified nursing assistant (CNA) care plan identified the resident received honey thick liquids. Observation of Resident #6's cares on 12/18/12 identified the following: *6:45 a.m. - Assisted with lower extremity exercises by a restorative therapy staff member (RA) (#18). At the end of the session, the RA (#18) wheeled the resident in the wheelchair to the television lounge. The RA (#18) failed to offer the resident fluids.	F 327	•Nurse Leader or designee to monitor all residents on an ongoing basis for signs and symptoms of dehydration via report sheets and verbal report from nursing staff (ongoing). •Dining room quality monitor to include fluid intake. Complete random observations per month per unit at various meals/total of 30 per month. •Initiate resident hydration monitoring tool. Complete random observations per month per unit at various times/total of 30 per month of residents identified to be at moderate or high risk of dehydration. •Develop quality monitor to ensure completion of resident intake and output. Monitor's the responsibility of Director of Quality Assurance or designee. Date of compliance for F-tag 327	2/08/2013

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 _____	12/20/2012

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 327	Continued From page 45 *7:55 to 9:00 a.m. - Resident #6 seated at a dining room table with a covered glass of thickened water on the table in front of her. Unidentified staff members passed by and did not offer assistance with the thickened water. Resident #6 did not make an attempt to access the water on her own. *11:05 a.m. - CNA (#15) provided personal cares for Resident #6 and transferred her to bed. The CNA reported the resident voided a small amount on the toilet, and her brief was dry. A glass of honey thick water with a pink sticker sat on a bedside table. The CNA failed to offer fluids to Resident #6. *12:08 p.m. - CNA (#15) assisted Resident #6 from her bed to the toilet and then to her wheelchair. The CNA reported the resident did not void or have a bowel movement on the toilet and her brief was dry. A glass of honey thick water with a pink sticker sat on a bedside table. The CNA transferred her to the dining room table. The CNA failed to offer fluids to Resident #6. *1:00 p.m. - CNA (#19) reported she toileted and changed Resident #6's brief. She stated the resident did not void on the toilet and her brief was dry. *3:25 p.m. - CNA (#20) checked Resident #6's brief and reported it dry. The CNA assisted the resident from bed to a wheelchair and provided oral cares with a water moistened toothette which the resident bit and held in her mouth. A glass of honey thick water with a pink sticker sat on a bedside table. The CNA (#20) failed to offer fluids to Resident #6. *Observation on 12/19/12 at 8:23 a.m., identified a CNA (#13) assisted Resident #6 from bed to the toilet. The CNA reported the resident's brief wet with urine and the resident voided on the	F 327		

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 _____	12/20/2012

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 327	Continued From page 46 toilet. The CNA transported the resident to the tub room for a bath and failed to offer fluids. Review of Resident #6's meal intake records from December 01-19, 2012, showed the resident consumed 50% or less of her pureed diet and honey thick liquids at meals for 25 of 57 meals (43.9%). The meal intake record for this period lacked documentation for 15 of 57 meals (26.3%). During interview, on 12/20/12 at 9:30 a.m., an administrative nursing staff member (#3) and two supervisory nursing staff members (#2) and (#9) stated they expected staff to offer Resident #6 fluids during each episode of care. Failure to provide Resident #6 fluids during cares may have contributed to a decrease in urine output and placed her at an increased risk for dehydration.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		

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 _____	12/20/2012

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 329	Continued From page 47 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility failed to monitor and assess for potential side effects of medications for 2 of 5 sampled residents (Resident #3 and #4) receiving scheduled antipsychotic medications, which by facility policy required Abnormal Involuntary Movement Scale testing. Providing antipsychotic medications without baseline testing for tardive dyskinesia (a form of involuntary muscle movements) prior to initiation placed these residents at risk of experiencing adverse drug effects related to their use. Findings include: Review of the facility policy/procedure titled "Medications - Tardive Dyskinesia Monitoring" occurred on 12/19/12. This policy/procedure, not dated, stated, "Policy - Residents who are prescribed antipsychotics . . . will be regularly evaluated for symptoms of Tardive Dyskinesia (TD). The Abnormal Involuntary Movement Scale (AIMS) shall be used for all assessments . . .	F 329	Resident #3 will have updated AIMS testing completed and transmitted to provider, if not already done so, no later than the end of day on 1/18/2013. Resident #4 will have updated AIMS testing completed and transmitted to provider, if not already, no later than the end of day on 1/18/2013. All residents currently on antipsychotic medication and Reglan have the potential to be affected by this violation •Current AIMS calendar will be reviewed, updated and amended if necessary to reflect all current residents on antipsychotic medications and Reglan, as well as those recently discontinued from or started on these medications. •Verbal and written communication will be provided for all charge nurses and unit coordinator staff to ensure copies of all changes in antipsychotic medications and/or Reglan is provided to AIMS assessor.	

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 _____	12/20/2012

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 329	Continued From page 48 Procedure . . . 2 Monitoring Schedule: Individuals who are prescribed an antipsychotic medication or other medications associated with TD will be checked at least once every six months. . . . 4. Baseline: if an antipsychotic medication or other medication associated with TD is to be initiated for an individual not currently prescribed such medication, a baseline rating will occur within one month of initiation of medication. . . ." - Review of Resident #3's medical record occurred on December 17-20, 2012. The facility identified diagnoses of Alzheimer's disease, anxiety, and dementia with behavioral disturbances. Resident #3's medical practitioner initiated the use of Seroquel (an antipsychotic medication) 25 milligrams (mg) daily on 07/27/12, increased it to 25 mg twice a day on 09/24/12, and increased it again to 50 mg twice daily on 10/29/12. On 09/10/12, the consultant pharmacist review noted, "Resident is currently receiving Seroquel 25 mg daily. . . AIMS testing q [every] 6 months." The medical practitioner replied on 10/8/12 and stated, "Agree, AIMS test please." The consultant pharmacist review of 12/10/12 identified, "Resident is receiving Seroquel [and] we need AIMS testing q 6 months. I could not find any report . . ." The unit manager (#2) identified an AIMS test, not dated, completed by facility staff. The form identified Resident #3 received Seroquel 25 mg twice a day; initiated 09/24/12. The facility failed to complete a baseline AIMS test within 30 days of the initiation of Seroquel on 07/27/12.	F 329	•The current AIMS calendar will serve as a s elf-monitoring tool by including antipsychotic and/ or Reglan start dates, stop dates, 30-day follow up testing, and 6-month ongoing testing. Clinical Nurse Manager or designee is responsible. Date of compliance with F-tag 329	2/08/2013

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 _____	12/20/2012

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 329	Continued From page 49 - Review of Resident #4's medical record occurred on December 17-20, 2012. The facility identified diagnoses of dementia with behavioral disturbances, depression, other psychologic/physical stress and unspecified mood disorders. Resident #4's medical practitioner initiated the use of Risperdal (an antipsychotic medication) 0.25 mg twice daily on 07/20/11, and decreased it to 0.25 mg at bedtime on 11/13/12. Facility staff completed an initial AIMS test on 09/21/11, two months after the medical practitioner initiated Risperdal for Resident #4. The facility completed AIMS testing on 03/15/12, six months later, and 11/28/12, eight months later, not every six months as per facility policy. During an interview on the morning of 12/20/12, the unit manager (#2) confirmed staff failed to complete initial AIMS tests for Resident #3 and #4 within 30 days of the initiation of an antipsychotic medication.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F 356	St. Luke's Home will post, for each shift, the scheduled hours as well as the actual staff hours for those that showed up for the shift, if they are different. This will be posted at each unit for that specific unit. The charge nurse for that each specific unit will be responsible to ensure this is completed before their shift begins.	1-25-2013

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 _____	12/20/2012

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 356	Continued From page 50 vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the actual hours worked per shift by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care at the beginning of each shift during 4 of 4 days of survey (December 17-20, 2012). Findings include: Observations made on the mornings of December 17-20, 2012 showed the posting of staff directly responsible for resident care in a display case located on the window ledge in the adjoining hallway [between Unit 1 and Units 2/3]	F 356	We will educate this at mandatory all nursing meeting scheduled for: We will monitor this daily for one month and after quarterly. Direct of Quality assurance or designee for monitoring. Date of compliance for F-tag 356	02/08/2013

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 _____	12/20/2012

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 356	Continued From page 51 near the Administrator's office. The posting of staff identified the total number of staff and the actual hours worked for the morning, evening, and night shifts each day. The facility failed to post staffing information at the beginning of each shift (days, evenings, and nights) and instead posted the information for the entire day. During an interview on 12/20/12 at 10:15 a.m., an administrative nurse (#3) confirmed staff post the daily posting of staff in the morning for all shifts.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must – (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's recommendations, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 main kitchen and 2 of 3 kitchenettes (Units 1 and 2). The facility failed to ensure proper cleaning in 1 of 1 main kitchen and to follow the manufacturer's guidelines for mixing kitchen sanitizing solutions on Units 1 and 2, which	F 371	The facility will mix a sanitizing solution of EcoLab "solid sanitizer" at a strength of 50-100ppm / not to exceed 100ppm and will test said sanitizer prior to use with a chlorine test strip. Implemented on This will protect all residents' of this facility from being placed at risk of food borne illness. •8 quart buckets were ordered and received to ensure proper mixing of EcoLab "Solid Sanitizer" solution •New form for recording sanitizing solution is in place on Units 1- 2- 3 (attached). This form gives the mixing directions, test strip (chlorine) to be used and strength to be met (50-100ppm), and that solution will be tested each time it is mixed for proper strength (not to exceed 100ppm). •Education of Nutrition and Food Services staff occurred on	12-28-12. 12-28-2012, .

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 _____	12/20/2012

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 371	Continued From page 52 placed residents at risk for foodborne illness. Findings include: Review of the facility policy titled "Sanitation" occurred on 12/20/12. This policy stated, ". . . Policy Interpretation and Implementation . . . 2. All . . . counters, shelves . . . shall be kept clean . . . 3. All equipment, food contact surfaces . . . shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. . . . 15. Kitchen and dining room surfaces . . . shall be cleaned and sanitized on a regular schedule and frequently enough to prevent accumulation of grime. . . . 16. Dining room tables will be cleaned and sanitized after each meal . . . 17. . . . Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. . . ." Review of the manufacturer's instructions for EcoLab's "Solid Sanitizer" solution occurred on 12/20/12. The instructions stated, ". . . Directions for Use . . . Solution Preparation Prepare a 50-100 ppm [parts per million] . . . sanitizing solution by thoroughly mixing 1 tablet of this product with 1.2 [4.8 quarts] to 2.2 [8.8 quarts] gallons of water . . ." - An initial dietary tour of the facility's main kitchen and 3 kitchenettes (Units 1, 2, and 3) occurred on 12/17/12 at 9:05 a.m. Observation showed the following: * The exterior and interior surfaces of the cupboards and drawers soiled with a build-up of	F 371	•We will follow up by completing the sanitation and safety Inspection: (attached), which includes checking the sanitizer of each unit is at correct strength and documentation. is complete. Weekly x 8 weeks 2 x month x 2 months Monthly there after Inspection to be performed 1 x month the first 3 months by the Dietitian. -Education of staff and/or corrective action to be completed if solution is not mixed appropriately, tested each time, or is found not to be at appropriate strength. Nutrition and Food Services Director and staff will ensure that food is stored, prepared and served under sanitary conditions, by doing proper cleaning and sanitizing of the kitchen to prevent foodborne illness. This will protect all residents' of this facility from being placed at risk of food borne illness. •Education of Nutrition and Food Services employees was performed at inservice 12/28/12 •Memo to staff posted 1-14-13 to relay information re: new assigned cleaning duties •Updated and implemented (1-14-13) Assigned Cleaning Schedule, with staff having to sign off on daily cleaning duties in areas that were found deficient during the survey. •Updated Nutrition and Food Services sanitation and safety inspection . (see attached) •Nutrition and Food Services Safety and Sanitation Inspection to be performed: Weekly x 8 weeks 2x month x 2 months Monthly there after Inspection to be performed 1 x month the first 3 months by the Dietitian -Education of staff and/or corrective action to be completed if assigned cleaning duties have not been completed on time or items are found to not be cleaned appropriately. Date of Compliance for F-tag 371	02/08/2013

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 _____	12/20/2012

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 371	Continued From page 53 food debris in the main kitchen. * One microwave in the main kitchen with food debris dried to the interior surfaces. * A plastic container of "Solid Sanitizer" solution and a red bucket containing a sanitizer mixed with water in the kitchenettes on Units 1 and 2. The container label stated, "1 bleach tablet per 4 quarts water [which is a stronger concentration than the manufacturer's recommendation]." During an interview following the dietary tour, a managerial dietary staff member (#5) stated the dietary staff use the sanitizing solution to clean the kitchen and dining room surfaces; including the counters, shelves, and tables. She further indicated she was unclear as to which type of test strip [quaternary or chlorine] is used to test the concentration of the "Solid Sanitizer," and confirmed the facility failed to monitor the concentration of the solution used in the kitchenettes on Units 1 and 2. Following the interview, observation showed the managerial dietary staff member (#5) tested the sanitizer solutions on each unit with a chlorine test strip which indicated a sanitizing concentration of 200 ppms per bucket. During the observation, this staff member presented a new form she developed; titled "Unit 1 - 2 - 3 Sanitizing Bucket Record," which indicated the test strips should "read between 50 ppm - 200 ppm [which is a stronger concentration than the manufacturer's recommendation]." - Observation on 12/18/12 at 1:35 p.m. showed a red bucket containing sanitizer mixed with water in each of the kitchenettes on Units 1 and 2. Unidentified dietary staff members tested the	F 371		

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 _____	12/20/2012

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 371	Continued From page 54 solutions which indicated a sanitizing concentration of 200 ppms per bucket. - Observation on 12/19/12 at 7:55 a.m. showed a red bucket containing sanitizer mixed with water in the kitchenette on Units 2. An unidentified dietary staff member tested the solution which indicated a sanitizing concentration of 200 ppms. A dietary tour of the facility's main kitchen and 3 kitchenettes (Units 1, 2 and 3) occurred on 12/19/12 at 5:00 p.m. Observation showed the exterior and interior surfaces of the cupboards and drawers in the main kitchen soiled with a build-up of food debris and two microwaves in the main kitchen with food debris dried to the interior surfaces. During an interview following the tour, the managerial dietary staff member (#5) confirmed the cupboards, drawers and microwaves should be cleaned daily.	F 371		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to store oxygen according to current Life Safety Code requirements in 1 of 1 oxygen storage area on the 300 unit. Failure to store the oxygen tank in a secure manner has the potential for the tank to fall and become a projectile potentially causing	F 454		

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 _____	12/20/2012

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 454	Continued From page 55 injury to residents, visitors, and staff. Findings include: NFPA 55 Standard for the Storage, Use, and Handling of Compressed and Liquefied Gases in Portable Cylinders, 1998 Edition, Chapter 6 Compressed Gas Cylinders, states, ". . . 6-6 Securing Cylinders. Compressed or liquefied gas cylinders in use or in storage shall be secured to prevent them from falling or being knocked over. . . ." Observation of oxygen storage occurred with a licensed nurse (#1) on 12/20/12 at 7:30 a.m. Observation showed an oxygen cylinder standing unsecured between the wall and a filled cylinder holder. During the observation, the nurse (#1) confirmed staff failed to store the oxygen cylinder correctly.	F 454	St Luke's Home secured the oxygen cylinder in the holder the moment we were aware We went through all oxygen storage areas to ensure all tanks were secure in holders. Director of Maintinance or desingee. St Luke's Home will monitor oxygen storage areas every Monday, Wednesday and Friday to ensure they are secured appropriately in holders. Director of Enviroment Services or designee is responsible for monitor. We will place signage stated all tanks must be secured at all times in the storage areas, and we will provide staff training to the nursing staff that handled the tanks as well as include in employee orientation. Date of compliance for F-tag 454	02/08/2013