

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER St Lukes Home		STREET ADDRESS, CITY, STATE, ZIP CODE 242 10th St W Dickinson, ND 58601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, policy review, and staff interview, the facility failed to follow infection control standards for 3 of 5 sampled residents (Resident #7, #12, and #71) observed during cares. Failure to follow infection control standards related to hand hygiene and glove use has the potential to spread infections throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 06/16/26. This policy, revised on 04/22/26, stated, . Staff will perform hand hygiene . using proper technique consistent with accepted standards of practice . After handling contaminated objects . Before applying and after removing personal protective equipment (PPE) . Before and after handling clean or soiled dressings . Before performing resident cares . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . When, during resident care, moving from a contaminated body site to a clean body site . After assistance with personal body functions . - Observation on 06/14/26 at 11:40 a.m. showed a nurse (#5) entered Resident #71's room, performed hand hygiene, and applied PPE. The nurse applied the prescribed medication patches to the resident's back, removed the gloves, and without performing hand hygiene, applied new gloves. The nurse removed a dressing from the resident's abdominal area, removed the soiled gloves, and without performing hand hygiene, applied clean gloves. Resident #71 asked the nurse for gloves; the nurse supplied the gloves the resident applied them. The nurse failed to offer or assist the resident with hand hygiene. The resident assisted the nurse to cleanse the wound and asked for a cotton swab. The nurse sprayed the swab with cleaning solution and the resident cleaned around the wound wiped wound debris on a facial tissue from the swab, and repeated the process. Resident #71 removed the soiled gloves. The nurse failed to assist or encourage the resident to perform hand hygiene. The nurse (#5) removed his/her soiled gloves, applied clean and applied a clean dressing to the residents wound. The nurse failed to perform hand hygiene between glove changes. During an interview on 06/16/26 at 7:03 a.m., an administrative staff member (#8) confirmed staff are expected to complete hand hygiene between glove changes and the nurse should have offered hand hygiene to resident#71. - Observation on 06/14/26 at 11:53 a.m. showed two certified nurse aides (CNAs) (#2 and #3) transferred Resident #7 from the bed to the wheelchair utilizing a full body mechanical lift. Following the transfer, the CNAs (#2) exited the room with the lift and placed it in the hallway alcove. The CNA (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(#2) failed to perform hand hygiene prior to exiting the room and failed to sanitize the lift. -Observation on 06/16/2026 at 1:44 p.m. showed a CNA (#4) enter Resident #12's room, completed hand hygiene, applied clean gloves, and transferred the resident from a wheelchair to the toileting utilizing a mechanical sit to stand lift. The CNA (#4) provided perineal care, and without removing the soiled gloves and completing hand hygiene, the CNA applied a clean brief, pants, and shoes, adjusted the resident's hands on the lift, and transferred the resident from the toilet to the wheelchair. During an interview on 06/17/2026 at 1:33 p.m., an administrative staff member (#1) confirmed nursing staff are expected to remove gloves and complete hand hygiene after completing perineal care and moving to a clean task. - Observation on 06/14/26 at 12:25 p.m., showed two unidentified staff members passed the noon meal to residents. Two staff members delivered drinking glasses to residents by touching the rims with their bare hands. The staff members failed to hold the drinking glass from the body of the glass. During an interview on 06/16/26 at 2:40 p.m., an administrative staff member (#7) confirmed staff are expected to pass glasses by holding onto the body of the glass.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, the facility failed to ensure the attending physician documented his/her rationale for continued use of a psychotropic medication for 1 of 5 sampled residents (Resident #3) reviewed for drug regimen. Failure to provide a rationale for continued use of an antianxiety medication may result in Resident #3 receiving an unnecessary medication and/or experiencing adverse consequences related to its continued use. Findings include: The facility failed to provide a copy of their policy addressing unnecessary medications per request. Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, anxiety, dementia with psychotic disturbance including hallucinations, and depression. Current physician's orders included an order for Buspirone (an antianxiety medication) 7.5 milligrams (mg) twice daily. The monthly pharmacy reviews for 01/05/26 showed the pharmacist identified/recommended an annual gradual dose reduction (GDR) for Resident #3's Buspirone. The attending physician failed to provide a rationale for the continued use of the medication and stated, Rejected. Need to continue. During an interview on 12/05/19 at 8:30 a.m., an administrative nurse (#1) confirmed the provider failed to provide a rationale for the continued use of Buspirone.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 3 of 6 supplemental residents (Residents #62, #68, and #77) observed during medication administration. Three medication errors occurred during staff administration of 37 medications, which resulted in an eight percent error rate. Failure to follow facility policy and failure to ensure correct labeling of medications may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled Insulin Pens occurred on 06/16/26. This policy, dated 04/28/25, stated, . 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. h. Prime the insulin pen: . With the needle pointing up, push the plunger, and watch to that at least one drop of insulin appears on the tip of the needle. -Observation on 06/14/26 at 12:33 p.m. showed a nurse (#5) prepared an insulin pen for Resident #77. The nurse dialed two units of insulin, removed the cap, and primed the pen horizontally. -Observation on 06/14/26 at 12:40 p.m. showed a nurse (#5) prepared an insulin pen for Resident #62. The nurse dialed two units of insulin, removed the cap, and primed the pen downwards. The nurse (#5) failed to prime Resident #77 and #62's insulin pens correctly. -Observation on 06/15/26 at 8:50 a.m. showed a medication aide (MA) (#6) prepared a medication for Resident #68, labeled, ARIPIPRAZOLE 15 MG [milligrams] TAKE 1/2 [one half] TABLET (7.5 MG) BY MOUTH EVERY NIGHT AT BEDTIME. The MA explained staff administer the medication in the morning and could not explain why the label identified bedtime. The physician's order, dated 04/14/26, stated, GDR [gradual dose reduction] decrease Aripiprazole from 10 to 7.5 mg QAM [every morning]. Facility staff failed to clarify the pharmacy label. During an interview on 06/15/2026 at 1:52 p.m., an administrative staff member (#1) confirmed the nursing staff are expected to address the label error with the provider or the pharmacy and agree facility staff primed the insulin pens incorrectly.		