STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	09/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARDS COMMUNITY NURSING HOME	613 1ST AVE SW HANKINSON, ND 58041

(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 09/12/11 and completed on 09/14/11, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, policy review, and staff interview, the facility failed to ensure proper positioning for 1 of 1 sampled resident (Resident #1) observed receiving nutrition via a gastrostomy tube (a tube placed directly into the stomach for long-term nutrition or gastric decompression). Failure of facility staff to ensure Resident #1 maintained a position of at least 30 degrees during the administration of a continuous tube feeding (TF) placed this resident at risk of developing aspiration pneumonia. Findings include:	F 322	For resident #1, physical therapy assistant ensured proper HOB elevation at 30° with goniometer and headboard marked for positioning. Nursing dept. staff education completed with each shift report, as well as by nursing dept. staff communication book. Licensed nurse meeting conducted by DON on 9/21/11 stressing optimal positioning to prevent aspiration for resident with tube feeding, nurses role in education of other nursing dept. staff and QA spot checks. Licensed nurses have been performing intermittent spot checks to ensure proper positioning being followed for residents with feeding tube. Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting Sept. 2011 through newly developed LTC dept. indicator labeled "Proper positioning not followed for resident with feeding tube." Problems or concerns will be documented on QA report and brought to QA committee.	10/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Dabbert
TITLE: Administrator
(X6) DATE: 9/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 322	Continued From page 1 Review of facility policy titled, "PROCEDURE FOR GASTROSTOMY/JEJUNOSTOMY FEEDINGS" occurred on 09/14/11. This policy, dated 08/2011, stated, " . . . 6. Elevate HOB [Head of bed] up to 45 [degrees] during feeding. (unless contraindicated by other problems ie [sic] pressure area) . . . 15. Assess resident tolerance of formula q [every] shift. Note signs/symptoms of nausea, vomiting, diarrhea, hyperactive bowel sounds or cramping, and document in nurses notes . . . ." Berman, Snyder, Kozier, and Erb. "Fundamentals of Nursing: Concepts, Process, and Practice," 8th edition, Pearson Education Inc., Upper Saddle River, New Jersey, 2008, pages 1272-1274, stated, "Administering a Tube Feeding . . . Assist the client to Fowler's position (at least 30 degrees elevation in bed) . . . If a sitting position is contraindicated, a slightly elevated right side-lying position is acceptable . . . Ask client to remain sitting upright in Fowler's position or slightly elevated right lateral position for at least 30 minutes . . . These positions facilitate digestion and movement of the feeding from stomach along alimentary tract and prevent the potential aspiration of the feeding into the lungs . . . ." Observations of Resident #1 on 09/12/11 at 1:45 p.m. and 5:20 p.m. showed the resident lying in bed with his tube feeding (TF) running at 70 cubic centimeters/hour (cc/hr) and the HOB elevated approximately 20 degrees. Observation of Resident #1 on 09/13/11 showed: * At 8:30 a.m., two certified nurse assistants (CNAs) (#4 and #5) repositioned the resident from side to side while in bed to observe a	F 322	By ensuring licensed nurses and CNA's have adequate knowledge of/and follow proper positioning of resident with tube feeding, we are able to properly provide appropriate treatment and services to such residents and avoid potential harm to all residents.	

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F 322	Continued From page 2 dressing on his coccyx. During this entire observation, Resident #1's HOB remained in a flat position while the TF infused. Observation showed Resident #1 coughed when the CNAs (#4 and #5) turned him from side to side. Prior to exiting the room, a CNA (#5) elevated the resident's HOB approximately 20 degrees. * At 9:20 a.m., while Resident #1 laid in bed with the HOB less than 30 degrees, he intermittently coughed while a nurse (#6) administered medications and water flushes via the gastrostomy tube (GT). The nurse (#6) resumed Resident #1's TF and observation showed the HOB remained elevated at less than 30 degrees. * 10:15 a.m. and 1:40 p.m., Resident #1 laid in bed with HOB approximately 20 degrees and TF running at 70 cc/hr. * At 1:45 p.m. Resident #1 laid in bed. A CNA (#5) lowered the HOB to a flat position with the TF running. This same CNA and a nurse (#7) turned the resident on his side and replaced a dressing to his coccyx. Resident #1 coughed during this dressing change. A CNA (#5) and the nurse (#7) then repositioned Resident #1 on his back and the CNA (#5) raised the HOB to less than 20 degrees. Observation on 09/14/11 at 8:35 a.m. showed Resident #1 received a TF at 70 cc/hr while lying on his back in bed and the HOB flat. At 9:00 a.m., observation showed a nurse (#6) administered water flush via GT to Resident #1 while the resident laid in bed with the HOB flat. Review of Resident #1's medical record occurred on September 12-14, 2011. The facility admitted Resident #1 on 08/17/11 from an acute care hospital with diagnoses of bacterial pneumonia,	F 322		

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F 322	Continued From page 3	F 322		

severe dysphagia, advanced dementia, and placement of percutaneous gastrostomy (PEG) on 08/09/11. Review of Resident #1's transfer paperwork from the acute care hospital included a physician progress note, dated 08/16/11, which stated ". . . New Right Sided Pneumonia. Likely secondary to aspiration of oral secretions. Aspiration precautions including elevation of bed, necessary in this patient . . . ."

On 08/17/11 Resident #1's physician ordered nothing by mouth (NPO) and a continuous tube feeding administration rate of 70 cc/hr.

The facility transferred Resident #1 to the emergency room/hospital on 08/27/11 with complaints of abdominal distention. Resident #1 returned to the facility on 08/31/11 with diagnosis including right lower lobe pneumonia, dementia and severe dysphagia. Resident #1's tube feeding rate remained unchanged at 70 cc/hr and he received Ceftin (an oral antibiotic) via GT through 09/10/11 for pneumonia.

Review of Resident #1's admission Minimum Data Set (MDS), dated 08/27/11, identified the resident with severe impairment with daily decision making, required extensive assistance of staff with bed mobility and transfers, and utilized a GT to receive all nutrition.

Review of Resident #1's Pressure Ulcer Care Area Assessment (CAA), dated 08/29/11, showed supporting documentation which stated the HOB elevated due to a continuous TF.

Review of Resident #1's current care plan included the following approaches pertaining to

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F 322	Continued From page 4 positioning: *Pressure Ulcer Care Plan, dated 08/17/11, and revised on 09/01/11, - included approaches of ". . . 9. Do not [arrow up] HOB [greater than] 30 [degrees] for prolonged time, unless medically necessary. . . ." *Skin Integrity Care Plan, dated 08/17/11, and updated 09/11/11, - included approaches of " . . . 13. Minimize friction & shearing by using lift sheets, HOB [no] more than 30 [degrees] . . . . " Resident #1's Dietary Care Plan, dated 09/01/11, and Upper Respiratory Infection Care Plan, dated 09/13/11, failed to include information regarding the need for proper positioning of the resident's HOB. Review of nursing notes, dated 09/13/11, stated: * 7:00 a.m. - Resident temperature 99.8 degrees (Fahrenheit) ". . . Mumbled speech. Confused. Color pale. Skin warm et [and] dry. Continues [with] low grade temp [temperature]. Noting loose cough . . . Lung sounds difficult to hear as moaning out, talking. [no] nasal drainage. Thick secretions in mouth . . . Feeding continuous at 70 cc/hr." * 9:40 a.m. - Resident temperature 100.8 degrees (Fahrenheit) - Tylenol 500 milligrams provided and physician updated via fax. * 12:30 p.m. - Resident temperature 97.7 degrees (Fahrenheit) ". . . Loose cough. Audible congestion noted . . . ." * 4:30 p.m. - Faxed orders received for resident to begin treatment with antibiotics via gastrostomy tube for upper respiratory infection. During interview on 09/14/11 at 8:45 a.m., an administrative nurse (#3) stated she expected Resident #1's HOB to be elevated at least 30	F 322		

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F 322	Continued From page 5 degrees during TF and/or administration of medication.	F 322		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	Education director met individually with PFA #1 reviewing specific details observed during evening meal who failed to follow proper infection control guidelines. Policy/procedure for proper feeding of residents reviewed in detail. Nursing dept. staff education completed with each shift report as well as by nursing dept. staff communication book. Licensed nurse meeting conducted by DON on 9/21/11, stressed proper infection control procedures to be followed when feeding residents, nurses role in continued education of other nursing dept. staff and QA spot checks. Licensed nurses have been performing intermittent spot checks to ensure proper infection control procedures are followed in assisted dining room. Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting Sept. 2011 through newly developed Infection Control Dept. indicator labeled "Procedures in dining rooms not being followed." Problems or concerns will be documented on QA report and brought to QA committee. By ensuring licensed nurses, CNA's and PFA's have adequate knowledge of/and follow proper infection control procedures when feeding residents, we are able to help ensure safe, sanitary	10/14/11

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F 441	Continued From page 6 infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure 1 of 3 paid feeding assistants (PFAs) followed infection control procedures when assisting residents during meal service. Failure to properly handle ready-to-eat foods and follow infection control practices has the potential for contamination and spread of infections to occur within the facility. Findings include: Review of the facility policy titled, "Proper Feeding of Residents" occurred on 09/14/11. This policy dated 09/2007, stated, ". . . Proper position [sic] important to prevent aspiration or inhaling of food or fluid into the lungs. Aspiration can lead to pneumonia and ultimately death . . . 5. Butter bread and cut meat. Mix cereal, etc. **use dietary glove when handling food, such as buttering bread, handing resident toast, etc. CANNOT TOUCH THE FOOD . . . 12. Test hot foods by dropping a small amount on the inside of your wrist before feeding them to the resident . . . 16. Wash your hands after each direct contact with a resident before coming in direct contact with another resident. Instant hand sanitizer may be used or wash with soap and water." During observation of the evening meal on 09/12/11, a PFA (#1) touched Resident 12's sandwich with her bare hand, held it up to the	F 441	(continued from page 6) and comfortable environment and help prevent the development and transmission of disease and infection, thus avoiding potential harm to all residents.	

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F 441	Continued From page 7 resident's mouth, and then placed the sandwich back on the resident's plate. Resident #12 proceeded to eat the sandwich throughout the meal. Twice the PFA (#1) took Resident's (#12 and #4) spoon out of her soup bowl, touched the spoon on top of her hand (to test the temperature of the soup) and replaced the spoon in the soup bowl. The PFA (#1) failed to perform any form of hand hygiene prior to bare hand contact with Resident #12's sandwich and soup spoon. During interview on 09/14/11 at 9:45 a.m., a supervisory nurse (#2) stated she expected staff to use gloves when handling ready-to-eat food, touch only the handle of a resident's spoon, perform hand sanitization between residents, and if testing the temperature of resident food items, to just place a drop of food on the inside of their wrist.	F 441		