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 _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	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 The standard Medicare/Medicaid recertification survey started on 05/13/19 and concluded 05/16/19.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		6/5/19

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

Electronically Signed | 05/29/2019

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F 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to provide the Centers for Medicare/Medicaid Services (CMS) Notice to Medicare Provider Non-coverage (NOMNC) form (CMS-10123) to 2 of 3 residents (Resident #28 and #29) reviewed who were discharged from Medicare Part A services. Failure to provide the correct notices upon termination of Medicare A services has the potential to hinder the residents' right to an expedited review of a service termination. Findings include: Review of the Medicare Part A letters/notices for Resident #28 and #29 on the afternoon of	F 582	Resident #28 was informed of change in coverage by Medicare with issuance of Form 10123 and signature obtained. Resident #29 has been discharged. Residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit was conducted on current residents who were admitted in past six months and corrective actions were completed 5/28/19. Advance Beneficiary Notice Policy developed. Administrator educated department	

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F 582	Continued From page 2 05/15/19 lacked the Notice to Medicare Provider Non-coverage form (CMS - 10123). The facility failed to issue the NOMNC when all covered services ended for coverage reasons. During an interview on the morning of 05/16/19 a business office staff member (#4) confirmed the residents/resident representative did not receive this form.	F 582	managers on Advance Beneficiary Notices process and policy on 5/20/19 and 5/28/19. Business Office Manager will conduct monthly audits to ensure that notices were issued timely and appropriately. Audit findings will be documented under indicator "Appropriate Medicare Forms Given (Form 10055, Form 10123)". Areas of concern will be addressed by QAPI Committee.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, review of facility water temperature logs, and staff interview, the facility failed to maintain acceptable hot water temperatures for 5 of 5 random residents' rooms (Room #102S, #103S, #108S, #103E, and #102N) observed for water temperature. Failure to ensure acceptable hot water temperatures has the potential for burn injuries to residents, visitors, and staff. Findings include: Upon request, the facility failed to provide a	F 689	Administrator alerted Maintenance Director, DON, ADON upon discovery of unacceptable water temperatures. DON, ADON communicated concern and provided education on necessary intervention to prevent injury to all staff, residents and visitors. Maintenance Director decreased water temp to acceptable range and documented temps at various intervals at various locations throughout the building. Residents were assessed and no injury had occurred. All residents have the potential to be	6/5/19

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F 689	Continued From page 3 policy regarding water temperatures. Observation on 05/13/19 showed the following water temperatures in resident bathrooms: 4:47 p.m. - Room 108S 143 degrees Fahrenheit (F) 4:49 p.m. - Room 103E 136.4 degrees F 4:51 p.m. - Room 103S 142.8 degrees F 4:53 p.m. - Room 102N 131.3 degrees F 4:55 p.m. - Room 102S 140 degrees F - An interview with administrative staff members (#1 and #2) regarding the hot water temperatures occurred on 05/13/19 at 5:15 p.m. The staff members (#1 and #2) stated they were not aware of the high temperature, had no reports of resident burns, and would notify maintenance staff immediately regarding the water temperatures. During an interview on 05/13/19 at 5:20 p.m., a certified nursing assistant (CNA) (#10) stated the water temperatures are "up and down, every day varies and every room varies," and she turns the cold water on so it is not so hot. During an interview on 05/13/19 at 5:32 p.m., a CNA (#5) stated, "I noticed today the water was hot and one time this winter it was hot. I just add cold water." During an interview on 05/13/19 at 5:36 p.m., Resident A stated the water was "really hot" but he had not gotten burned. When asked if he reported the hot water, he stated "oh they [staff] know, they are working on it." During an interview on 05/13/19 at 5:47 p.m.. a	F 689	affected. Water Tempering Valve with Automatic Balancing System to be installed. Safe Water Temperature policy developed. Administrator educated dept. managers on standard of practice/regulation and process for safe water temps on 5/20/19, 5/28/19. DON educated licensed nurse staff 5/22/19. Safety Director educated Safety Committee on 5/28/19. Education Director provided education to other direct care staff on 5/30/19. Remaining staff educated through departmental meetings. Director of Maintenance will check water heater temperature controls and temperatures of tap water at multiple points throughout building weekly and document. Summary of results monitored on Maintenance Dept. QA labeled "Hot Water Temps Checked Weekly in Compliance" and "Hot Water Temp Check Completed in Each Resident Corridor". Areas of concern will be addressed by QAPI Committee.	

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F 689	Continued From page 4 maintenance staff member (#9) stated he checked the water temperatures every morning, today the temperature measured 113 degrees F. He explained he had changed the water system today from the large boiler to a smaller boiler due to the "change of season" and at 3:00 p.m. it measured 114 degrees F. He agreed the present water temperature showed over 140 degrees. Review of the Maintenance Departments "QA [Quality Assurance] Daily Check List" from August 2018 to April 2019 identified monthly temperatures between 108 - 112 degrees F. Review of a maintenance notebook identified staff documented water temperatures two to three times per month, with temperatures ranging from 108 - 112 degrees F. The facility failed to maintain acceptable water temperatures after making a water system change.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/5/19

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F 880	Continued From page 5 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 6 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 2 of 2 sampled residents (Resident #28 and #179) observed during pressure ulcer dressing changes, and 1 of 8 sampled residents (Resident #12) observed during toileting/personal cares. Failure to follow appropriate infection control practices may result in the spread of infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled, "Hand Hygiene" occurred on 05/16/19. This undated policy stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. . . . The following is a list of some situations that require hand washing with soap and water: . . . Before and after assisting a resident with toileting, . . . cleansing/wiping perineal area . . ."	F 880	All Certified Nursing Assistants immediately educated with each shift report in regards to infection prevention and control specifically pertaining to performing hand hygiene after performing perineal cares and prior to performing other tasks. All residents, staff, and visitors have the potential to be affected. Certified Nurse Assistant meeting will be conducted on May, 30, 2019 regarding the importance of proper infection prevention and control practices specifically addressing hand hygiene standards. Facility policies and control practices will be reviewed and discussed. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed.	

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F 880	Continued From page 7 Review of the facility policy titled, "Perineal Care After Urinary or Fecal Incontinence" occurred on 05/16/19. This policy, dated February 2010, stated, ". . . Procedure with Resident Using the Bathroom: . . . 3. Put on disposable gloves . . . 5. When resident is finished, cleanse peri-area . . . 7. Remove and discard gloves . . . 8. Pull up pad/brief and adjust clothing 9. Assist resident to safe position/area 10. Wash your hands. . . . " - Observation of personal cares occurred on 05/13/19 at 3:36 p.m. Two certified nursing assistants (CNAs) (#5 and #8) assisted Resident #12 to a standing position from the toilet after the resident voided and had a small bowel movement. One CNA (#8) donned gloves and provided perineal cares, removed her gloves and assisted the other CNA (#5) with transferring the resident to the wheelchair. The CNA (#8) removed her gloves, repositioned the resident in her chair, applied wheelchair pedals, and combed the resident's hair. The CNA (#8) performed hand hygiene with an alcohol-based hand rub in the hallway as he/she wheeled the resident to the lounge area. The CNA (#8) failed to perform hand hygiene after performing perineal cares and prior to performing other tasks. - Observation on 05/14/19 at 9:59 a.m. showed a licensed nurse (#6) performed hand hygiene, donned gloves, sprayed two gauze pads with wound cleanser, removed Resident #28's pressure ulcer dressing to the left heel, and cleansed the area with a gauze pad. Without changing gloves or performing hand hygiene, the nurse (#6) removed the right heel pressure ulcer	F 880	Random spot checks will continue daily until 5/29/19 by charge nurse. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to the QA committee. The Quality Assurance Director will conduct weekly audits to ensure compliance X4, then monthly under the Quality Assurance checklist labeled, "Hand hygiene performed correctly with peri cares." All Licensed Nurse's were immediately educated with each shift report in regards to infection prevention and control specifically pertaining to failure to perform hand hygiene after cleansing and prior to removing another dressing; performing hand hygiene after removing dressing/gloves before continuing wound cares which has the potential for transmission of infection to residents. All residents have the potential to be affected. Licensed nurse meeting was conducted on May 22, 2019 regarding the importance of and proper infection prevention and control practices. Facility policies reviewed and discussed. Validation checks were also performed with Licensed Nurse's to determine if hand hygiene procedures were followed accordingly.	

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F 880	Continued From page 8 dressing, obtained the other gauze pad and cleansed the right heel. The nurse (#6) failed to change gloves and perform hand hygiene after cleansing the left heel and prior to removing the right heel dressing. - Observation on 05/15/19 at 9:09 a.m. showed a licensed nurse (#7) performed hand hygiene, donned gloves, and removed Resident #179's dressing from his left foot. The nurse (#7) removed his/her gloves and without performing hand hygiene donned gloves and applied the antibiotic ointment to the open area. During an interview on 05/16/19 at 9:30 a.m. a nurse manager (#2) stated she expected staff to remove gloves and perform hand hygiene after removing a dressing from a pressure ulcer before continuing with further wound care.	F 880	Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 5/29/19 conducted by a nurse. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to Quality Assurance Committee. The Quality Assurance Director will conduct weekly audits to ensure compliance X4 then monthly under the Quality Assurance Checklist labeled, "Hand hygiene performed correctly with dressing changes." Areas of concern will be discussed at monthly Quality Assurance meeting.	