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 _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

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E 000	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 6/24/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS An Abbreviated COVID-19 Focused Infection Control Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on 6/24/2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Deficiencies were found with 42 CFR483.21 and 42 CFR §483.80.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/14/2020

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to develop a comprehensive resident-centered care plan consistent with measurable interventions for one (Resident 48) of the two residents looked at for care planning. Specifically, the facility failed to identify a medical focus that requires interventions to sustain life on the care plan. This failure places the resident at risk for not having their needs met.	F 656		

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F 656	Continued From page 2 Findings include: Resident 48 was admitted on 10/30/2012. The resident's diagnoses includes, but is not limited to, Delusional Disorder, epilepsy, TBI (Traumatic Brain Injury), and Sleep Apnea. On 6/23/20 at 12:00 PM, Resident 48 was observed asleep in bed with CPAP (Continuous Positive Airway Pressure) with O2 (Oxygen) tubing connected to the CPAP tubing and the O2 concentrator set at 2L/M (Liters per Minute) of oxygen. Record review of Resident 48's Care Plan Goal reads, "I will be able to participate in my cares while ambulating with extensive assist throughout facility next 3 months." Status is "Active", Review date "8/31/2020", Start date "4/5/2018". Under subsection intervention reads, " I will utilize oxygen as ordered attached to my CPAP at bed rest as I allow." Status reads "Active"; Role(S) reads, "Nursing, Nursing Assistant," Start Date reads "2/19/2019". In reviewing the comprehensive 39 pages of Resident 48's Care Plan, no goal/focus is listed for Resident 48's diagnosis of Sleep Apnea or for the usage of CPAP. Record Review of the policy entitled "Nursing Care Plans", Revised 11/17, subsection of the policy reads, "A person-centered plan of care shall be developed within 14 days of admission by an interdisciplinary team." Number three reads, "Areas to be discussed and addressed in the care plan are Dietary, Bowel and Bladder, Medical, Social, Emotional, and Activities." Number four reads, "Problems in these areas are	F 656		

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F 656	Continued From page 3 discussed along with approaches and goals." Record review of the policy entitled "Oxygen Therapy" revised on 2/1/2016. Under subsection "Policy" reads in pertinent part, "Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences." Subsection titled, "Policy Explanation and Compliance Guidelines" Number two reads, "Personnel authorized to initiate oxygen therapy include physicians, RN's, LPNs, and respiratory therapists." Number five reads, "The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders." On 6/23/2020 at 2:00 PM, in an interview with the Assistant Director of Nursing (ADON), when shared Resident 48's care plan states roles for assuring the CPAP and oxygen are attached to the resident is to be done by nursing assistant, the ADON says it is her expectation that nursing supervised the placement of the CPAP after the nursing assistant applies it to the resident. When asked does Resident 48 have oxygen attached to the CPAP; the ADON replied, "Yes." When shared, the facility policy states authorize personnel for oxygen initiation, or placement, excludes nursing assistants from applying oxygen. The ADON acknowledged. When the ADON/NHA (Nursing Home Administrator) was asked why CPAP was not a focus on the care plan, the ADON states there is a care plan for activities and everything. When asked for a comprehensive care plan addressing	F 656		

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F 656	Continued From page 4 measurable interventions for Resident 48's Sleep Apnea diagnosis or the wearing/maintenance of the CPAP, no care plan addressing those concerns for Resident 48 made available during this survey.	F 656		
F 880 SS=E	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: §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	F 880		

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F 880	Continued From page 5 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 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 observations, interviews, and record	F 880	1. Corrective Action	

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F 880	Continued From page 6 reviews, the facility failed to ensure that staff was performing proper hand hygiene to prevent transmittable diseases. Specifically, the staff did not use the correct sequence for washing hands, and staff was touching resident's food trays in multiple residents' rooms without performing hand hygiene (HH). Findings include: 1. On 6/23/20 at 12:19 PM, observation of Certified Nurse Aide 1 (CNA1) revealed CNA1 approach a sink on the East hall, CNA1 using her left hand dispensed soap into the left hand (without rinsing hands first), with right-hand turned faucet on, and then began soaping hands first. After CNA1 dried her hands, when asked about the sequence of soaping before rinsing hands, CNA1 replied, "I was a little distracted". Above the sink was signage that had the correct series for washing hands. On 6/23/20 at 12:50 PM, in an interview with the IPC-Nurse (infection control preventionist), when shared observation of the incorrect sequence, IPC-Nurse states she does monitors hand hygiene, and her goal is 95% compliance. Review of policy title "Hand Hygiene" effective 3/09/2020, subsection title, "Policy Explanation and Compliance Guidelines:" number five subsection Hand hygiene techniques when using soap and water: a. Wet hands with water. b. Apply enough soap to cover all hand surfaces. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use towel to	F 880	The facility will immediately implement an appropriate infection prevention and intervention plan consist with the requirements of §483.80 for the infection control deficient practices identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete the following: (1) Identify and implement safe, sanitary room tray removal procedures consistent with current nursing facility guidelines from the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services. (2) Develop and implement hand hygiene procedures for staff, utilizing guidelines including proper sequence of handwashing. 2. Identification of Others The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 7/16/2020 the facility shall complete the following actions:	

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F 880	Continued From page 7 turn off the faucet." On 6/23/20 at 1:10 PM, in an interview with the Nursing Home Administrator (NHA) shared observations of CNA1 washing hands, NHA replied what is wrong with using soap first. Explained to NHA what best practices for the prevention of transmittable diseases are to rinse hands before using soap, and illustrated that the facility policy and signage align with best practices. The NHA acknowledged. 2. On 6/23/20 at 12:30 PM, Dietary Aide 1 (DA1) was observed picking up lunch trays from residents' rooms, exiting the room, and discarding left food items from the plate and disposing of food items in a bucket on top of the cart (out in the hall) while wearing gloves. Then DA1 submerses the towel into a bucket of liquid and enters the resident room and proceeds to clean the bedside table, where the tray was, manipulating resident's personal items to clean the surface of the bedside table. Then DA1 exits the room, again without hand hygiene and wearing the same gloves, then returns the towel into the bucket, he then enters into another resident's room, no hand hygiene, and wearing the same gloves. DA1 repeats the sequence from the resident's room, as described earlier. Observed the DA1 continue to enter into another resident room, but was stopped by this surveyor. On 6/23/20 at 12:38 PM, in an interview with DA1, when shared observations, DA1 states, "Yea, I probably should have changed them [gloves]" later states he usually keeps gloves in his pocket. The IPC-Nurse approached and shared observations. When asked what her	F 880	(1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure guidelines for safe, sanitary room tray removal procedures were not implemented. b. Failure to ensure hand hygiene was consistently done by staff members, following the correct sequence for performing hand hygiene. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON and IP will ensure education is provided for the following: a. All staff are educated on safe, sanitary room tray removal procedures in accordance with current CDC and CMS guidelines. b. All staff are educated on when and how to perform hand hygiene in the correct sequence to reduce and control the spread of infections. Training on hand hygiene is available from the CDC at https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility.	

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F 880	Continued From page 8 expectation of staff upon entry and exiting residents' rooms, the IPC-Nurse states, she would expect staff to wash hands, change gloves, and hand hygiene between changing gloves. When informed IPC-Nurse, there are no gloves on the food cart; the IPC-Nurse then points to the end of the hall (approximately 20 feet) where the box of gloves was. Record review of Hand Hygiene policy effective 3/9/2020, subtitle number six, "Additional Considerations" section "b" reads, "The use of gloves does not replace hand washing." Under title page, "Hand Hygiene" reads in pertinent part, "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 hygiene (even if gloves are used): Before and after eating or handling food (handwashing with soap and water);" On 6/23/20 at 1:12 PM, in an interview with the NHA, when shared observations of DA1, the NHA verbally acknowledged.	F 880	4. Monitoring Monitoring of approaches to ensure infection control and prevention are effective will include: (1) Weekly for no less than 12 weeks, the IP, DON and will conduct on-going monitoring via observation to ensure staff are complying with requirements for: a. Compliance with room tray removal procedure requirements. b. Compliance with proper sequence of hand hygiene. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 7/16/2020	