| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355038 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/23/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST GERARD'S COMMUNITY OF CARE | 613 1ST AVE SW PO BOX 448, HANKINSON, North Dakota, 58041 |

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| F0000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 07/21/25 and concluded on 07/23/25. | F0000 | | 08/04/2025 |
| F0658<br>SS = D | Services Provided Meet Professional Standards<br><br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 3 of 3 residents (Residents #8, #16, and #23) observed for insulin preparation and administration. Failure to properly prime an insulin pen and administer insulin correctly may result in residents receiving an inaccurate dose of insulin.<br><br>Findings include:<br><br>Review of the facility policy titled, "Insulin Pen" occurred on 07/23/25. This policy, dated 04/09/23, stated, ". . . Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. . . ."<br><br>-Observation on 07/22/25 at 5:30 p.m. showed a nurse (#4) prepared Resident #16's insulin pen for administration. The nurse (#4) dialed the pen to 3 units and with the needle cap on, primed the pen with the needle pointed horizontally. The nurse primed the insulin pen with 3 units instead of 2 units and failed to remove the needle cap and hold the pen upward when priming. | F0658 | Corrective Action for Affected Residents: On 8/1/25, the Director of Nursing (DON) assessed residents #8, #16, and #23 for any adverse effects related to improper insulin administration technique, with no negative outcomes identified.<br><br>Identifying other Residents having the Potential to be Affected: The DON conducted a facility-wide audit of residents receiving insulin via insulin pens to identify residents with the potential to be affected by this practice. All residents receiving insulin via insulin pen have potential to be affected.<br><br>Measures put into place or Systemic Changes: The DON will provide education to Licensed nurses and Medication Aides regarding proper insulin pen preparation and administration completing education by 8/5/25, including:<br><br>Proper priming technique with needle cap removed<br><br>Holding pen upward during priming<br><br>Using 2 units for priming as specified in facility policy<br><br>Verifying insulin droplet at needle tip<br><br>The facility's insulin administration policy was reviewed and remains current. Competency validation through return demonstration will be completed for Licensed nurses and Medication Aides who administer insulin by 08/05/2025.<br><br>Plan to Monitor Performance: The charge nurse will conduct audits of insulin pen preparation and administration technique 3 times weekly for 2 weeks starting 7/24/25 ending 8/7/25, then weekly for 2 weeks starting 8/8/25 ending on 8/22/25, then quarterly in conjunction with the QAPI walkthrough completed by the | 08/22/2025 |

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 reverse for further 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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| F0658 SS = D | Continued from page 1<br>-Observation on 07/22/25 at 6:00 p.m. showed a nurse (#4) prepared Resident #23's insulin pen for administration. The nurse (#4) dialed the pen to 3 units and with the needle cap on, primed the pen with the needle pointed horizontally. The nurse primed the insulin pen with 3 units instead of 2 units and failed to remove the needle cap and hold the pen upward when priming.<br><br>-Observation on 07/23/25 at 11:14 a.m. showed a medication aide (MA) (#6) prepared Resident #8's insulin pen for administration. The MA (#6) dialed the pen to 2 units and with the needle cap on, primed the pen with the needle pointed horizontally. The MA failed to remove the needle cap and hold the pen upward when priming.<br><br>During an interview on 07/23/25 at 1:30 p.m., an administrative staff member (#5) stated she expected staff to prime an insulin pen with the cap off and the needle pointed upward. | F0658 | Continued from page 1<br>QAPI chairperson. The audits will include direct observation of technique and documentation review. Results of these audits will be reported to the Director of Nursing.<br><br>The Director of Nursing will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the effectiveness of the plan and make recommendations for changes as needed until substantial compliance is achieved and maintained. | |
| F0880 SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F0880 | Corrective Action for Affected Residents: On 8/1/25, the Director of Nursing (DON) assessed resident #8, Resident #15, and Resident #18 for any adverse effects related to improper infection control practices; no adverse effects were identified.<br><br>Identifying other Residents having the Potential to be Affected: The Infection Preventionist (IP) conducted a facility-wide audit on 07/24/25 to identify residents requiring Enhanced Barrier Precautions and residents requiring assistance with personal care/toileting. All residents have the potential to be affected by this deficient practice. The DON and IP reviewed current infection control policies and practices both of which remain current best practices.<br><br>Measures put into place or Systemic Changes: The DON and IP will provide 1:1 education to Licensed Nurses and CNAs emphasizing the following areas listed below. Education will be completed by 8/11/25.<br><br>Proper implementation of Enhanced Barrier Precautions including required PPE for high-contact resident care activities<br><br>Hand hygiene requirements including performing hand hygiene after removing soiled gloves and before applying clean gloves<br><br>Offering hand hygiene to residents after toileting | 08/22/2025 |

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| F0880 SS = D | Continued from page 2<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention | F0880 | Continued from page 2<br>Documentation requirements for infection control practices<br><br>The IP verified visual aids remain posted near hand hygiene stations and in resident care areas to reinforce proper infection control practices.<br><br>Plan to Monitor Performance: The charge nurse will conduct random audits of staff members providing direct resident care to observe compliance with Enhanced Barrier Precautions and hand hygiene practices. Audits will occur daily for one week starting 7/24/25 completing 7/30/24, three times per week for 3 weeks starting 7/31/25 completing 8/22/25. Then resuming monthly auditing by IP.<br><br>The Director of Nursing or IP will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review findings at each meeting and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained for three consecutive months. | |

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| F0880 SS = D | Continued from page 3<br>for 2 of 8 sampled residents (Residents #8 and #15) and 1 supplemental resident (Resident #18) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP) and hand hygiene has the potential to spread infection throughout the facility.<br><br>Findings include:<br><br>Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 07/23/25. This policy, dated 04/08/24, stated, ". . . Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. . . . Initiation of Enhanced Barrier Precautions: An order for enhanced barrier precautions will be obtained for residents with any of the following: . . . indwelling medical devices (e.g., central lines, urinary catheters . . . Implementation of Enhanced Barrier Precautions: . . . PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include: . . . Providing hygiene . . . Changing briefs or assisting with toileting . . . device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes . . ."<br><br>Review of the facility "Infectious Disease Control Manual" occurred on 07/23/25. This manual, dated May 2007, page 28 stated, ". . . j. Handwashing . . . when to wash your hands . . . 2. Should be first thing you do when you enter resident's room and, last thing you do before leaving. . . . 7. After removing your gloves. 8. Before and after handling dressing, catheters, bedpans, specimens, and urinals. Between procedures on the same resident. 9. Before and after assisting residents with any personal needs. . . ."<br><br>-Review of Resident #8's medical record occurred on all days of survey. A physician's order stated, "Change ostomy [a surgically created opening in the abdomen, that allows waste to be diverted from its usual pathway] pouch twice weekly and as needed." The current care plan stated, ". . . Staff will use enhanced barrier precautions during the following high-contact activities: . . . caring for or using an indwelling medical device: colostomy and catheter. | F0880 | | |

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| F0880 SS = D | Continued from page 4<br><br>-Observation on 07/21/25 at 3:36 p.m. showed a certified nurse aide (CNA) (#1) applied a gown and gloves to change Resident #8's colostomy bag. A nurse (#4) entered the room with additional supplies. The CNA (#1) removed the pouch and placed it in the garbage bag. The nurse (#4), without performing hand hygiene, applied gloves and assisted the CNA by wiping stool from the colostomy stoma (opening) with disposable wipes and placed them in the garbage bag. The CNA tied the garbage bag and gave it to the nurse who exited the room. The CNA (#1) removed the gown and gloves, performed hand hygiene, and exited the room.<br><br>The nurse (#4) failed to apply a gown before assisting with colostomy cares.<br><br>During an interview on 07/23/25 at 1:30 p.m., an administrative staff member (#5) stated she expected staff to apply PPE when providing cares to residents on EBP.<br><br>Observation on 07/21/25 at 1:25 p.m. showed two CNA's (#1 and #3) completed hand hygiene and applied gloves. The CNAs transferred Resident #18 from the wheelchair to the bed using a mechanical sling lift. The CNA (#1) removed Resident #18's soiled brief, performed perineal care, removed the soiled gloves, applied a clean brief, and positioned Resident #18's pants. The CNA (#1) failed to perform hand hygiene after removing the soiled gloves and failed to apply new gloves before applying a clean brief.<br><br>Observation on 07/22/24 at 3:40 p.m. showed a CNA (#2) assisted Resident #15 to the toilet. The resident voided and performed toileting hygiene. The CNA (#2) applied gloves, provided additional perineal care, removed the soiled gloves, and without performing hand hygiene, applied clean gloves, positioned Resident #15's brief and pants, and assisted Resident #15 to the recliner.<br><br>The CNA (#2) failed to complete hand hygiene after removing the soiled gloves and before applying clean gloves and failed to offer hand hygiene to Resident #15.<br><br>During an interview on 07/23/25 at 2:00 p.m., an | F0880 | | |

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| F0880 SS = D | Continued from page 5<br>administrative nurse (#5) stated she expected staff to perform hand hygiene after removing soiled gloves. | F0880 | | |