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 _____	03/10/2021

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 03/08/21 and concluded on 03/10/21.	F 000		
F 689 SS=D	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, record review, facility policy, and staff interview the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #28) and 1 supplemental resident (Resident #11) observed during transfers. Failure to use a gait belt during transfers placed the residents at risk of accidents and injury. Findings include: Review of facility policy titled "Gait Belt" occurred on 03/10/21. This undated policy stated, ". . . PURPOSE OF GAIT BELT: 1. Provide increased security for the resident and staff. . . . POLICY: A gait belt is to be used during ambulation or movement of residents who need the security . . ." - Review of Resident #11's medical record	F 689	All certified nursing assistants were immediately educated with each shift report in regards to providing adequate supervision and use of necessary assistive devices, specifically that gait belts must be used during transfers to prevent accidents and injury including for Resident #28 & 11. Residents that require staff assistance with transfers have the potential to be affected. Careplans for Resident #28 & 11 as well as for those who require staff assist with transfers were reviewed to ensure accuracy. Resident #28 & 11 were assessed to ensure no actual harm had resulted from deficient practice of not using gait belt for transfers.	4/6/21

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

Electronically Signed | 03/25/2021

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F 689	Continued From page 1 occurred on 03/09/21 and included diagnoses of osteoarthritis and Alzheimer's disease. A quarterly Minimum Data Set (MDS), dated 01/08/21, identified extensive assist for transfers and two or more falls with no injury. During an observation on 03/08/21 at 4:21 p.m. a certified nurse aide (CNA) (#6) transferred Resident #11 from the bed to the wheelchair. During the transfer the CNA placed her arm under Resident #11's right axilla and assisted the resident to stand. The CNA failed to utilize a gait belt during the transfer. - Review of Resident #28's medical record occurred on all days of survey and included a diagnosis of mild cognitive impairment. An annual MDS, dated 02/19/21, identified extensive assist for transfers and one fall with no injury. During an observation on 03/08/21 at 4:09 p.m. a CNA (#6) transferred Resident #28 from the bed to the wheelchair. During the transfer the CNA placed her arm under Resident #28's right axilla and assisted the resident to stand. The CNA failed to use a gait belt during the transfer. During an interview on 03/10/21 at 12:30 p.m., an administrative nurse (#1) stated she expected staff to use a gait belt when assisting residents to stand.	F 689	CNA meeting was held 3/24/2021 regarding: Policy on Gait Belt use, education regarding the use of gait belts, a review of the residents that use gait belts including Resident #28 & 11 and staff assistance with transfers were covered with all CNA's in nursing and ss/act departments. DON conducted meeting. Quality Assurance spot checks were implemented immediately for random checks to ensure the standard is followed. Random spot checks will continue daily until 3/23/2021 by a licensed 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 Coordinator will conduct weekly audits to ensure compliance x4, then monthly under the quality assurance checklist labeled, "Failure to use gait belt during transfers". All licensed nurses were immediately educated with each shift report in regards to providing adequate supervision and use of necessary assistive devices, specifically gait belts must be used during transfers to prevent accidents and injury during transfers including for Residents #28 & 11. Residents that require staff assistance with transfers have the potential to be affected.	

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F 689	Continued From page 2	F 689	Licensed nurse meeting was conducted by DON 3/23/21 regarding the importance of proper supervision and the correct use of necessary assistance devices, specifically "gait belts" to prevent accidents and injury during transfers. The facility policy was reviewed and discussed as well as the expectation to perform random spot checks on CNA staff to ensure standard is followed. Administrator educated department managers on adequate hydration and use of gait belts on 3/11/21. DON educated licensed nurse staff 3/23/2021 and other direct care staff on 3/24/2021. Remaining staff educated through departmental meetings.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		4/6/21

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F 692	Continued From page 3 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 6 of 12 sampled residents (Residents #3, #5, #22, #24, #25, and #27) and 2 supplemental residents (Residents #11 and #12) during cares. Failure to offer fluids with cares may result in dehydration, constipation, and urinary tract infections (UTI's). Findings include: Review of the facility policy titled "Hydration" occurred on 03/10/21. This policy, dated November 2017, stated, ". . . Nursing and CNAs [certified nursing assistants] . . . encourage resident to drink every time you see them . . . Offer appropriate assistance as needed if resident cannot drink without help . . ." - Review of Resident #3's medical record occurred on all days of survey and included the diagnosis of constipation. Observation on 03/08/21 at 3:06 p.m. showed two CNAs (#3 and #6) failed to offer fluids to Resident #3 after assisting her to the bathroom and transferring her to the recliner. Observation showed a pitcher of water located on the bed side table but not within the resident's reach. - Review of Resident #5's medical record	F 692	All certified nursing assistants were immediately educated with each shift report in regards to the expectation for offering fluids and assisting with intake of fluids with cares to decrease the risk of dehydration, constipation and urinary tract infections. All residents have the potential to be affected. DON/CDM reassessed the hydration status and fluid needs of residents #3,5,11,12,22,24,25 and 27 to ensure no actual harm noted. Careplans reviewed. Resident #27 careplan was revised to reflect individual resident needs r/t hydration. CNA meeting was held 3/24/21 regarding: Policy on Hydration, importance of sufficient fluid intake and hydration standard to CNAs in both the nursing department and ss/act department. DON conducted meeting. Quality assurance spot checks were implemented immediately for random checks to ensure that standard is followed. Random spot checks will continue daily until 3/23/2021 by a	

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F 692	Continued From page 4 occurred on all days of survey and included the diagnosis of Alzheimer's disease. Observation on 03/08/21 at 2:46 p.m. showed two CNAs (#3 and #6) failed to offer fluids to Resident #5 after assisting her from the wheelchair to the bed. Observation on 03/09/21 at 12:52 p.m. showed two CNAs (#4 and #5) failed to offer fluids to Resident #5 after assisting her from the wheelchair to the bed. - Review of Resident #11's medical record on 03/09/21 and included the diagnosis of Alzheimer's disease. The current care plan stated, ". . . I am at risk for dehydration due to hx [history] of poor intake . . ." Observation on 03/08/21 at 4:21 p.m. showed a CNA (#6) failed to offer fluids to Resident #11 after assisting her from the bed to the wheelchair. - Review of Resident #12's medical record occurred on 03/09/21 and included the diagnosis of dementia. Observation on 03/08/21 at 2:44 p.m. showed a CNA (#6) failed to offer fluids to Resident #12 after offering the resident assistance with using the bathroom. - Review of Resident #22's medical record occurred on all days of survey and included the diagnosis of Alzhiemer's disease and dementia. Observation on 03/08/21 at 3:50 p.m. showed two CNAs (#10 and #11) failed to offer fluids to	F 692	licensed nurse and then completed randomly. Areas of concern will be addressed with individual staff members at the time of the occurrence with results going to the QA Committee. The Quality Assurance Coordinator will conduct weekly audits to ensure compliance x4, then monthly under the Quality Assurance checklist labeled, "daily food and fluid intake not observed and not encouraged, supplements, etc. are not documented". All licensed nurses were immediately educated with each shift report in regards to the expectation for providing and encouraging adequate fluid intake with all cares to help decrease the risk of dehydration, constipation and urinary tract infections. All residents have to potential to be affected. Licensed nurses meeting was conducted by DON 3/23/21 regarding proper hydration to help decrease the risk of dehydration, constipation and urinary tract infections. Facility hydration policy was reviewed and discussed as well as the expectation to perform random spot checks on CNA staff to ensure standard is followed. Administrator educated department managers on adequate hydration and use of gait belts on 3/11/21.	

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F 692	Continued From page 5 Resident #22 after assisting her from the bed to the wheelchair. Observation on 03/09/21 at 1:58 p.m. showed two CNAs (#4 and #5) failed to offer fluids to Resident #22 after assisting her from the wheelchair to the bed. - Review of Resident #24's medical record occurred on all days of survey and included the diagnosis of dementia. Observation on 03/08/21 at 2:44 p.m. showed a CNA (#6) failed to offer Resident #24 fluids after offering assistance with the bathroom. Observation on 03/09/21 at 11:38 a.m. showed two CNAs (#8 and #9) failed to offer Resident #24 fluids after assisting him to use the bathroom. - Review of Resident #25's medical record occurred on all days of survey. The current care plan stated, ". . . I have short term memory impairment . . ." Observation on 03/08/21 at 3:05 p.m. showed a CNA (#6) failed to offer Resident #25 fluids after offering assistance with the bathroom. - Review of Resident #27's medical record occurred on all days of survey. The current care plan stated, ". . . I am at risk for dehydration related to my medication use of a diuretic . . . Offer me fluids between meals. . . . I need help with my ADLs [activities of daily living], my balance is not so great, I have left sided weakness related to history of TBI [traumatic	F 692	DON educated licensed nurse staff 3/23/2021 and other direct care staff on 3/24/2021. Remaining staff educated through departmental meetings.	

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F 692	Continued From page 6 brain injury] . . . I transfer with 1 assist and cane . . ." Observation on 03/09/21 at 3:56 p.m. showed a CNA (#7) assisted Resident #27 from his bed to the bathroom. Upon completion of cares, the CNA assisted Resident #27 to sit in a chair. Observation showed a water mug on the dresser next to the TV, but not within the resident's reach. The CNA failed to offer/encourage fluids during this observation. During an interview on 03/10/21 at 12:26 p.m., an administrative nurse (#1) stated staff should offer fluids to residents with each interaction.	F 692		