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 _____	05/19/2016

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 For the standard Medicare/Medicaid recertification survey started on May 16, 2016 and completed on May 19, 2016, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner and environment that maintained or enhanced each resident's dignity/self-esteem for 1 of 9 sampled residents (Resident #2) and 2 of 2 supplemental residents (Resident #12 and #13). Failure to ensure dignity and respect during administration of insulin (Resident #12 and #13) and failure to provide privacy during pericares (Resident #2) does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: PERSONAL CARES - Observation on 05/17/16 at 9:52 a.m. showed two certified nurse assistants (CNAs) (#1 and #2)	F 241	Nursing department staff education completed promptly with each shift regarding providing care in a manner and environment that maintains resident's dignity and self esteem. Specific education provided re: resident #2,#12,#13 as well as all residents. Mobile privacy screen has been implemented re: insulin injections. All Nursing Department staff were educated on 5/25 & 5/26/16 regarding importance of maintaining dignity and respect of individuality at in-service. Licensed Nurses also educated regarding importance of this standard on 5/25 & 5/26/16 at licensed nurse meeting. Both	6/21/16

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

Electronically Signed | 06/03/2016

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 _____	05/19/2016

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 241	Continued From page 1 transferred Resident #2 from his wheelchair to the bed. The CNAs pulled down his pants, opened his brief, and assisted him with the bedpan and urinal. While Resident #2 was on the bedpan, the CNA (#2) opened the resident's door and exited the room. The CNAs failed to utilize the privacy curtain to ensure resident privacy. Observation on 05/17/16 at 2:46 p.m. showed Resident #2 laying on his bed with his shirt pulled up to his chest, his pants pulled down to his ankles, and positioned on the bedpan. The facility failed to close Resident #2's door and utilize the privacy curtain to ensure resident privacy. Observation on 05/17/16 at 2:52 p.m. showed Resident #2 laying in the bed undressed with a blanket covering his midsection. Two CNAs (#3 and #4) assisted Resident #2 to use the urinal, and dressed the resident with his roommate present in the room. The CNAs failed to utilize the privacy curtain between the residents. Observation on 05/17/16 at 4:12 p.m. showed two CNAs (#5 and #6) pulled Resident #2's pants down and assisted him with the urinal and the bedpan. After a bowel movement, the CNAs provided pericare. The CNAs failed to utilize the privacy curtain to ensure resident privacy. INSULIN ADMINISTRATION - Observation on 05/17/16 at 11:34 a.m. showed a nurse (#7) administered insulin to Resident #12 while he sat at the dining room table. Another resident and her family member were also at the table. The nurse (#7) pulled up Resident #12's shirt, exposed his abdomen, and injected the	F 241	meetings were conducted by Director of Nursing. QA spot checks were implemented immediately for random checks to ensure standard is followed. Findings were reviewed with each individual as warranted with results going to QA committee. The QA director will conduct random monthly observations of staff over the next three (3) months then quarterly to ensure staff are promoting & maintaining compliance with standard, under the Long Term Care Department QA checklist labeled "Privacy and Dignity Protected." By ensuring that staff have adequate knowledge of and follow concepts of dignity & respect of individuality, we are able to provide cares in a dignified manner & in turn to help promote resident's psychosocial well-being. By following these concepts the potential to negatively affect residents: #2, #12,& #13 Dignity and Respect of Individuality has been averted as well as avoiding potential harm to all residents.	

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 _____	05/19/2016

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 241	Continued From page 2 insulin. The family member turned to face another direction while the nurse administered the insulin. The nurse failed to provide privacy and ensure dignity during the administration of the medication. - Observation on 05/17/16 at 5:45 p.m. showed a certified medical assistant (CMA) (#9) administered insulin to Resident #12 while he sat at the dining room table with another resident. The CMA (#9) pulled up Resident #12's shirt, exposed his abdomen, and injected the insulin. The CMA failed to provide privacy and ensure dignity during the administration of the medication. - Observation on 05/17/16 at 11:40 a.m. showed a nurse (#7) transported Resident #13 from the dining room table to another location in the dining room. The nurse (#7) pulled up the resident's shirt, exposed her abdomen, and injected the insulin. Observation showed several residents seated in the dining room within view of Resident #13. During an interview on 05/19/16 at 9:49 a.m., an administrative staff member (#8) stated she expected staff to pull the privacy curtain while residents are provided pericares and administer insulin in a private setting.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		6/21/16

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 _____	05/19/2016

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 278	Continued From page 3 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, and staff interview, the facility failed to ensure staff accurately coded the Minimum Data Sets (MDSs) for 3 of 3 sampled residents (Resident #1, #2, and #5,) coded for a restraint. Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs. Findings include:	F 278	Resident's #1, #2, & #5 were reassessed on 5/18 & 5/25/2016 which included the review of the CMS coding guidelines pertaining to coding side rails under section P as Physical Restraint. Guidelines revealed side rails should have not been coded as a Physical Restraint as they are utilized for positioning purposes. These residents #1, #2 & #5 have been re-assessed & corrections to prior MDS's have been implemented and submitted.	

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 _____	05/19/2016

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 278	Continued From page 4 The Long-Term Care Facility RAI User's Manual, revised October 2015, on page P-1 stated, " . . . The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100 . . . Definition: Physical restraint, Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." - Review of Resident #1's significant change MDS, dated 05/15/16, identified extensive assist of one person for bed mobility, transfers, and restraint in bed with bed rail used daily. The current care plan stated, ". . . 1/4 side rails for repositioning per resident request. . . ." - Review of Resident #2's quarterly MDS, dated 03/29/16, identified extensive assist of one person for bed mobility, total assistance for transfers, restraint in bed with bed rail used daily. The current care plan stated, ". . . Side rails [up] for positioning in bed . . . " - Review of Resident #5's quarterly MDS, dated 12/31/15, identified extensive assist of one person for bed mobility, transfers, and restraint in bed with bed rail used daily. The current care plan stated, ". . . Side rails may be kept [up] for	F 278	A licensed nurse meeting attended by licensed nurses and MDS nurses was conducted on 5/25 & 5/26/16 by DON addressing the importance & accuracy with need for accurate assessment of residents current status and needs including Physical Restraints & specific qualifications. All nursing department staff in-service education provided on 5/25 & 5/26/16 regarding definition of physical restraint, accurate assessments, etc. conducted by Director of Nursing. The QA Director will conduct a random audit of two (2) resident's MDS per month for three (3) consecutive months then quarterly thereafter to ensure continued compliance under Long Term Care Department QA checklist "MDS assessment does not accurately reflect individual resident's current status." Areas of concern will be addressed at monthly QA meeting. By ensuring that nursing department staff have adequate knowledge of ensuring accuracy of MDS assessments this ensures continued compliance and averts potential harm to all residents.	

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 _____	05/19/2016

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 278	Continued From page 5 positioning purposes . . . " During an interview on 05/19/16 at 9:49 a.m., an administrative staff member (#8) stated Resident #1, #2, and #5's MDS should not have been coded for restraints.	F 278		
F 441 SS=E	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.	F 441		6/21/16

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 _____	05/19/2016

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 441	Continued From page 6 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: CONTACT PRECAUTIONS 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 2 sampled residents (#7 and #8) on contact precautions. Failure to follow infection control practices related to hand hygiene and contact precautions has the potential to spread infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled "HAND HYGIENE" occurred on 05/19/16. This undated policy stated, ". . . some situations that require hand hygiene: . . . Before and after resident contact . . . Before and after performing any invasive procedure (e.g. [example], finger stick blood sampling) . . . Before and after entering isolation precaution settings . . . Upon and after coming in contact with a resident's intact skin, e.g. when taking a pulse or blood pressure, and lifting a resident) . . . After completing duty. . . ." Review of the facility policy titled "CARE OF RESIDENTS WITH MRSA (Methicillin resistant Staphylococcus aureus)" occurred on 05/19/16. This policy, dated July 2014, stated, ". . . To	F 441	Proper signage was placed outside resident #7's room in order to inform visitors, staff, and residents of the proper precautions utilized. Nursing department staff education completed promptly with each shift report as well as by nursing department staff communication book Re: Infection control practices under Contact/Isolation Precautions, Hand Hygiene, proper use of signage with Precautions, Disinfecting time between each tub bath of allowing the chemical to remain on the wet surface for ten minutes. Specific education provided re: resident #7 & 8. Note: To properly disinfect tub bath between each resident use, the chemical manufacturer's recommendations will be followed. Licensed Nurse's meeting was conducted on 5/25 & 5/26/16 by Director of Nursing, which stressed the importance of proper hand hygiene,policy review of "Hand Hygiene", Contact precaution guidelines,posting signage with contact	

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 _____	05/19/2016

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 441	Continued From page 7 control the spread of MRSA, contact precautions are recommended for those infected or colonized with the microorganism. . . . Washing hands with soap & [and] water after touching the resident or potentially contaminated articles and before caring for another resident whether or not gloves are worn. . . ." Review of the facility policy titled "CONTACT PRECAUTIONS" occurred on 05/19/16. This undated policy stated, ". . . Gloves and handwashing are both necessary with gloves worn when entering the room. . . . Remove gloves before leaving the patient environment and wash with antimicrobial soap or hand degermer. Assure that hands are not recontaminated by touching contaminated surfaces. . . ." - Review of Resident #8's medical record occurred on 05/18/16. Diagnosis included MRSA (contact precautions). Observation on 05/17/16 at 11:35 a.m. showed a nurse (#10) entered Resident #8's room, applied gloves, administered insulin, removed her gloves, and left the room. The nurse failed to wash her hands before leaving the room. Observation on 05/18/16 at 3:59 p.m. showed Resident #8 seated in her wheelchair with a gaitbelt dragging on the floor. A certified nurse assistant (CNA) (#6) entered the room, removed the gait belt from Resident #8's wheelchair, obtained Resident #8's roommate's clothing out of the drawer, and exited the room. The CNA (#6) failed to wash her hands after handling Resident #8's personal equipment, before obtaining	F 441	and/or isolation precaution, along with manufactures guidelines for disinfecting tub bath after each use,and general infection control procedures, etc. Nursing Department staff meeting was conducted on 5/25 & 5/26/16 by Director of Nursing, which stressed the importance of proper hand hygiene, policy review of "Hand Hygiene", Contact precaution guidelines, posting signage with contact and/or isolation precaution, along with manufactures guidelines for disinfecting tub bath after each use, and general infection control procedures, etc. QA spot checks were implemented immediately for random checks to ensure standard is being met. Findings were reviewed with each individual as warranted with results going to QA committee. The QA Director will conduct random monthly observations of staff over the next three (3) months then quarterly to ensure staff are maintaining compliance with standard, under the infection control checklist labeled "Disinfecting techniques and procedures are not adequate and not followed", "Proper hand hygiene not completed with medications pass", "Hand washing per policy/procedure", "Proper infection control signage utilized." By ensuring Nursing staff have adequate knowledge of and follow concepts of usage of signage during Contact/Isolation	

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 _____	05/19/2016

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 441	Continued From page 8 another resident's clothing and before exiting the room. During an interview on 05/18/16 at 9:49 a.m., an administrative staff member (#8) stated she expected staff to wash their hands after handling equipment for a resident on contact precaution. - Review of Resident #7's medical record occurred on 05/18/16. Diagnoses included herpes zoster and impetigo. Resident #7's physician progress notes stated the following: * 05/09/16: ". . . rash . . . likely shingles . . . Valtrex 1gm [gram] (antiviral for shingles) . . ." *05/16/16: ". . . room restriction . . ." * 05/16/16: ". . . He has had an evolving eruption along the neckline, . . . , weepy, problematic, and appears to be itchy. . . . Exam revealed a V-shaped eruption with eschar and a yellow debris, more right than left, but problematic in nature with secondary excoriations. . . . Complicated skin infection, impetiginous. . . ." Review of Resident #7's nursing progress note stated the following: * 05/14/16 at 7:05 a.m.: "Residents neck [continues] to be reddened and weepy. . . . Noted [large amount] of yellow/orange drainage to shirt wore to bed and bed sheets. . . ." *05/15/16 at 7:31 p.m.: "Resident had taken off abd [abdominal dressing] pad placed earlier in the day, . . . Moderate amount of yellow drainage noted on old abd pad. . . ." * 05/16/16 at 5:43 p.m.: ". . . [diagnoses] of impetigo. . . . Area is reddened with yellow colored drainage noted on shirt. . . . Contact	F 441	Precautions, tub bath disinfecting time, infection control practices during Contact/Isolation Precautions with emphasis of hand hygiene, the safety of all residents and visitors will be assured as well as avoiding potential harm to all residents.	

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 _____	05/19/2016

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 441	Continued From page 9 precautions in place. * 05/17/16 at 9:29 a.m.: . . . minimal drainage noted to ABD, clear/yellow. Will leave open to air. . . ." Observation on 5/16/16 at 1:20 p.m. showed Resident #7's neck reddened with drainage present. An administrative staff member (#12) stated "I am not sure what the rash is but the facility was waiting to find out today what it is." Facility staff failed to place signage outside Resident #7's door indicating contact precautions. During an interview on the morning of 05/19/16, an administrative staff member (#11) stated Resident #7's physician diagnosed the neck rash as shingles on 05/09/16. On 05/16/16, the physician re-diagnosed the rash as impetigo. This staff member confirmed the facility staff placed signage for contact isolation after the initial tour of the facility on 05/16/16. The facility failed to post appropriate contact and/or isolation precaution signage on Resident #7's door to inform visitors, staff, and residents of the precautions. BATHTUB DISINFECTION 2. Based on observation, review of chemical manufacturer's recommendation, and staff interview, the facility failed to follow accepted infection control practices for 1 of 1 bathtub. Failure to follow the accepted infection control practices when disinfecting the bathtub between residents has the potential to spread infection within the facility.	F 441		

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 _____	05/19/2016

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 441	Continued From page 10 Findings include: Review of the chemical manufacturer instructions titled "Spartan HDQ Neutral" occurred on 05/19/16. The undated instructions stated, "Preparation of disinfection/fungicidal/virucidal use solution: . . . to disinfect hard, non-porous surfaces. Treated surfaces must remain wet for 10 minutes. Rinse or allow to air dry. . . ." Observation on the morning of 05/19/16 showed the chemical disinfectant used to clean the bath tub labeled Spartan HDQ Neutral. The label instructions stated, ". . . Preparation of disinfection/fungicidal/virucidal use solution: . . . to disinfect hard, non-porous surfaces. Treated surfaces must remain wet for 10 minutes. Rinse or allow to air dry. . . ." During an interview on 05/19/16 at 8:00 a.m., a staff member (#13) stated the process to clean the tubs between each resident is to "rinse the tub, use Quat, scrub, and rinse the tub . . . the quat needs to sit usually 3-4 minutes before the next resident, before next use . . . " During an interview on the afternoon of 05/19/16, an administrative staff member (#11) confirmed the facility process is to allow the chemical to sit for 2-3 minutes for disinfecting. The facility failed to follow the the chemical manufacturer's recommendations of allowing the chemical to remain on the wet surface for ten minutes to properly disinfect the bathtub between each resident use.	F 441		