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 _____	05/22/2018

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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F 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 05/20/18 and concluded on 05/22/18.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care	F 657	Resident #3 care plan was immediately reviewed and revised to reflect in placing a rolled cloth into palm of right contracted	6/18/18

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

Electronically Signed | 06/05/2018

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F 657	Continued From page 1 plan for 3 of 14 sampled residents (Resident #3, #6, and #16). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Nursing Care Plans" occurred on 05/23/18. This policy, revised November 2017, stated, ". . . Plan of Care will also be reviewed in the event of a significant change day to day changes will be added/deleted by charge nurse ongoing.. . . ." - Review of Resident #3's medical record occurred on all days of survey. An annual Minimum Data Set (MDS), dated 03/13/18, identified impaired upper extremity range of motion (ROM) on one side. Observation on 05/21/18 at 11:06 a.m. showed two certified nurse aides (CNAs) (#1 and #2) sanitized Resident #3's hands before rolling a cloth, and placing it in the palm of Resident #3's right hand. This was the first observation of Resident #3 holding an assistive device in her right contracted hand. The current care plan failed to identify any interventions fot Resident #3's contracted right hand. During an interview on 05/22/18 at 11:00 a.m., an administrative nurse (#3) confirmed staff failed to transfer the intervention onto Resident #3's current care plan.	F 657	hand. Resident #6 care plan was immediately reviewed and revised to reflect medical diagnosis of Constipation along with interventions implemented. Resident #16 care plan was reviewed and revised to reflect transfers. PT was immediately notified for evaluation of transfers. On 5/24/18 PT noting changes to transfer which were implemented accordingly to plan of care. All residents have the potential to be affected regarding the failure to revise the care plan limiting the ability of staff to communicate care needs to ensure continuity of care for each resident. Nursing department education completed promptly with each shift report regarding care plan timing and revision. Specific education provided regarding resident #3, #6, & #16 as well as all residents. All residents comprehensive care plans were reviewed and revised accordingly to reflect continuity of care. A Licensed Nurse meeting was held on May 23, 2018. Education provided regarding the failure to revise the care plan limiting the ability of staff to communicate care needs and ensure continuity of care for each resident. Meeting was conducted by the Director of Nursing.	

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F 657	Continued From page 2 - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included constipation. Current medications included Senna plus every day, milk of magnesia 30 milliters (ml) every day as needed (PRN) for constipation, and Dulcolax suppository every day PRN. Review of the Medication Administration Record identified the following: * March 2018 - received six PRN constipation medications * April 2018 - received eight PRN constipation medication * May 1-21, 2018 - received two PRN constipation medications The current care plan failed to identify Resident #6's problem of constipation, or any interventions for staff to implement regarding the constipation. - Review of Resident #16's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease and depression. An quarterly MDS, dated 04/05/18, identified the resident required extensive assistance of two staff members for transfers and toileting. The current care plan stated, ". . . I require assist of 2 with walker and I am not able to take care of my personal needs. . . . I will transfer up with assist of two and walker. I will utilize PRN EZ Stand [sit-to-stand mechanical lift]. . . . A physician's order dated 10/06/17 stated, "Up with assist of 2 and walker. Pivot transfer." Observation on 05/20/18 at 5:08 p.m. showed a CNA (#4) and an unidentified CNA attempted to	F 657	Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 6/8/18 by the Quality Assurance Director. Area of concern will be addressed with individual staff members. The Quality Assurance Director will conduct weekly audits thereafter to ensure compliance X4, then monthly under "Comprehensive Care Plan Review and Revise." Areas of concern will be addressed at monthly Quality Assurance meeting.	

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F 657	Continued From page 3 transfer Resident #16 out of bed using the sit-to-stand lift. The resident refused to hold onto the lift handles. The CNAs removed the lift sling, applied a gait belt and transferred the resident into her wheelchair. During an interview 05/22/18 at 9:25 a.m., an administrative nurse (#5) stated she expected staff to transfer Resident #16 using a gait belt and assist of two. If the resident is unable to transfer using a gait belt the CNAs should consult with the nurse before using the sit-to-stand lift. The current care plan failed to clearly identify the method of transfer for Resident #16.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, facility staff failed to follow standards of practice for 1 of 1 sampled resident (Resident #24) who received medications late. Failure to administer medications within one hour before or one hour after the scheduled time may result in adverse consequences such as uncontrolled pain. Findings include: Review of the facility policy titled "Medication	F 658	The standard of practice was immediately reviewed with the medication aide involved to assure that resident #24 and all other residents medications are given in accordance to practice which include: right drug, right resident, right dose, right route, right time and properly documented. All other medication aides and nurses were immediately educated via shift report regarding Services Provided Meet Professional Standards. On May 23, 2018 a licensed nurse	6/18/18

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F 658	Continued From page 4 Administration Policy" occurred on 05/22/18. This policy, dated 03/14/17, stated, PURPOSE: To assure that the right drug and dose are given to the right resident by the right route at the right time and are properly documented . . . PROCEDURE: . . . To begin . . . obtain meds [medications] indicated for that resident and the time period using safety and accuracy checks. . . ." Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th edition, Pearson Education, Inc., page 773, stated, ". . . Non-Time-Critical Scheduled Medications: . . . Medications prescribed more frequently than daily, but no more frequently then every 4 hours [administer] Within 1 hour before or after the scheduled time . . ." Observation on 05/22/18 at 8:25 a.m. showed a medication aide (MA) (#6) prepared Resident #24's medications. The Medication Adminisration Record (MAR) identified the following medications to be administered at 7:00 a.m.: Valium (anti-anxiety), scheduled for three times a day; Baclofen (muscle relaxant), scheduled for three times a day; and tizanidine (muscle relaxant), scheduled for three times a day; as well as 10 additional medications. At 8:35 a.m., the MA entered Resident #24's room and administered the medications one hour and 35 minutes past the scheduled time. During an interview on 05/22/18 at 9:30 a.m., an administrative nurse (#5) stated staff are allowed one hour before and one hour after the scheduled time to administer a resident's	F 658	meeting was conducted addressing the 6 rights of Medication Administration along with facility standards and policies. Residents #24 medications times were readjusted per resident preference along with review of all other residents medication and need for time adjustments. All residents have the potential to be affected. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 6/8/18 conducted by charge nurse. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. The Quality Assurance Director will conduct weekly audits to ensure compliance X4, then monthly under the Quality Assurance checklist labeled "6 rights of medication administration compliance."	

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F 658	Continued From page 5 medications.	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the cleaning logs, and staff interview, the facility failed to serve, prepare, and store food in a safe and sanitary manner for 1 of 1 kitchen. Failure to ensure dishware is free from dust/debris increased the risk for contamination and may affect all residents who consume food stored, prepared, or served in the kitchen. Findings include: Review of the 2017 Food and Drug	F 812	Fans blowing air directly onto racks of dishware in the clean area of dish room were immediately removed. All fans in dish room were cleaned. New racks and cart for drying dishes were purchased in order to allow proper air drying. All residents have the potential to be affected and described measures have been implemented to prevent such risk to residents.	6/18/18

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F 812	Continued From page 6 Administration (FDA) Food Code, Protection of Clean Items, F-901.11, page 151, stated, ". . . After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining . . ." Review of the 2017 FDA Food Code, Annex 3 - Public Health Reasons/Administrative Guidelines, 4-903.12, page 572, stated, "The improper storage of clean and sanitized equipment, utensils . . . may allow contamination before their intended use. Contamination can be caused by . . . dust, and other materials. . . ." A tour of the kitchen occurred on 05/20/18 at 1:19 p.m. Observation showed two dusty fans blowing air directly onto two separate racks of dishware at the clean end of the dishwasher and another dusty fan blowing air onto the floor. During interview, a dietary aide (#7) stated the facility has always used fans to dry dishware because they would not dry otherwise. When asked how often the fans are cleaned, the dietary aide (#7) stated weekly and showed a cleaning log which identified staff had not cleaned the fans for three weeks. Review of the kitchen cleaning logs occurred on 05/22/18 at 10:38 a.m. with the dietary manager (#8). The logs identified dietary staff cleaned the fans earlier that day.	F 812	All dishwashers and other dietary staff were educated by CDM at beginning of first scheduled shift following survey regarding need to follow cleaning schedules already in place and on new practice of air drying clean dishes. Review of this education will be covered again during monthly dietary meeting of 6/15/18. Quality Assurance spot checks for both the am and pm shift were implemented immediately to ensure standard is followed. These spot checks will continue four days per week until 6/8/18. Areas of concern will be addressed with individual staff members at that time. Then QA checks will be completed weekly x4, then monthly under Dietary Department QA listing "Dishes Air Dried - No fans used". CDM is responsible for QA. Areas of concern will be addressed at monthly Quality Assurance meeting.	
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	F 880		6/18/18

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F 880	Continued From page 7 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 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	F 880		

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F 880	Continued From page 8 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 observation, review of facility policy, and staff interview, facility staff failed to follow infection control practices on 1 of 3 days of observation of medication administration (05/20/18). Failure to perform hand hygiene between residents and handle medications in a sanitary manner has the potential for transmission of communicable diseases and infections to residents. Findings include:	F 880	The medication aide involved was immediately educated in regards to infection prevention and control specifically pertaining to failure to perform hand hygiene between residents and handle medications in a sanitary manner which has the potential for transmission of communicable diseases and infections to residents. All other medication aides and nurses were educated promptly with each shift report regarding infection prevention and control emphasizing performing	

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F 880	Continued From page 9 Review of the facility policy titled "Hand Hygiene" occurred on 05/22/18. 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 hygiene: . . . Before and after resident contact . . . Upon and after coming in contact with a resident's intact skin . . ." Observation on 05/20/18 from 3:24 p.m. to 3:52 p.m. showed a medication aide (MA) (#6) prepared and administered medication to eight residents. During the medication preparation at 3:43 p.m., the MA (#6) dropped a pill onto the medication cart, picked it up with her bare fingers, and placed it into the medication cup. The MA failed to perform hand hygiene between residents and failed to ensure no bare hand contact with medications administered to residents. During an interview on 05/22/18 at 1:55 p.m., an administrative nurse (#5) stated she expected staff to perform hand hygiene between residents and not to touch medications with their bare hands.	F 880	appropriate hand hygiene between residents and handling of medications in a sanitary manner. All residents have the potential to be affected. Licensed nurse meeting was also conducted on May 23, 2018 regarding the importance of proper infection prevention and control practices. Facility policies reviewed and discussed. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 6/8/18 conducted by charge 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 with medication administration," & "Handling medications in a sanitary manner." Areas of concern will be addressed at monthly Quality Assurance meeting.	