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 _____	06/13/2024

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 Risk Based Survey started on 06/11/24 and concluded on 06/13/24. An extended survey was also completed on 06/13/24.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and family and staff interviews, the facility failed to ensure 3 of 3 supplemental residents (Resident #13, #19, and #23) with impaired cognition and unable to consent were free from resident to resident abuse. Failure to assess, care plan, and operationalize a plan/process may result in unwanted physical and/or sexual contact and may cause residents to experience fear, anxiety, and psychosocial harm. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA)	F 600	It is the facility's policy to ensure residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in 42 CFR 483.12. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Immediate, constant observation of Res #24 with documentation every 15 minutes on specific form 24/7 by various staff	8/9/24

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

Electronically Signed | 08/10/2024

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F 600	Continued From page 1 and determined an Immediate Jeopardy (IJ) situation existed on 06/09/24. The facility failed to assess, care plan, and operationalize a plan/process for; (1) a resident who seeks frequent close physical contact to do so safely and (2) cognitively impaired residents vulnerable to being the subject of unwanted physical and/or sexual contact, to ensure that all residents only had desired, safe contact with each other. The IJ was identified when a nurse's note in Resident #24's medical record, dated 06/09/24, identified he had kissed two female residents on the cheek (Resident #19 and #23). An observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. These findings placed the residents in immediate danger of fear, anxiety, or psychosocial harm in response to Resident #24's actions. * 06/12/24 at 7:20 p.m. - The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. * 06/13/24 at 8:04 a.m. - The facility submitted a removal plan. * 06/13/24 at 1:00 p.m. - The survey team reviewed and accepted the facility's written plan	F 600	implemented on 6/12/24. Res #24 will be in constant observation of a staff member ongoing. Staff educated on this expectation, including night staff. Night shift staffed with only three total staff members. Expectation is that Res #24 will be in constant observation 24/7, even during night shift. Resident #24 care plan reviewed & updated. The DON and ADON did investigation of alleged resident to resident abuse immediately upon notification 6/12/24 involving resident #23 & 24. Guidelines from State Survey Agency were followed. Initial Allegation of Abuse Report completed on-line. Staff interviews also conducted 6/12/24. Immediate education provided by DON, ADON to all staff working on 6/12/24. All licensed nurses, CNAs, activity staff, social services & other direct care staff received training prior to start of next shift starting 6/12/24. Education specifically focused on how to identify what constitutes resident to resident abuse or the potential of such abuse and the importance of implementing procedures to ensure the safety of the resident involved as well as the potential for all residents in the facility. Great Plains Quality Innovation Network utilized as resource for this education. All staff were assigned similar education through Health Care Academy with completion date of 6/20/24.	

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F 600	Continued From page 2 for the removal of the IJ situation. The removal plan included the following: * Investigation of alleged resident to resident abuse completed including staff interviews. * Notification to the State Survey Agency. * Immediate constant observation of Resident #24. * Immediate education provided by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) to all staff working on 06/12/24. All licensed nurses, certified nurse aides (CNAs), activity staff, social services and direct care staff not working on 06/12/24 will receive education prior to the start of their next shift. Education specifically focused on how to identify what constitutes resident to resident abuse or the potential of such abuse and the importance of implementing procedures to ensure the safety of the resident involved as well as the potential for all residents in the facility. * All staff assigned to healthcare academy (online training) regarding abuse to be completed within a week. * Will contact Great Plains Quality Innovation Network as a resource for education regarding this topic for Administrator, DON, Abuse Coordinator, and other leaders by 06/18/24. * To ensure compliance with this regulation is maintained, F600 will become part of the Quality Assurance program and completed by DON, ADON, or Abuse Coordinator. * Governing Board President and Secretary updated regarding most recent events and plan of correction. * 06/13/24 at 2:55 p.m. - The survey team verified the implementation of the removal plan as of	F 600	SSD updated spouse of resident #23 on 6/12/24. Spouse voiced no concerns nor noted any change in wife since encounter. SSD attempted to update guardian of resident #19 on 6/12/24 but unable to reach. DON & SSD interviewed/assessed residents for potential abuse because all residents have the potential to be affected. No concerns were noted or identified during this assessment/interview process. Resident #24 discharged from facility 7/25/24. DON, ADON or SSD will conduct random staff interviews of five staff members weekly x4 then monthly to ensure staff are able to identify what constitutes resident to resident abuse or the potential of such abuse, how to ensure the safety of the resident involved as well as potential other residents and importance of notifying administration. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. Quality Assurance Director will ensure compliance with audits under the Social Service Quality Assurance checklist labeled "Abuse Prevention-Staff Recognize What Constitutes Abuse".	

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F 600	Continued From page 3	F 600		

06/13/24 and removed the IJ. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy.

Findings include:

Review of the facility policy titled "Abuse, Neglect and Exploitation Policy" occurred on 06/13/24. This policy, dated June 2023, stated, ". . . It is the policy of St. Gerard's Community of Care to provide protections for the health, welfare and rights of each resident . . . Assess, monitor, and develop appropriate plans of care for residents with needs and behaviors which may lead to conflict . . . Identify, correct, and intervene in situations in which abuse . . . is more likely to occur. . . . Required to report . . . Sexual activity . . . where one of the resident's capacity to consent to sexual activity is unknown. . . ."

Observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation.

During an interview on 06/12/24 at 3:08 p.m., the nurse (#3) stated, "This happens everyday. If we try to take her away she gets mad." The nurse stated she was not aware if the facility notified the families of the situation and referred the surveyor to an administrative nurse. At 3:09 p.m.,

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F 600	Continued From page 4	F 600		

an administrative nurse (#2) stated, "Yes, we contacted both family representative/guardians and they gave consent for hugging and holding hands."

- Review of Resident #24's medical record occurred on June 12-13, 2024 and included a diagnosis of severe dementia. The quarterly Minimum Data Set (MDS), dated 02/22/24, identified a brief interview for mental status (BIMS) of 6, indicating severely impaired cognition. The care plan, dated 05/28/24, stated, ". . . My wish to engage in consensual acts of hand holding, hugging, caressing each other, providing tenderness and comfort in the comfort of our public living area will be granted . . . Acts of tenderness will occur in the public common areas . . . My POA or representative will continue to approve of my desired relationship . . . Staff may redirect us if actions become inappropriate or if others in area provide concern." Resident #24's care plan failed to address interventions related to Resident #24 entering female residents' rooms.

Resident #24's nurses' notes included the following:
* 03/25/24 at 12:30 p.m., ". . . Call placed to guardian [guardian's name] updates given that this resident and female resident have found comfort in each others companionship which at times leads to hugging and holding hands. Resident has gone into female residents [sic] room and is escorted out by staff at times to discontentment of both residents. Sought clearance from guardian on situation and states no concerns with same interactions and agrees resident does not have capacity for any further

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F 600	Continued From page 5	F 600		

physical interactions. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. . . ."

* 06/09/24 at 4:36 p.m. ". . . Resident was wandering into everyone's room this afternoon and trying to kiss different females multiple times. Resident does not listen even if the person asks him not to touch them. . . ."

During an interview on 06/12/24 at 3:46 p.m., a nurse (#3) who witnessed the incidents on 06/09/24 stated Resident #24 kissed Resident #19 and Resident #23 on the cheek in a public area. The nurse stated, "Usually he is just tapping people on the shoulders and most residents' do not like it when he does tap them on the shoulder." When the nurse (#3) told Resident #24 he could not kiss Resident #19, Resident #19 stated, "He can do that." The nurse (#3) stated Resident #24's kiss elicited no response verbally or non-verbally from Resident #23. The nurse (#3) stated she immediately attempted to redirect Resident #24 who was difficult to redirect and just started talking about other things. The nurse verified she did not notify the DON, administrator, or abuse coordinator about the incident, stating, "I didn't even think of it as abuse, but I should because I would not want my family member touched like that."

- Review of Resident #13's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The quarterly MDS, dated 03/29/24, identified moderately impaired cognition skills and may make poor decisions. The care plan stated, ". . . My wish to engage in

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F 600	Continued From page 6	F 600		

consensual acts of hand holding, hugging, caressing each other, providing tenderness and comfort in the comfort of our public living area will be granted. . Acts of tenderness will occur in the public common areas . . . My POA or representative will continue to approve of my desired relationship . . ."

A nurses' note, dated, 03/25/24 at 12:31 p.m., stated, ". . . Call placed to daughter [daughter's name] that this resident and a male resident have found comfort in each others companionship which at times leads to hugging and holding hands. Male resident has gone into residents [sic] room and is escorted out by staff at times to discontentment of both residents. Sought clearance from daughter on situation and states no concerns with same interactions and agrees resident does not have capacity for any further physical interactions. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. . . ."

During an interview on 06/12/24 at 3:50 p.m., Resident #13's daughter (#2) stated, "My sister and I do not want him [Resident #24] touching our mother. My sister has told the facility we do not want him [Resident #24] touching our mother."

During an interview on 06/12/24 at 4:19 p.m., Resident #13's daughter and Power of Attorney (POA) (#1) stated, "They [the facility] did contact me in March about the situation and at that time we were ok with hugging and holding hands. His [Resident #24's] behavior is progressing and we do not want him touching our mother. When my

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niece and I were visiting my mother one day in May that man [Resident #24] came into her room and my niece told him he needed to leave and he did. Then myself and my niece told staff we do not want him [Resident #24] in my mother's room or touching her." The surveyor asked daughter (#2) if her mother was cognitively intact, would she be ok with Resident #24's hugging, touching her face and holding hands and the daughter responded, "Absolutely not."

- Review of Resident #19's medical record occurred on June 12-13, 2024 and included a diagnosis of Alzheimer's disease. The quarterly MDS, dated 04/15/24, showed a brief interview for mental status (BIMS) score of 5, indicating severely impaired cognition. Resident #19's care plan, updated 08/14/23, failed to address the resident's wishes for engaging in physical contact with other residents.

- Review of Resident #23's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The admission MDS, dated 05/22/24, identified severely impaired cognition. Resident #23's care plan, updated 04/10/24, failed to address the resident's wishes for engaging in physical contact with other residents.

During an interview on 06/12/24 at 4:07 p.m., four administrative staff members (Administrator, Director of Nursing, Assistant Director of Nursing and Abuse Coordinator) all stated they had not been notified of Resident #34's behaviors and they did not identify the actions as sexual abuse. Administrative staff (#10) stated all staff received abuse orientation upon hire and annually and

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F 600	Continued From page 8 staff are expected to report any abuse immediately to the administrator, DON, and ADON, who in return notify the state health department. The facility failed to have a system and policy and procedures in place for assessing all resident 's needs, desires, and usual preferences to determine how to care plan according to the assessment.	F 600		
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		8/9/24

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F 607	Continued From page 9 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, and staff interview, the facility failed to protect all residents in the facility (31 of 31 residents) by failing to screen unlicensed employees prior to employment. Failure to screen unlicensed employees placed all residents at risk for abuse, neglect, exploitation, and misappropriation of resident property. Findings included: Review of the facility policy titled "Abuse, Neglect, and Exploitation" occurred on 06/13/24. This policy, revised June 2023, stated, "It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. . . ." A. Screening 1. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. a. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. b. Screenings will be conducted by the facility itself, third-part agency or academic institution.	F 607	It is the facility's policy to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. A comprehensive review of all unlicensed employees was conducted to verify that abuse screening was completed. Any unlicensed employee found not to have adequate screening underwent the necessary background screenings by 8/9/2024. Documentation is maintained in each affected employee's personnel record. All residents have the potential to be affected by the deficient practice.	

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F 607	Continued From page 10 Review of the facility's "802 Centers for Medicare and Medicaid Services (CMS) Matrix" showed 31 residents resided in the facility on the first day of survey, 06/11/24. During an interview on 6/13/2024, at 11:50 a.m., the administrator stated the facility did not conduct criminal history checks on unlicensed employees or new hires. Instead, employees are asked on the application form if they have been convicted of any felonies, and the facility relies on their honesty. The administrator stated the facility would run all unlicensed employees through the nurse aide registry. The administrator acknowledged that without a license, the facility cannot verify if an individual had a conviction that would disqualify them from employment. She stated the facility's process for conducting background and criminal history checks on unlicensed employees and new hires needed improvement. She said the facility is in a small-town setting; therefore, the facility also depends on community word-of-mouth to identify any criminal activity or convictions of employees or new hires. The administrator stated there is no system in place to screen non-licensed staff to ensure they have not been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.	F 607	The facility's 'New Hire Process' policy was updated to include the process for screening any potential unlicensed employee, as outlined in St. Gerard's Abuse, Neglect and Exploitation Policy. The HR Director, Business Office staff, and Department Managers were educated on the new screening process and the importance of compliance with abuse prevention regulations on 8/8/2024. The HR Director or designee will conduct random audits monthly to ensure continued compliance with this standard under the Business Office Quality Assurance checklist labeled "Potential Employees Not Screened for Hx of Abuse/Neglect/Etc. Properly". More frequent audits can be completed if new hires are more frequent. Areas of concern will be addressed with individual department managers at the time of occurrence, with results reported to the Quality Assurance committee.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		8/9/24

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F 609	Continued From page 11 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to report incidents of resident to resident abuse to the Administrator and State Survey Agency (SSA) for 3 of 3 supplemental residents (Resident #13, #19, and #23) with cognitive impairments and unable to consent. Failure to report incidents of abuse may result in unwanted physical and/or sexual contact and may cause residents to experience fear, anxiety, and psychosocial harm. Findings include:	F 609	It is the facility's policy to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State	

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	355038	A. BUILDING _____ B. WING _____	06/13/2024

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 609	Continued From page 12 Review of the facility policy titled, "Abuse, Neglect and Exploitation Policy" occurred on 06/13/24. This policy, dated June 2023 stated, ". . . It is the policy of St. Gerard's Community of Care to provide protections for the health, welfare and rights of each resident . . . A. Any staff witnessing or possessing reliable knowledge of any act, or suspect act, involving . . . abuse . . . must notify their department supervisor immediately. . . ." Observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. During an interview on 06/12/24 at 3:08 p.m., the nurse (#3) stated, "This happens everyday. If we try to take her away she gets mad." The nurse stated she was not aware if the facility notified the families of the situation and referred the surveyor to an administrative nurse. At 3:09 p.m., an administrative nurse (#2) stated, "Yes, we contacted both family representative/guardians and they gave consent for hugging and holding hands." - Review of Resident #13's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The quarterly Minimum Data Set (MDS), dated 03/29/24, identified	F 609	Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. [F609] The DON and ADON did investigation of alleged resident to resident abuse immediately upon notification 6/12/24 involving resident #23 & 24. Guidelines from State Survey Agency were followed. Initial Allegation of Abuse Report completed on-line. Immediate, constant observation of Res #24 with documentation every 15 minutes on specific form 24/7 by various staff implemented on 6/12/24. Res #24 will be in constant observation of a staff member ongoing. Staff educated on this expectation, including night staff. Night shift staffed with only three total staff members. Expectation is that Res #24 will be in constant observation 24/7, even during night shift. Resident #24 care plan reviewed & updated. Immediate education provided by DON, ADON to all staff working on 6/12/24. All licensed nurses, CNAs, activity staff, social services & other direct care staff received training prior to start of next shift starting 6/12/24. Education specifically stated that if a staff member witnesses an alleged incident of abuse, they are to notify the charge nurse. The charge nurse will notify the DON and/or the administrator, or the person designated to	

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F 609	Continued From page 13 moderately impaired cognition and poor daily decision making skills. A nurses' note, dated, 03/25/24 at 12:31 p.m., stated, ". . . Call placed to daughter [daughter's name] that this resident and a male resident have found comfort in each others companionship which at times leads to hugging and holding hands. . . . Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. . . ." During an interview on 06/12/24 at 3:50 p.m., Resident #13's daughter (#2) stated, "My sister and I do not want him [Resident #24] touching our mother. My sister has told the facility we do not want him [Resident #24] touching our mother." During an interview on 06/12/24 at 4:19 p.m., Resident #13's daughter and Power of Attorney (POA) (#1) stated, "They [the facility] did contact me in March about the situation and at that time we were ok with hugging and holding hands. His [Resident #24's] behavior is progressing and we do not want him touching our mother. When my niece and I were visiting my mother one day in May that man [Resident #24] came into her room and my niece told him he needed to leave and he did. Then myself and my niece told staff we do not want him [Resident #24] in my mother's room or touching her." The surveyor asked daughter (#2) about her mother's cognition and if she would be ok with Resident #24's hugging, touching her face and holding hands and the daughter responded, "Absolutely not." The staff member who Resident #13's daughter and niece	F 609	act on their behalf when not available, of all alleged abuse and the proper notification will be made to state agencies to ensure the safety of the resident involved as well as the potential for all residents in the facility. Great Plains Quality Innovation Network utilized as resource for this education. All staff were assigned similar education through Health Care Academy with completion date of 6/20/24. SSD updated spouse of resident #23 on 6/12/24. Spouse voiced no concerns nor noted any change in wife since encounter. SSD attempted to update guardian of resident #19 on 6/12/24 but unable to reach. DON & SSD interviewed/assessed residents for potential abuse because all residents have the potential to be affected. No concerns were noted or identified during this assessment/interview process. Resident #24 discharged from facility 7/25/24. DON, ADON or SSD will conduct random staff interviews of five staff members weekly x4 then monthly to ensure staff are aware of reporting guidelines and proper steps to take if abuse is suspected. Areas of concern will be addressed to individual staff members at the time of occurrence with results going to QA committee.	

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F 609	Continued From page 14 reported the incident to in May failed to identify this as abuse and failed to report this to the administrator. - Review of Resident #24's medical record occurred on June 12-13, 2024 and included a diagnosis of severe dementia. The quarterly MDS, dated 02/22/24, identified a brief interview for mental status (BIMS) of 6, indicating severely impaired cognition. A nurses' note, dated 06/09/24 at 4:36 p.m., stated, ". . . Resident was wandering into everyone's room this afternoon and trying to kiss different females multiple times. Resident does not listen even if the person asks him not to touch them. . . ." During an interview on 06/12/24 at 3:46 p.m., a nurse (#3) who witnessed the incidents on 06/09/24 stated Resident #24 kissed Resident #19 and Resident #23 on the cheek in a public area. The nurse stated, "Usually he is just tapping people on the shoulders and most residents do not like it when he does tap them on the shoulder." When the nurse (#3) told Resident #24 he could not kiss Resident #19, Resident #19 stated, "He can do that." The nurse (#3) stated Resident #24's kiss elicited no response verbally or non-verbally from Resident #23. The nurse (#3) stated she immediately attempted to redirect Resident #24 who was difficult to redirect and just started talking about other things. The nurse verified she did not notify the DON, administrator, or abuse coordinator about the incident, stating, "I didn't even think of it as abuse, but I should because I would not want my family member touched like that."	F 609	Quality Assurance Director will ensure compliance with audits under the Social Service Quality Assurance checklist labeled "Abuse Prevention-Staff Aware of Reporting Guidelines".	

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F 609	Continued From page 15 - Review of Resident #19's medical record occurred on June 12-13, 2024 and included a diagnosis of Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 04/15/24, identified a brief interview for mental status (BIMS) of 5, indicating severely impaired cognition. - Review of Resident #23's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The admission MDS, dated 05/22/24, identified severely impaired cognition. During an interview on 06/12/24 at 4:07 p.m., four administrative staff members (Administrator, Director of Nursing, Assistant Director of Nursing ,and Abuse Coordinator) stated they had not been notified of Resident #24's behaviors and staff are expected to report any abuse immediately to the administrator, DON, and ADON, who notify the SSA. The facility lacked evidence the above incidents (06/09/24 and 06/12/24) were reported to the administrator and the SSA.	F 609		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		8/9/24

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F 610	Continued From page 16 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and family and staff interview, the facility failed investigate incidents of resident to resident abuse for 3 or 3 supplemental resident (Resident #13, #19, and #23) with impaired cognition and unable to consent. Failure to investigate incidents of abuse may result in unwanted physical and/or sexual contact and may cause residents to experience fear, anxiety, and psychosocial harm. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 06/09/24. The facility failed to investigate resident to resident abuse. The IJ was identified when a nurse's note in Resident #24's medical record, dated 06/09/24, stated he had kissed two female residents on the cheek (Resident #19 and #23). An observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with	F 610	It is the facility's policy to thoroughly investigate all alleged violations of abuse, neglect, exploitation, or mistreatment, prevent further potential abuse while the investigation is in progress, and report the results of all investigations to the administrator and other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and take appropriate corrective action if the alleged violation is verified [F610]. The DON and ADON did investigation of alleged resident to resident abuse immediately upon notification 6/12/24 involving resident #23 & 24. Guidelines from State Survey Agency were followed. Initial Allegation of Abuse Report completed on-line. Staff interviews also conducted 6/12/24. Immediate, constant observation of Res #24 with documentation every 15 minutes on specific form 24/7 by various staff implemented on 6/12/24. Res #24 will be	

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F 610	Continued From page 17 his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. These findings placed the residents in immediate danger of fear, anxiety, or psychosocial harm in response to Resident #24's actions. * 06/12/24 at 7:20 p.m. - The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. * 06/13/24 at 8:04 a.m. - The facility submitted a removal plan. * 06/13/24 at 1:00 p.m. - The survey team reviewed and accepted the facility's written plan for the removal of the IJ situation. The removal plan included the following: * Investigation of alleged resident to resident abuse completed including staff interviews. * Notification to the State Survey Agency. * Immediate constant observation of Resident #24. * Immediate education provided by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) to all staff working on 06/12/24. All licensed nurses, certified nurse aides (CNAs), activity staff, social services and direct care staff not working on 06/12/24 will receive education prior to the start of their next shift. The education specifically stated that all alleged abuse allegations of any kind will be investigated. The investigation will include interviews with all staff members and non-staff individuals involved.	F 610	in constant observation of a staff member ongoing. Staff educated on this expectation, including night staff. Night shift staffed with only three total staff members. Expectation is that Res #24 will be in constant observation 24/7, even during night shift. Resident #24 care plan reviewed & updated. Immediate education provided by DON, ADON to all staff working on 6/12/24. All licensed nurses, CNAs, activity staff, social services & other direct care staff received training prior to start of next shift starting 6/12/24. Education specifically stated that all abuse allegations of any kind will be investigated, which includes interviews with all staff members and non-staff individuals involved as well as providing safety for all residents. The charge nurse will notify the DON and/or the administrator, or the person designated to act on their behalf when not available, of all alleged abuse and the proper notification will be made to state agencies to ensure the safety of the resident involved as well as the potential for all residents in the facility. Great Plains Quality Innovation Network utilized as resource for education. All staff were assigned similar education through Health Care Academy with completion date of 6/20/24. SSD updated spouse of resident #23 on 6/12/24. Spouse voiced no concerns nor noted any change in wife since encounter. SSD attempted to update	

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F 610	Continued From page 18 * All staff assigned to healthcare academy (online training) to be completed within a week. * Will contact Great Plains Quality Innovation Network as a resource for education regarding this topic for Administrator, DON, Abuse Coordinator, and other leaders by 06/18/24. * To ensure compliance with this regulation is maintained, F610 will become part of the QA [Quality Assurance] program and completed by DON, ADON, or Abuse Coordinator. * Governing Board President and Secretary updated regarding most recent events and plan of corrections. * 06/13/24 at 2:55 p.m. - The survey team verified the implementation of the removal plan as of 06/13/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled, "Abuse, Neglect and Exploitation" occurred on 06/13/24. This policy, dated June 2023, stated, "To provide protections for the health, welfare and rights of each resident . . . that prohibit and prevent abuse . . . When suspicion of abuse . . . or reports of abuse . . . occur, an investigation is immediately warranted. Once the resident is immediately cared for and initial reporting has been shared between the charge nurse and DON an investigation will be conducted, and the administrator must be notified. Observation showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was	F 610	guardian of resident #19 on 6/12/24 but unable to reach. DON & SSD interviewed/assessed residents for potential abuse because all residents have the potential to be affected. No concerns were noted or identified during this assessment/interview process. Resident #24 discharged from facility 7/25/24. DON, ADON or SSD will conduct random staff interviews of five staff members weekly x4 then monthly to ensure staff are aware of investigation guidelines which includes interviews with all staff members and non-staff individuals involved. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. Quality Assurance Director will ensure compliance with audits under the Social Service Quality Assurance checklist labeled "Abuse Prevention - Staff Aware of Investigation Process to Include Resident Safety".	

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sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation.

During an interview on 06/12/24 at 3:08 p.m., the nurse (#3) stated, "This happens everyday. If we try to take her away she gets mad." The nurse stated she was not aware if the facility notified the families of the situation and referred the surveyor to an administrative nurse. At 3:09 p.m., an administrative nurse (#2) stated, "Yes, we contacted both family representative/guardians and they gave consent for hugging and holding hands."

- Review of Resident #13's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The quarterly Minimum Data Set (MDS), dated 03/29/24, identified moderately impaired cognition.

A nurses' note, dated, 03/25/24 at 12:31 p.m., stated, ". . . Call placed to daughter [daughter's name] that this resident and a male resident have found comfort in each others companionship which at times leads to hugging and holding hands. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. . . ."

During an interview on 06/12/24 at 3:50 p.m., Resident #13's daughter (#2) stated, "My sister and I do not want him [Resident #24] touching

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our mother. My sister has told the facility we do not want him [Resident #24] touching our mother."

During an interview on 06/12/24 at 4:19 p.m., Resident #13's daughter and Power of Attorney (POA) (#1) stated, "They [the facility] did contact me in March about the situation and at that time we were ok with hugging and holding hands. His [Resident #24's] behavior is progressing and we do not want him touching our mother. When my niece and I were visiting my mother one day in May that man [Resident #24] came into her room and my niece told him he needed to leave and he did. Then myself and my niece told staff we do not want him [Resident #24] in my mother's room or touching her." The surveyor asked daughter (#2) if her mother was cognitively intact, would she be ok with Resident #24's hugging, touching her face and holding hands and the daughter responded, "Absolutely not."

Resident #13's daughter and niece reported Resident #24's behaviors to a staff member in May and the staff member failed to identify Resident #24's actions as abuse, failed to report it to the administrator therefore, the facility didn't know abuse existed and failed to investigate.

- Review of Resident #24's medical record occurred on June 12-13, 2024 and included a diagnosis of severe dementia. The quarterly Minimum Data Set (MDS), dated 02/22/24, identified a brief interview for mental status (BIMS) of 6, indicating severely impaired cognition. A nurse's note, dated 06/09/24 at 4:36 p.m., stated, ". . . Resident was wandering into everyone's room this afternoon and trying to kiss

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different females multiple times. Resident does not listen even if the person asks him not to touch them. . . ."

During an interview on 06/12/24 at 3:46 p.m., a nurse (#3) who witnessed the incidents on 06/09/24 stated Resident #24 kissed Resident #19 and Resident #23 on the cheek in a public area. The nurse stated, "Usually he is just tapping people on the shoulders and most residents' do not like it when he does tap them on the shoulder." When the nurse (#3) told Resident #24 he could not kiss Resident #19, Resident #19 stated, "He can do that." The nurse (#3) stated Resident #24's kiss elicited no response verbally or non-verbally from Resident #23. The nurse (#3) stated she immediately attempted to redirect Resident #24 who was difficult to redirect and just started talking about other things. The nurse verified she did not notify the DON, administrator, or abuse coordinator about the incident, stating, "I didn't even think of it as abuse, but I should because I would not want my family member touched like that."

Failure to report the observations does not allow the facility to investigate and protect these residents and all residents from the actions of Resident #24.

- Review of Resident #19's medical record occurred on June 12-13, 2024 and included a diagnosis of Alzheimer's disease. The quarterly MDS, dated 04/15/24, identified a BIMS score of 5, indicating severely impaired cognition.

- Review of Resident #23's medical record occurred on June 12-13, 2024 and included a

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F 610	Continued From page 22 diagnosis of dementia. The admission Minimum Data Set (MDS), dated 05/22/24, indicated severely impaired cognition. During an interview on 06/12/24 at 4:07 p.m., four administrative staff members (Administrator, Director of Nursing, Assistant Director of Nursing and abuse coordinator) all stated they had not been notified of Resident #24's behaviors therefore did not investigate any of his actions as abuse and did not report them to the SSA.	F 610		
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	F 657		8/9/24

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F 657	Continued From page 23 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 care plans to reflect residents' current status for 2 of 3 sampled residents (Resident #4 and #10). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Nursing Care Plans" occurred on 06/13/24. This policy, dated November 2017, stated, ". . . POLICY: A person centered plan of care shall be developed . . . Evaluation of approaches and goals shall be charted on care plans by the nurse doing the monthly charting for the resident. . . ." - Review of Resident #4's medical record occurred on all days of survey and included diagnoses of traumatic brain disorder and epilepsy. The current care plan stated, ". . . No water in room . . ." The significant change Minimum Data Set (MDS), dated 05/17/24, identified a brief interview for mental status (BIMS) score of 15, indicating cognitively intact. Observation on 06/11/24 at 10:57 a.m. showed no water cup in Resident #4's room. When asked why he doesn't have a water cup in his room, the resident stated, "When I finish drinking the water they take the cup and then bring some [water]	F 657	The standard of practice of care plan timing and revision was reviewed with nursing department staff with each shift report regarding the fact that care plans reflect the residents' current status and if care plans are not reviewed and updated, the staffs' ability to communicate needs and ensure continuity of care are limited. The fundamental principle of care plan timing and revision as it applies to all resident cares and treatments were reviewed for all residents with focus on resident #4 and #10 to ensure comprehensive care plan reflects resident's current status. Order and clarification of treatment plan was obtained from the primary MD regarding resident #4's structured fluid/water intake. Care plan was updated and reflect clarifications. Care plan for resident #10 was updated to reflect MD order for transfers along with consultation with PT. Quality Assurance Director will conduct monthly review of five random charts to ensure continued compliance with standard under LTC Quality Assurance checklist labeled "Care plan does not reflect resident current status".	

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F 657	Continued From page 24 back to me later." Observation on 06/12/24 at 8:37 a.m. showed no water cup in Resident #4's room. When the resident asked for water a certified nurse aide (CNA) (#9) stated, "You already had your water." During an interview on 06/12/24 at 11:32 a.m., Resident #4 stated he has to request water when he wants it and the staff have not told him why he cannot have a water cup in his room. During an interview on 06/12/24 at 11:44 a.m., when asked why Resident #4 has to ask for water instead of water being available for him in his room at all times, a licensed nurse (#3) stated, "We can't give him excessive amounts of water due to his medications, specifically lithium. He has an obsessive-compulsive disorder and would drink large amounts if it is left in his room. There are very specific times he requests water. There is no specific amount of water he can have." During an interview on 06/12/24 at 11:49 a.m., when asked about Resident #4's care plan stating no water in room, an administrative nurse (#2) stated, "There are very specific times that he [Resident #4] requests and receives water." Resident #4's care plan failed to address specific times to provide the resident with water/fluids and reason why he is not able to have a water cup in his room. - Review of Resident #10's medical record occurred on all days of survey and included a diagnosis of osteoarthritis. The current care plan	F 657		

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F 657	Continued From page 25 stated, ". . . I will transfer with . . . EZ stand [sit-to-stand mechanical lift] with 1x [1 staff assist] assist . . . I am at risk to fall . . ." The physician's orders included, ". . . Transfer: EZ stand 1x assist with buttocks and leg strap . . ." Observation on 06/11/24 at 3:08 p.m. showed a CNA (#8) transferred Resident #10 from the wheelchair to the bathroom using the EZ stand lift without using the buttocks sling and leg strap. Resident #10's care plan failed to include use of the leg strap and buttocks sling with the EZ stand lift transfers. During an interview on 06/12/24 at 2:41 p.m., an administrative nurse (#1) stated she expected care plans to be individualized.	F 657		
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, review of facility policy, review of manufacturer's instructions, review of facility investigation reports, and staff interview, the facility failed to provide adequate assistance for 2 of 2 sampled residents (Resident #3 and #10) observed during a sit-to-stand mechanical lift transfer and failed to	F 689	It is the facility's policy to ensure that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents (F689).	8/9/24

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F 689	Continued From page 26 complete an investigation for 1 of 1 sampled resident (Resident #4) with a history of falls and a fracture. Failure to ensure proper use of the stand lift, including use of the seat and leg strap, and failure complete a fall investigation, including intervention to alleviate falls, placed the residents at risk of experiencing pain/discomfort and/or possible accidents with/without injury. Findings include: Review of the facility policy titled "RESIDENT INCIDENT FOLLOWUP REPORT" occurred on 06/13/24. This policy, dated March 2016, stated, ". . . To review the individual incident reports and state the corrective action taken . . . 1. The DON [director of nursing] or charge nurse will review each incident report within 24 hours of the occurrence. 2. After reviewing the incident report, the nurse is responsible for completing the Resident incident report concerning that incident. . . ." Review of the facility policy titled "EZ WAY STAND AID" occurred on 06/13/24. This policy, dated December 2021, stated, ". . . The EZ Way Stand Aid will be used as a resident transferring device for those residents who have adequate arm strength to pull themselves upward and enough leg strength to support their own weight. . . ." The manufacturer's instructions for the EZ Way Seat Strap stated, ". . . Applying the seat strap: Stand behind the patient, and using the hand control, press the UP button to raise the patient slightly off the surface. Tighten the harness buckle. 7. Slide the seat strap under the patient's	F 689	The Director of Nursing Services met with nursing care and staff on 6/14/2024. Observation of transfers and consultation with PT were completed for Residents #3 and #10. Appropriate revisions were made to the care plans to reflect all current safety interventions and appropriate method of transfers. The revised assessments and care plans were reviewed with staff involved in the care of each resident. The Director of Nursing Services also completed a review of resident #4's fall risk care plan and it is appropriate to reflect safety measures in regard to appropriateness of correct transfers to ensure prevention of recurring falls. Part of the fall prevention plan includes the timed scheduling of fluids to help provide a regular routine for resident #4 as he is very time/routine oriented. The revisions to the care plan was reviewed with staff involved in the care of this resident. Identification of other residents having the potential to be affected was accomplished by the Director of Nursing evaluating the residents who are currently using the mechanical stand for transfers to ensure that is the appropriate method to transfer them safely. Care plans and orders were reviewed for these residents and found to be appropriate and accurate. Orders match the care plans. All Licensed Nursing staff were educated on the facility policy for Accidents with the	

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F 689	Continued From page 27 buttocks. . . ." - Review of Resident #3's medical record occurred on all days of survey and included diagnoses of muscle weakness and arthritis. The current care plan stated, ". . . I am at risk to fall . . . I will utilize the EZ Stand with seat strap and 1 assist for transfers. . . ." Observation on 06/11/24 at 10:03 a.m. showed a certified nurse aide (CNA) (#12) transferred Resident #3 from the wheelchair to the toilet using the EZ way stand lift. As the CNA began to raise the resident, the resident failed to hold onto the handles. The CNA stated, "I better use the butt sling [seat strap]." The CNA then utilized the seat strap. The resident, unable to bear weight, hung from the chest harness in a semi-seated position. The harness straps pulled upward into Resident #3's axillae and caused the shoulders to raise to ear level with the elbows extended horizontally. Observation on 06/12/24 at 10:04 a.m. showed a CNA (#7) transferred Resident #3 from the wheelchair to the bathroom using the EZ way stand lift with the seat strap positioned above the resident's buttocks rather than under the buttocks. The resident could not lift his upper body enough to hold onto the handle bars and grabbed onto another part of the lift directly in front of him. The CNA placed the resident's hands on the handle bars. His hands immediately fell off and the resident grabbed the part of the lift in front him. The resident, unable to bear weight, hung from the chest harness in a semi-seated position. The harness straps pulled upward into Resident #3's axillae and caused the shoulders	F 689	switching to Point Click Care for charting the format for incidents has changed and licensed nurses were educated on the new system. The Director of Nursing will review each incident report upon occurrence to ensure appropriate interventions are implemented and the updated plan of care is placed in the care plan. Quality Assurance Director will conduct audits to ensure personnel are performing the procedures in accordance with our facility's policy and according to resident plan of care. These audits will be completed every shift for 3 days then at random times daily for 1 week and then weekly for 4 weeks. The Quality Assurance Director or designee will complete monthly review of 4 random staff observations to ensure continued compliance with standard/policy under the Long-Term Care Quality Assurance Checklist labeled "Care plan does not reflect resident current status" and "Correct use of mechanical lift/stand".	

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F 689	Continued From page 28 raised to ear level with the elbows extended horizontally. During an interview on 06/12/24 at 11:36 a.m., a licensed nurse (#3) stated, "I know he [Resident #3] hangs there, but there is no way we could get the hoyer [full body lift] into the bathroom." - Review of Resident #10's medical record occurred on all days of survey and included diagnoses of dementia and osteoarthritis. The current care plan stated, ". . . I will transfer . . . EZ stand with 1x [one staff] assist. . . . I am at risk to fall . . ." The medical record included the following physicians order, "Transfer: EZ stand 1x assist with butt [buttocks] and leg strap . . ." Observation on 06/11/24 at 3:08 p.m. showed a CNA (#8) transferred Resident #10 from the wheelchair to the toilet using the EZ way stand lift and failed to apply the seat/buttocks and leg straps. - Review of Resident #4's medical record occurred on all days of survey and included a diagnosis of hemiplegia (one-sided weakness or paralysis). The current care plan stated, ". . . I am at risk to fall . . . monitor my falls for any pattern. . . ." The medical record showed Resident #4 experienced seven falls between 03/31/24 to 05/31/24, one with a major injury. Resident #4 progress notes included the following: * 05/09/2024 at 9:45 p.m. ". . . Res [resident] chair alarm was sounding, Staff entered room to find res on the floor. this [sic] nurse entered room to find res lying on his left side with his backside	F 689		

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F 689	Continued From page 29 facing the dresser in his room. . . . TV [television] had ended up on the floor behind res unplugged and cord under his left leg. no injuries noted at this time, ROM [range of motion] WNL [within normal limits] for resident. Will continue to monitor. * 05/10/2024 at 6:27 a.m. ". . . Res started to c/o [complain of] left elbow pain during the night. No swelling noted, tender to touch just above the elbow. Tylenol given at 2AM [2:00 a.m.] with some relief noted at the time. Res currently c/o pain again, will have med aid give another dose of Tylenol. . . ." * 5/10/2024 at 7:48 a.m. " . . . updates to [nurse practitioner] provided on fall with pain complaints. Decision that resident will go for clinic appt [appointment] . . . today at 2pm for x-ray and seen by . . ." * 05/10/2024 at 4:28 p.m. ". . . Resident returned from appointment with . . . x-ray showed a fractured left ulna [bone in forearm] proximal-non displaced. . . ." The investigation related to the above fall and fracture stated, ". . . [Resident #4] with no additional injury. He has been noted to fluctuate in his physical abilities. He is working with therapy regarding his positioning in chair. We will work with therapists to determine best method for transfers at this time. . . ." During an interview on 06/12/24 at 2:41 p.m., an administrative nurse (#1) confirmed staff failed to complete the investigation including a corrective action plan related to Resident #4's falls and failed to update the care plan since 2020.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/9/24

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F 880	Continued From page 30 §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 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;	F 880		

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F 880	Continued From page 31 (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 observation, record review, review of facility policy, and staff interview, the facility failed to ensure an effective infection prevention and control program for a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infections for 2 of 3 sampled residents (Resident #10 and #18) observed during care and 1 of 2 certified nurse	F 880	It is the facility's policy to 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 (F880).	

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F 880	Continued From page 32 aides (CNAs) reviewed for handwashing (CNA #4). Failure to removed soiled gloves and perform hand hygiene after incontinence cares and failure to disinfect multi-use equipment may result in exposure of infections to residents, staff, and visitors. Findings included: Review of the facility policy titled "Infectious Disease Control Manual" occurred on 06/12/24. This undated policy stated, "General Aseptic Technique" section: ii. 10 key times to wash your hands 2.) Should be first thing you do when you enter the resident room and the last thing you do before leaving. 4.) Between resident contacts. 5.) Before and after tending to any personal needs or contact with your face, or mouth (sneezing, blowing your nose, combing your hair, using the toilet, before and after you smoke). 7.) After removing our gloves. 8.) Before and after handling dressings, catheters, bedpans, specimens, and urinals. Between procedures on the same resident. 9.) Before and after assisting residents with any personal needs. - Observation on 06/11/24 at 10:08 a.m. showed the CNA (#4) left Resident #11's room after transferring her to a wheelchair using a sit-to-stand lift. The CNA (#4) failed to clean or disinfect the lift after using it with Resident #11 and taking it to Resident #18's room.	F 880	Corrective Action for Affected Residents: On 6/14/24, the Director of Nursing Services met with Nursing Department staff and addressed proper hand hygiene and cleansing of mechanical machines used for transfers of residents. All staff were educated on the importance of hand hygiene and appropriate times to remove gloves and when to perform hand hygiene along with the cleansing of machines used for transfers. Identifying other Residents having the Potential to be Affected: The facility has determined that all residents have the potential to be affected by the cited deficient practices related to infection control. Measures put into place: All nursing department staff were educated on the policy for hand hygiene and the cleansing of machines. The education included observation of staff performing hand hygiene and cleansing of the machines used for transfers according to facility policy. Corrective action is provided as needed. This education will be included in new employee orientation and annual infection control training going forward. Plan to Monitor Performance: The Director of Nursing and/or Infection Control nurse will conduct staff audits to ensure personnel are performing the procedures in accordance with our facility's policy. These audits will be	

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F 880	Continued From page 33 Observation on 06/11/24 at 10:11 a.m. showed the CNA (#4) applied gloves and transferred Resident #18 from the bed to the toilet using the sit-to-stand lift just used for Resident #11's transfer. The CNA removed Resident #18's pants and brief, sat the resident on the toilet, and removed her gloves. The CNA (#4) failed to sanitize her hand and touched the resident's blanket and sheets and straightened the bed cover. The CNA (#4) sat on Resident #18's bed until the resident finished using the toilet. The CNA applied gloves and provided perineal cares for the resident. While still wearing the soiled gloves, the CNA retrieved a clean brief, placed it on the resident, pulled up the resident's pants, and used the sit-to-stand lift to transfer Resident #18 into her wheelchair. The (CNA) #4 removed her gloves, placed the oxygen tubing into the resident's nose, flushed the toilet, disposed of the soiled brief in the trash can, and then washed her hands. During an interview with CNA (#4) on 6/11/24 at 2:38 p.m., she confirmed she did not wash her hands or change her gloves appropriately while providing care to Resident #18. She acknowledged that she should have washed her hands after removing her gloves and before touching clean items with dirty hands or gloves. During an interview with an the DON on 6/12/24 at 10:30 a.m., she stated staff were to wash their hands before they initiated care for a resident, after, and after gloves were removed. The DON said the staff should clean and disinfect the sit-to-stand lift between each resident to prevent the spread of infection.	F 880	completed every shift for 3 days then at random times daily for 1 week and then weekly for 4 weeks. The Infection Control Nurse will conduct monthly review of 4 random staff observations to ensure continued compliance with standard/policy under the Infection Control Checklist labeled "Hand Hygiene performed correctly after tasks" and "Machines used for transfers cleansed correctly after each use".	

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 _____	06/13/2024

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 880	Continued From page 34 - Observation on 06/11/24 at 3:08 p.m. showed a CNA (#8) assisted Resident #10 to the bathroom using the sit-to-stand lift. After assisting the resident, the CNA exited the resident's room without disinfecting the lift. During interview on 6/13/24 at 9:17 a.m., the CNA (#8) stated she used the sit-to-stand lift to transfer residents, but does not clean or disinfect the lift between uses. She added housekeeping handles the cleaning, as her routine involves using the lift to assist residents and then placing it at the end of the hall for others to use.	F 880		