DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	07/10/2014

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 For the standard Medicare/Medicaid recertification survey started on July 7, 2014 and completed on July 10, 2014, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	Resident #2: Physician & Family were notified on 7/14/14 of incident of emesis which occurred on 7/4/14. No changes to plan of care made. MD noted emesis. All nursing staff education provided promptly with each shift report regarding notification of change in residents status. A nurse's meeting was conducted on7/23/14 by Director of Nursing addressing circumstances that require notification of the resident's physician, legal representative or family member. SBAR communication form available as a guide, for all LN, for reporting changes.	8/12/14

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

Jill Fontaine RN AIT — 7/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician of the change in condition for 1 of 1 sampled resident (Resident #2) who experienced an episode of coffee ground emesis. Failure of facility staff to notify the resident's physician did not provide the opportunity for the physician to provide input and/or changes to Resident #2's treatment plan. Findings include: Review of Resident #2's medical record occurred on all days of survey. Review of Resident #2's nurses notes identified the following: * 07/04/14, 1:20 a.m., stated, "Called into Res [resident] room observed res lying on side in bed had lrg [large] coffee-ground emesis also audible wheezes noted, T [temperature] 99.6 degree, Res denied having 'upset stomach' stated was coughing et [and] that caused emesis. When sat Res on edge of bed also c/o [complained of] weakness noted Res shaking slightly also denied HA [headache], transferred to w/c [wheelchair] [with] [two assist] et gait belt, was cooperative [with] transfer et [change] of clothing [after] incont [incontinent] completed [sic] Res lied [sic] on L) [left] side [arrow up] HOB [head of bed]. will monitor" 1:35 a.m., Vital T -99.6 104/56 20 97% RA [room	F 157	All nursing dept. staff educated at inservice meeting held on 7/30/14 regarding the importance to report to supervisor/ licensed nurse of suspected change in status. The QA director will conduct a random audit of two (2) residents for three (3) months then quarterly thereafter to ensure continued compliance with this standard. QA form enclosed. Areas of concern will be addressed at monthly QA meeting. By ensuring nursing department staff have adequate education and knowledge regarding need to notify MD/Family, this averts potential harm to all residents. QA Director is responsible for continued compliance.	

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F 157	Continued From page 2 air] 90 [sic] et assessment completed lung sound wheezes Bil [bilateral] et audible wheezes noted, skin warm, dry, eyes closed respiration [with] audible wheezes, calm, cooperative [no] further episodes of emesis [no] SOB [short of breath] or coughing noted @ [at] this time will monitor." 4:00 a.m., "Res resting eyes closed easy respirations [no] SOB [no] cough, [no] further emesis noted @ this time faint wheezes noted when listening to lung sound Bil" 8:30 a.m., "Resident was up for breakfast, pleasant, cooperative [no] c/o nausea or upset stomach. Alert ate fairly well [with] [no] complaints" During an interview on the morning of 07/10/14, the staff nurse (#3) working that night stated she did not notify the physician of the episode. An administrative nurse (#4) stated the facility did not have a policy/procedure on physician notification.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote dignity for 2 of 9 sampled residents (Resident #4 and A) during toileting (Resident #4) and during a confidential resident interview (Resident A). Failure to prevent exposure during toileting for Resident #4 and failure to knock before entering Resident A's	F 241	Nursing department staff education completed promptly with each shift regarding maintaining resident's dignity, etc. All Nursing Department and Social Service/Activity Department staff were educated on 7/30/14 regarding importance of maintaining dignity and respect of individuality. Licensed nurse's also educated regarding importance of this standard on 7/23/14. Both meetings were conducted by Director of Nursing. Attendance sheet enclosed. QA spot checks were implemented immediately for random checks to ensure standard is being	8/12/14

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F 241	Continued From page 3 room, did not maintain respect or enhance the residents' dignity. Findings include: Upon entering Resident #4's room on 07/08/14 at 7:50 a.m., observation showed Resident #4's roommate seated in her recliner with a direct view into the bathroom, the bathroom door wide open, and Resident #4 sitting on toilet. The certified nurse aide (CNA) (#2) present and assisting Resident #4 failed to pull the privacy curtain to prevent the roommate's direct visual access into the bathroom while Resident #4 sat on the toilet. During a confidential interview on the morning of 07/09/14 from 12:20 p.m.-12:30 p.m. with Resident A, a CNA (#2) opened the closed door to Resident A's room without knocking or announcing herself on two separate occasions. On both occasions, the CNA (#2) observed the surveyor in the room visiting with Resident A and the CNA immediately left the room. On the afternoon of 07/09/14 when informed of the above observations involving a CNA (#2), an administrative staff member (#5) stated she expected all facility staff members to promote dignity and privacy during toilet use and when residents are conversing with visitors.	F 241	followed. Findings were reviewed with each individual as warranted with results going to QA committee. The QA Director will conduct random observations of staff over the next three (3) months then quarterly to ensure staff are promoting& maintaining compliance with standard. QA form enclosed By ensuring that staff have adequate knowledge of and follow concepts of dignity & respect of individuality, we are able to provide cares in a dignified manner & in turn to help promote resident's psychosocial well-being. By following these concepts the potential to negatively affect residents #2 & A psychosocial well-being has been averted as well as avoiding potential harm to all residents.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278	Resident's #2 & 6 were reassessed on 7/15/14 & 7/30/14 which included the review of most recent MDS toileting schedule & bladder assessment resulting in a toileting schedule which is	8/12/14

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F 278	Continued From page 4 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 3 of 9 sampled residents (Resident #2, #3, and #6). Resident (#2 and #6) coded on the MDS with a toileting plan and Resident #3 coded with delusions. Failure to accurately assess and code the MDS may affect the level of care provided to residents and the accurate development of the comprehensive care plan.	F 278	not reimbursable for MDS, which had been coded as reimbursable. These residents # 2 & 6 & all residents have been assessed & corrections to prior MDS have been implemented on 7/15/14 & 7/30/14 to ensure that the effects of toileting schedules used are identified, properly evaluated, & documented in the medical record for MDS reimbursement. A licensed nurse meeting which included MDS coordinators was conducted on 7/23/14 held by DON addressing the importance & accuracy with coding reimbursable toileting schedules & specific qualifications. All nursing dept staff inservice education provided on 7/30/14 regarding the importance of effective toileting schedules, etc. & specifics for MDS reimbursement conducted by DON.	

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F 278	Continued From page 5 Findings include: The Long-Term Care Facility RAI User's Manual: version 3.0, October 2013, page H-5 ". . . implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern, evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report, notations of the resident's response to the toileting program and subsequent evaluations as needed." - Review of Resident #2's medical record occurred on July 7-10, 2014. A quarterly MDS, dated 05/17/14, identified the resident currently on a toileting plan and frequently incontinent. Review of the resident's "TOILETING SCHEDULE" flow sheets stated, "Toilet on rising - [after] brkfst [breakfast] - [after] dinner - [after] pm act [activity] - B/4 [before] bed - 1 am [and] 4 am @ [at] on demand." Review of Resident #2's current care plan section evaluating bladder control stated, "3/10/14 frequent IU [incontinent urine], BI [bowel incontinence] toilet schedule [no] longer reimbursable. 6/10/14 frequent IU cont [continue] on toilet schedule to promote continence . . . " A care conference note, dated 06/10/14, stated, ". . . Remains on toilet schedule [not] for MDS reimbursement but to promote continence @ times will refuse to get [arrow up] @ NOC [night] incontinent [check's] then completed, IU	F 278	The QA director will conduct a random audit of one (1) resident per month who are reimbursable for MDS purposes for toileting schedule for three (3) consecutive months then quarterly thereafter to ensure continued compliance. Areas of concern will be addressed at monthly QA meeting. By ensuring that nursing dept. staff have adequate knowledge of ensuring accuracy of MDS assessments this ensures continued compliance and averts potential to affect all residents.	

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F 278	Continued From page 6 [incontinent urine] frequently . . . " -Review of Resident #6's medical record occurred on July 7-10, 2014. A quarterly MDS dated 03/31/14, identified the resident as currently on a toileting schedule and frequently incontinent. Review of the resident's "TOILETING SCHEDULE" flow sheets stated, "Toilet on rising -[after] brkfst -[after] dinner - [after] pm act - [after] supper bedtime - on demand - at NOC @ PRN [as needed]" Review of Resident #6's current care plan section evaluating bladder control stated, ". . . 1/23/14 Incontinent urine approx [approximately] x1 [one time] toileting schedule effective . . . 4/08/14 IU 2-3 x day toilet schedule effective does VC [voided correctly] when placed . . . 5/28/14 [no] [change] cont POC [plan of care] . . ." A care conference note dated 05/28/14, stated, " . . . Wears pad/brief system remains on toilet schedule [not] for reimbursement IU approx 1-2 x/ day. . . " The facility failed to develop an individualized toileting program based on the Resident #2 and #6 unique voiding patterns. The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages E-2 - E-3 stated: ". . .E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnoses. Check all that apply. . . . *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a	F 278	Resident #3 was reassessed on 7/15/14 which included the Review of Quarterly MDS on 7/1/14 Section E0100 potential Indicators of psychosis. Section B had been coded incorrectly as resident did not present with delusions. Corrections to MDS have been completed & Submitted on 7/15/14.	

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F 278	Continued From page 7 fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations, *If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. *If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. . . ." Review of Resident #3's medical record occurred on July 07-10, 2014. Resident #3's quarterly MDS, dated 06/30/14, identified the resident displayed delusions during the 7-day assessment period. Review of Resident #3's Nurse's Note, dated 06/27/14 at 8:00 a.m., stated, "Resident [at] times confused today - asking about a man who will be taking her someplace. Easily redirected. Pleasant." During interview on the afternoon of 07/09/14 the surveyor requested the MDS nurse (#1) to provide the documentation for the coding of delusions on the 06/20/14 MDS for Resident #3. This MDS nurse stated she coded delusions based on the 06/27/14 nurse's notes. After discussion, the MDS nurse (#1) confirmed the entry written on 06/27/14 does not meet the definition of a true delusion as defined in the RAI manual.	F 278	A licensed nurse meeting was conducted on 7/23/14 by the Director of Nursing Services including MDS coordinators addressing the importance of Identifying delusions. All nursing Dept. meeting held on 7/30/14 Addressing importance for reporting behaviors to supervisor promptly. The QA director will conduct a random audit of two (2) residents per month for (3) three consecutive months, then quarterly thereafter to ensure continued compliance. Areas of concern will be addressed at monthly QA meeting. By ensuring that nursing dept. staff have adequate knowledge of ensuring accuracy of MDS assessments this ensures continued compliance and averts potential to affect all residents. QA Director is responsible for continued compliance.	