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 _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARDS COMMUNITY NURSING HOME	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/23/12 and completed on 07/26/12, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 7 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Dabbert	Administrator	8-15-12

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to provide a denial notice to 3 of 3 supplemental residents (Resident #12, #13, #14) discharged from Medicare Part A services. Failure to provide the correct notices upon termination of Medicare A services has the potential to hinder the residents' right to appeal and to request a demand bill. Any Medicare eligible resident is affected by the facility ' s denial notice system failure.	F 156	A SNF Determination on Continued Stay form along with the form 10123 will be given out two days prior to Medicare A ending to every resident with the potential to be affected. To identify other residents having the potential to be affected by the same deficient practice, we will be using the attached Daily Medicare A Checklist. Measures put into place to ensure the deficient practice will not recur are that the DON, therapy and Medicare billing will meet every Wednesday to review all Medicare and pending Medicare cases. We will keep a log of these meetings (attached). Performance will be monitored by adding a line to our Business Office QA checklist (attached and new line highlighted).	8-15-12

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F 156	Continued From page 3 Findings include: During the survey, the Medicare review process occurred on 07/25/12 at 8:00 a.m. Review of the files for Resident #12, #13, and #14 lacked the mandatory denial notice (CMS - 10055). This form asks the resident or the responsible party if they wish a demand bill (a review of the Medicare Part A services). During an interview on 07/25/12 at 8:00 a.m., an office staff member (#10) stated the residents did not receive this form.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to assess safety of the self-administration for 1 of 1 sampled resident (Resident #11) of all medications left at the bedside. Failure to ensure facility staff completed a self administration assessment has the potential to result in a medication error. Findings include: Review of the facility policy and procedure SELF-ADMINISTRATION OF DRUGS occurred	F 176	Resident #11 expressed desire to self - administer meds as per facility policy. IDT met and determined resident can safely self-administer meds once set up by LN. Self-medication Assessment completed, order obtained, care plan updated, resident education provided. Licensed nurse meeting 8/8/12 conducted by DON reviewed specifics of self-aministration of meds policy to ensure proper process being followed.	8/29/12

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F 176	Continued From page 4 on 07/25/12. The policy, dated 11/96 stated, ". . . Residents may self-administer drugs so long as they are capable . . . a. An interdisciplinary team (IDT) will meet to assess whether that resident can safely self-administer drugs using the Self-Medication Assessment Form (SMAF). . . . c. If the IDT determines that resident can safely self-administer drugs . . . an appropriate care plan is written. The decision is documented on the SMAF, which remains in the resident's record and a physician order is obtained. d. If the IDT determines that the resident is not capable of safely self-administering medications, that decision is noted on the SMAF, appropriate care plan notes are made. . . ." During observation on the morning of 07/24/12, a nursing staff member (#1) obtained a medication, Miralax 17 grams (a laxative), for Resident #11. The staff member (#1) took the medication to Resident #11's room and left the medication at the resident's bedside, at the direction of the resident. Review of Resident #11's medical record occurred on the afternoon of 07/24/12. The record lacked a physician's order for self-administration of oral medications. Resident #11's current care plan identified a problem of ". . . Resident requests to self-administer topical ointment per self [with] med [medication] left @ [at] bedside to administer as ordered Topical med: apply bid [two times a day] Triamcinalone crm. [cream] [topical cream] PRN [as necessary] BID," with approaches including "1. Evaluate resident's ability . . . 2. Obtain order from MD [medical doctor] . . . 3. Complete Self-Medication Assessment Form (SMAF) . . . 5. Be alert to	F 176	Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting Aug. 2012 through existing pharmacy Dept. indicator labeled "Medications not dispensed correctly according to physician's order." Problems or concerns will be documented on QA report and brought to QA committee. By ensuring licensed nurses have adequate knowledge of, and follow proper process to assess safety of the self-administration of meds, we are able to provide appropriate treatment and services to our residents and avoid potential harm to all residents.	

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

OMB NO. 0938-0391

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F 176	Continued From page 5 ." Resident #11's SMAF form, dated 03/02/10 and updated quarterly, included an IDT determination of self-administration of a topical medication and lacked the inclusion of oral medications. During interview on the morning of 07/25/12, a supervisory staff member (#2) stated the facility completes a self-administration assessment to determine which residents can self-administer their own medications. The staff member stated Resident #11's SMAF did not include self-administration of the Miralax.	F 176		
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 staff failed to provide cares in a dignified manner for 2 of 9 sampled residents (Resident #5 and #6) and 2 supplemental residents (Resident #15 and #16). Failure to provide cares in a dignified manner has the potential to affect residents' psychosocial well- being. Findings include: - On 07/24/12 at 9:20 a.m., a nursing staff member (#1) failed to close the door when providing a treatment (tracheostomy care) for	F 241	Nursing department staff education completed promptly with each shift report as well as by nursing dept. staff communication book Re: maintaining residents dignity, etc. Licensed nurse's meeting, 8/8/12, conducted by DON stressed importance of promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality, nurses role in continued education of other nursing dept. staff and QA spot checks. All nursing dept. staff educated regarding same at mandatory inservice on 8/15/12, conducted by DON.	8/29/12

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F 241	Continued From page 6 providing a treatment (tracheostomy care) for Resident #5 in her room. During this treatment, another resident approached the door and stopped at the entrance while two unidentified certified nursing assistants (CNAs) attempted to remove the resident. The CNAs also failed to close the door, leaving Resident #5 in full view during the treatment. - On 07/25/12 at 5:00 p.m., a nursing staff member (#3) wheeled Resident #6 behind the nurse ' s station and poked the resident ' s finger twice for a blood test while in full view of other residents and staff members. - On 07/25/12 at 5:45 p.m., Resident #15 sat at an assisted dining table with three other residents. A staff member (#5) held a napkin up to Resident #15 ' s mouth due to spitting. The resident continued to spit eight times and the staff member tried to contain the spit in the napkin. The staff member failed to remove the resident to avoid the potential of the three other residents at the table getting spit on. - On 07/24/12 at 11:50 a.m., Resident #16 sat at an assisted dining room table with two other residents. A nursing staff member (#1) approached Resident #16 and stated, "I have your eye drops." The nurse then administered the eye drops in full view of other residents. During interview on the morning of 07/26/12, an administrative staff (#4) agreed that the door should be closed during treatments, and staff should have removed Resident #15 from table when spitting.	F 241	Licensed nurses have been performing intermittent spot checks to ensure cares are being provided in a dignified manner. Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting Aug. 2012 through existing SS/Rec. Dept. indicator labeled "Resident was not treated in dignified and respectful manner". Problems or concerns will be documented on QA report and brought to QA committee. By ensuring that nursing dept. staff have adequate knowledge of and follow concepts of dignity and respect of individuality, we are able to provide cares in a dignified manner, and thus help promote resident's psychosocial well-being. By following these concepts, the potential to negatively affect residents #5,6,15,16 psychosocial well-being has been averted as well as avoiding potential harm to all residents.	

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OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to ensure staff appropriately used assistive devices for 3 of 6 sampled residents (Resident #2, #3, and #8) observed transferred with a gait belt. Failure to properly use a gait belt has the potential to cause harm and discomfort to a resident and may lead to avoidable falls or injury. Findings include: Review of the facility policy titled "Gait Belt (Ambulation Belt)" occurred on 07/26/12. This policy, dated March 2010, stated, "Purpose of a Gait Belt: 1 Provide increased security for the resident and staff. 2. Prevent injury during ambulation and movement of resident. . . . Procedure: 1 Apply the belt around the resident's waist snugly enough to elminate [sic] the possibility of sliding up on the ribs. 2 Bring the resident to a standing position by grasping the belt with both hands while remaining upright yourself. 3 Use the belt during ambulation to stabilize the resident by grasping the belt firmly in the middle of the resident's back. . . ."	F 323	Nursing dept. staff education completed promptly with each shift report as well as by nursing dept. staff communication book Re: proper use of gait belts. Licensed nurse's meeting on 8/8/12 conducted by DON, stressed importance of proper use of gait belts to avoid resident harm/discomfort, nurses role in continued education of other nursing dept. staff and QA spot checks. All nursing dept. staff educated regarding same at mandatory inservice, 8/15/12, conducted by DON. Licensed nurses have been performing intermittent spot checks to ensure gait belts are being used properly. Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting Aug. 2012 on newly developed Safety Dept. indicator labeled "Gait belts not used properly". Problems or concerns will be documented on QA report and brought to QA committee.	8/29/12

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F 323	Continued From page 8 - On 07/24/12 at 11:00 a.m., observation showed two certified nurse aides (CNAs) (#6 and #7) assisted Resident #3 to sit on the edge of the bed. One CNA (#6) applied a gait belt around the resident's waist. Each CNA placed one arm under the resident's axilla and held onto the gait belt with the other hand. The gait belt was loose and slid upward on Resident #3's back as the CNAs pulled up on the gait belt and resident ' s arms. The CNAs failed to tighten the gait belt before continuing the transfer. Resident #3 was unable to fully straighten her legs and her feet crossed as the CNAs attempted to pivot Resident #3 to sit in the wheelchair. On 07/24/12 at 2:05 p.m., observation showed two CNAs (#6 and #7) assisted Resident #3 to sit on the edge of the bed. The resident moved stiffly and said " owh." The CNAs placed a gait belt around the resident ' s waist, and positioned one arm under the resident's axilla and the other hand on the gait belt. As the CNAs pulled up on the gait belt and resident's arms, the gait belt slid upward on the resident's back. The CNAs pivoted the resident into the wheelchair without tightening the gait belt. Review of Resident #3's medical record occurred on July 24-25, 2012. Diagnoses included rheumatoid arthritis, osteoporosis, degenerative joint disease, and history of vertebroplasty (vertebrae compression fracture treatment). The annual Minimum Data Set (MDS), dated 06/10/12, indicated extensive assistance of two or more people for transfers. - On 07/24/12 at 3:50 p.m., observation showed a	F 323	By ensuring nursing dept. staff have adequate knowledge of, and follow concepts of proper gait belt use, the safety of residents #2,3 & 8 are ensured as well as avoiding potential harm to all residents.	

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F 323	Continued From page 9 CNA (#8) assisted Resident #2 to stand from the toilet and ambulate with a walker across the room to a recliner. The gait belt around the resident ' s waist was loose and the CNA twisted the belt in her hand to decrease the space between the belt and the resident's back. The CNA failed to tighten the gait belt before ambulating with the resident. Review of Resident #2's medical record occurred on July 24-25, 2012. Diagnoses included a prior hip fracture, history of falls, osteoporosis, and osteoarthritis. The quarterly MDS, dated 05/01/12, indicated extensive assistance of one person for transfers and walking. The Care Area Assessment (CAA) for falls, dated 11/04/11, stated, ". . . balance loss with turning . . . high fall risk . . . ambulate with walker and one person assist . . ." - On 07/25/12 at 1:30 p.m., observation showed Resident #8 in the bathroom with a gait belt around her waist. With several attempts, a CNA (#9) assisted Resident #8 to stand from the toilet using the gait belt and pulling upward under one of the resident's arms. The gait belt was loose and slid upward on the resident's back. The resident stated, "You need to be stronger than that." The CNA provided pericares, adjusted Resident #8's clothes and ambulated the resident down the hall using a walker, without tightening the gait belt. Review of Resident #8 ' s medical record occurred on July 25-26, 2012. Diagnoses included osteoporosis and degenerative joint disease. The quarterly MDS, dated 07/16/12, indicated extensive assistance of one person for transfers and limited assistance of one person for	F 323		

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F 323	Continued From page 10 ambulation. The CAA, dated 10/19/11, stated, ". . . poor safety awareness . . . 5 falls this quarter . . . " During an interview on 07/26/12 at 8:55 a.m., an administrative nurse (#4) agreed a gait belt should be snug around the resident ' s waist for transfers and ambulation. Failure to place a gait belt snugly around a resident ' s waist decreases the gait belt's effectiveness and has the potential to increase the amount of force on the resident's arms, as the resident is pulled to a standing position. Pulling on Resident #2, #3, and #8's arms may cause increased levels of pain due to their diagnosis of arthritis. Improper use of the gait belt may contribute to falls, with increased potential for injury or fracture to these residents due to their diagnosis of osteoporosis and/or prior fall or fracture.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	Licensed nurse's education completed promptly with each shift report as well as by nursing dept. staff communication book Re: proper hand hygiene/infection control process during med pass. Licensed nurse's meeting, 8/8/12, conducted by DON, stressed importance of proper glove usage and proper hand hygiene related to glove usage, as well as general infection control procedure during med pass, etc.	8/29/12

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F 441	Continued From page 11 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure proper hand hygiene during the administration of eye drops for 1 of 1 supplemental resident (Resident #17) observed receiving eye drops, and before and after medication administration on 1 of 1 day (07/24/12) observation of medication pass occurred. Failure to perform proper hand hygiene has the potential to spread infections from resident to resident during administration of medications.	F 441	All nursing dept. staff educated regarding proper hand hygiene and glove usage at mandatory inservice on 8/15/12, conducted by DON. DON has been performing intermittent spot checks to ensure proper hand hygiene procedures are being followed with med pass. Performance reviews for med pass observation were completed on licensed nurses focusing on areas of concern. Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting Aug. 2012 on newly developed Infection Control Dept. indicator labeled "Proper hand hygiene not completed with med pass". Problems or concerns will be documented on QA report & brought to QA committee. By ensuring licensed nursing staff have adequate knowledge of and follow concepts of proper hand hygiene and glove usage, the safety of resident #17 will be ensured as well as avoiding potential harm to all residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARDS COMMUNITY NURSING HOME	613 1ST AVE SW HANKINSON, ND 58041

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F 441	Continued From page 12 Findings include: Review of the facility " HAND HYGIENE " policy occurred on 07/25/12. The policy, undated, stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. . . . Hand hygiene is the general term that applies to washing hands with water and either plain soap or soap/detergent containing an antiseptic agent; or thoroughly applying an alcohol-based hand rub . . . The following is a list of some situations that require hand washing with soap and water: . . . Before and after administering eye drops. . . . The following is a list of some situations that require hand hygiene: . . . Before and after resident contact . . ." Review of facility " GLOVE USAGE POLICY " occurred on 07/25/12. The policy, undated, stated, "Wash your hands with soap and water immediately after removal of gloves (always insuring resident's safety). . . ." Observation of medication pass occurred on 07/24/12 and showed the following: * During morning medication (med) pass, a nursing staff member (#1) failed to perform hand hygiene after the administration of six meds and prior to the next administration of meds to another resident. The staff member dropped one of the meds onto the med record, picked up the med with bare hands, cut the pill in half, and then again touched the pill to place in the med cup. * During afternoon med pass a nursing staff member (#3) donned gloves, administered eye drops to Resident #17, removed her gloves, and failed to perform hand hygiene prior to and after administration of the drops.	F 441		

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F 441	Continued From page 13 * During afternoon med pass, a nursing staff member (#3) failed to perform hand hygiene before the administration of meds on two occasions, and after med pass on one occasion. During interview on the morning of 07/25/12, a supervisory nurse (#2) stated she would expect nursing staff to wear gloves to cut pills for administration and stated if pills drop on the med record/cart prior to administration, the pill(s) should be replaced. During interview on the afternoon of 07/25/12, an administrative nurse (#4) stated she would expect nursing staff to perform hand hygiene between residents during med pass, and staff should wash or sanitize their hands before donning gloves and after removal of gloves when administering eye medication.	F 441		