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 _____	09/23/2010

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/20/10 and completed on 09/23/10 the sample included two residents for complete review, seven residents for focused review, and one closed record for review. The sample included two additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure the services provided met professional standards for 1 or 2 sampled resident (Resident #8) observed during the administration of an inhaler. Failure to clarify the dosage on an inhaler has the potential for a resident to experience adverse effects related to the incorrect dosage of a medication. Findings include: Review of the facility policy titled "Medication Administration Policy" occurred on 09/23/10. This policy, dated February 2010, stated, "PURPOSE: To assure that the right drug and dose are given to the right resident . . . in accordance with the medical and Nurse Practice Act of ND [North Dakota]. . . ." Taylor, Lillis, Lemone, "Fundamentals of Nursing, The Art and Science of Nursing Care," 4th ed.,	F 281	For resident #8, original order of 11/5/07 verified correct dose to be administered. Additional clarifying MD order obtained 10/13/10 from primary MD. Order transcribed to MAR, monthly renewal, cardex. Correct dosage had been administered. No order changes received. Licensed nurse meeting conducted by DON on 10/14/10 addressed acceptable professional standards for medication administration and facility policy "Medication Administration". Education stressed that the Licensed Nurse must assure the right drug and dose are given to the right resident, by the right route, at the right time and is properly documented. (Agenda and attendance included). Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting October 2010 through the existing pharmacy indicator labeled "Incomplete	10/26/10

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

Karen Dalbert — Administrator — 10-14-10

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 281	Continued From page 1 J.B. Lippincott Company, Pennsylvania, page 574 stated, "No medication may be given to a patient without a medication order from a physician . . ."; page 576 stated, "The medication order consists of seven parts . . . dosage of the drug . . ."; and page 581 stated, "The five rights help to ensure accuracy when administering medications. The nurse gives the . . . (3) the right dosage. . ." Observation of medication administration occurred on 09/21/10 at 9:50 a.m. with a nurse (#5) and 09/22/10 at 9:55 a.m. with a nurse (#6). Observation showed the nurses obtained an Advair inhaler from the medication cart and confirmed the medication against Resident #8's Medication Administration Record (MAR). The nurses (#5 and #6) proceeded to give the inhaler to Resident #8. Review of Resident #8's physician's orders occurred on 09/21/10. The physician's order stated "Advair [one] puff BID [twice a day]. Both the physician's order and the MAR failed to specify the strength of the Advair inhaler. During an interview on the afternoon of 09/22/10, an administrative nurse (#1) agreed Resident #8's MAR and physician's orders failed to identify the strength of the Advair inhaler and the nursing staff failed to clarify the physician's order.	F 281	Continued From page 1 medication orders transcribed on MAR". Problems or concerns will be documented on QA report and brought to QA committee. By ensuring that licensed nurses have adequate knowledge of/and follow acceptable professional standards for medication administration, we are able to safely administer medications and avoid potential harm to all residents.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	Licensed nurse meeting conducted by DON on 10/14/10 addressed the standards of practice regarding bladder incontinence which requires a resident to receive appropriate treatment and services to restore as much normal bladder function as possible. This involves thorough	10/26/10

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F 315	Continued From page 2 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to adequately assess the voiding habit/pattern, and implement scheduled toileting at times consistent with the assessment for 3 of 8 sampled residents (Resident #4, #8, and #9) experiencing bladder incontinence. Failure to implement/review scheduled toileting programs, at times consistent with the residents' determined voiding habits/patterns, has the potential to cause avoidable bladder incontinence, compromise individual dignity, and place these residents at an increased risk for urinary tract infections. Finding include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding bladder incontinence which requires a resident to receive the appropriate treatment and services to restore as much normal bladder function as possible. This involves completing an assessment of factors that may predispose the resident to having urinary incontinence, implementing appropriate, individualized interventions that address the incontinence, monitoring the effectiveness of the interventions, and determining the type of urinary incontinence to allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status. A	F 315	Continued From page 2 assessment of urinary incontinence, implementing appropriate individualized interventions, monitoring the effectiveness, and updating as indicated. Bladder program Policy and Bladder Assessment form (copies enclosed) were developed in order to meet this standard and education to Licensed Nurse staff and MDS nurses completed at Licensed Nurse's meeting 10/14/10. (Agenda and attendance included) Education regarding this information will also be provided to CNA's and other nursing deparment staff members at the fall inservice to be held October 20 & 21, 2010.	

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F 315	Continued From page 3 resident should be evaluated at admission and whenever there is a change in cognition, physical ability, or urinary tract function. - Review of Resident #9's medical record occurred on September 22-23, 2010. Medical diagnoses for Resident #9 included dementia with behavior disorder, anxiety, mood disorder, psychotic disorder, Parkinson's disease, and depression. The most recent Minimum Data Set (MDS), dated 07/04/10, identified Resident #9 required extensive assistance of two or more staff for transfer, total assist of one staff member for toileting and personal hygiene, frequently incontinent of bladder, incontinent of bowel, and on a scheduled toileting plan. Resident #9's current plan of care identified the following: * "PROBLEMS/STRENGTHS: Incontinent of bowel and bladder frequently . . . IMPLEMENTATION: toileting schedule started, routine incontinence checks @ [at] nite [night]. EVALUATION: 11/10/09, Goal revised for incontinence to better reflect resident's current condition - has freq. [frequent] daily urinary incont [incontinent] episodes but also does void correctly @ times when placed on the toilet . . . 02/04/10: BI [bowel incontinent] 50%. cont [continue] same. 05/04/10: [increased] incontinence but does void correctly at times . . . 08/31/10 incont of bowels 50% of time, voids correctly on toilet occas [occasional]." Review of Resident #9's nurses note, dated 09/01/10, stated, "Quarterly care conference . . . She is on a routine toileting schedule-has numerous daily incont. episodes but does void correctly @ times when placed on the toilet. . . ."	F 315	Continued From page 3 For resident #9, a bladder assessment was completed 10/12/10 (copy enclosed). Through this assessment it was determined resident no longer appropriate for effective toileting program due to significant cognitive impairments, etc. Toileting of resident #9 will continue, but will no longer consider it a reimbursable plan for MDS. For resident #8, toileting schedule was reviewed and modified with 9/27/10 care conference. Bladder assessment completed 10/12/10. Review of current toileting schedule, which had added two additional toileting times during the day, indicated that in October at 11:00am resident had only 1 day of incontinence out of 12. In October at 5:00pm toileting resident had 3 days of incontinence. Feel that this	

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F 315	Continued From page 4 Review of Resident #9's Toileting Record stated, "Toilet on Rising - [after] breakfast - b/4 [before] dinner - [after] dinner - [after] pm act [p.m. activity] - [after] supper - bedtime - on demand during noc [night] [with] incont [checks] (routine)." Review of Resident #9's toileting records from May 2010 through September 22, 2010 identified facility staff documented incontinent of urine the following times: * May 2010: 25 of 31 days between 6:00 and 7:00 a.m., 19 of 31 days at 9:00 a.m., 25 of 31 days at 1:00 p.m., 28 of 31 days at 4:00 p.m., and 26 of 31 days at 7:00 p.m. * June 2010: 26 of 30 days between 6:00 and 7:00 a.m., 22 of 30 days at 9:00 a.m., 24 of 30 days at 1:00 p.m., 25 of 30 days at 4:00 p.m., and 29 of 30 days at 7:00 p.m. * July 2010: 27 of 31 days at 6:00 a.m., 21 of 31 days at 9:00 a.m., 29 of 31 days at 1:00 p.m., 24 of 31 days at 4:00 p.m., and 29 of 31 days between 7:00 and 8:00 p.m. * August 2010: 29 of 31 days at 7:00 a.m., 25 of 31 days at 9:00 a.m., 30 of 31 days at 1:00 p.m., 28 of 31 days at 4:00 p.m., and 29 of 31 days between 7:00 and 8:00 p.m. The record showed Resident #9 dry and voided on the toilet 25 of 28 days at 11:00 a.m. * September: 22 of 22 times at 6:00 a.m., 15 of 22 times at 9:00 a.m., 17 of 22 times at 1:00 p.m., 21 of 22 times at 4:00 p.m., and 19 of 22 times at 7:00 p.m. The record showed Resident #9 dry and voided on the toilet 8 of 20 days at 11:00 a.m. Observation, at 12:45 p.m. on 09/22/10, showed a certified nurse assistant (CNA) (#2) utilized a sit to stand lift and assisted Resident #9 to the toilet in her room. The CNA removed the resident's	F 315	Continued From page 4 adjustment has been effective and will continue. (Copies enclosed) For resident #4, a bladder assessment was completed 10/12/10 (copy enclosed). Through this assessment it was determined that resident was no longer appropriate for effective toileting program due to significant cognitive impairments, etc. Toileting of resident #4 will continue, but will no longer consider it a reimbursable plan for MDS.	

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F 315	Continued From page 5 brief and observation showed the brief wet and soiled with stool. Resident #9 failed to void on the toilet. Observation, at 3:55 p.m. on 09/22/10, showed a CNA (#4) utilized a sit to stand lift and assisted Resident #9 to the toilet in her room. Observation showed Resident #9 incontinent of urine and voided a small amount while on the toilet. Based on the above observations and review of the toileting records, Resident #9's toileting plan failed to promote or maintain her continence. - Review of Resident #8's medical record occurred on September 21-23, 2010. Medical diagnoses included dementia and a history of urinary tract infections. The current MDS, dated 08/03/10, identified Resident #8 frequently incontinent of bowel and bladder, required extensive assistance for toilet use, and on a scheduled toileting plan. Previous MDSs, dated 05/04/10 and 08/04/09, identified the same. Resident #8's urinary incontinence Resident Assessment Protocol (RAP), dated 08/03/10, stated to refer to the urinary incontinence RAP done 08/05/09. The 08/05/09 RAP stated, "Monitor effectiveness of toileting schedule & [and] adjust as needed . . ." Resident #8's current care plan stated, "Toileting schedule and on demand." The resident's Toileting Record stated, "Toilet on Rising - [after] breakfast - [after] dinner - [after] pm act [p.m. activity] - [after] supper - bedtime. Incont [incontinent] [checks] @ [at] noc [night]." Review of Resident #8's toileting records from May 2010 through September 22, 2010 identified	F 315	Continued From page 5 Our QA director will be monitoring performance to ensure solutions are permanent. This will be done monthly starting October 2010 through the newly developed long term care indicator, "Toileting schedules evaluated for effectiveness with each MDS assessment". Problems or concerns will be documented on QA report and brought to QA committee. By ensuring that licensed nurses, MDS nurses, and CNA's have adequate knowledge of/and follow acceptable professional standards regarding bladder incontinence, complete and accurate assessments and individualized plans to allow resident to improve/attain maximum bowel/bladder continence, we are able to avoid potential harm to all residents.	

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F 315	Continued From page 6 facility staff documented "incontinent of urine" the following times: * May 2010: 30 of 31 days at 7:00 a.m., 14 of 31 days between 9:00 and 10:00 a.m., 25 of 31 days at 1:00 p.m., 28 of 31 days between 4:00 and 5:00 p.m., and 29 of 31 days between 7:00 and 8:00 p.m. * June 2010: 27 of 30 days between 6:00 and 7:00 a.m., 11 of 30 days between 9:00 and 10:00 a.m., 23 of 30 days between 1:00 and 2:00 p.m., 26 of 30 days at 4:00 p.m., and 28 of 30 days at 7:00 p.m. * July 2010: 31 of 31 days at 6:00 a.m., 12 of 31 days at 9:00 a.m., 29 of 31 days at 1:00 p.m., 21 of 31 days at 4:00 p.m., and 29 of 31 days between 7:00 and 8:00 p.m. * August 2010: 29 of 31 days between 6:00 and 7:00 a.m., 17 of 31 days between 9:00 and 10:00 a.m., 21 of 31 days at 1:00 p.m., 23 of 31 days between 4:00 and 5:00 p.m., and 29 of 31 days between 7:00 and 8:00 p.m. * September 2010: 22 of 22 days at 7:00 a.m., 12 of 22 days at 9:00 a.m., 17 of 22 days at 1:00 p.m., 19 of 22 days at 4:00 p.m., and 18 of 22 days at 7:00 p.m. Observation on 09/22/10 at 12:45 p.m., showed the CNA (#9) assisted Resident #8 onto the toilet. The CNA removed the resident's wet brief and stated "she's usually wet." Resident #8 failed to void on the toilet. Observation on 09/22/10 at 4:15 p.m., showed the CNA (#8) assisted Resident #8 onto the toilet. The CNA removed the resident's wet brief and stated the resident "is always wet" and "never [voids] in the toilet." Resident #8 failed to void on the toilet.	F 315		

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F 315	Continued From page 7 Based on the above observations and review of toileting records, Resident #8's toileting plan failed to promote or maintain her continence. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included a history of recurrent urinary tract infections, neurogenic bladder, and dementia. The current MDS, dated 09/10/10, indicated Resident #4 required total assistance from one person for toilet use, was frequently incontinent of bladder, and participated in a scheduled toileting plan. Previous MDSs, dated 06/11/10 and 09/11/09, indicated the same. Resident #4's current care plan stated, ". . . ASSESSMENT . . . urinary incontinence of long term duration . . . IMPLEMENTATION . . . Toileting schedule during the day [with] incont. [incontinent] checks @ nite [sic] . . . EVALUATION . . . 07/06/10 Incont. of urine but does void correctly @ times when on toilet. Cont. [continue] same . . ." Resident #4's Toileting Record indicated facility staff developed a toileting schedule for Resident #4 at the following times: between 5:00 and 6:00 a.m., 9:00 a.m., 1:00 p.m., 4:00 p.m., 7:00 p.m., and 10:00 p.m. Review of the toileting records from March 2010 through September 22, 2010 revealed facility staff documented "incontinent of urine" and/or "toileted but did not void" at the following times: * March 2010: 31 of 31 days at 6:00 a.m., 21 of 31 days at 9:00 a.m., and 12 of 31 days at 4:00	F 315		

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F 315	Continued From page 8 p.m. * April 2010: 30 of 30 days at 6:00 a.m., 22 of 30 days at 4:00 p.m., and 14 of 30 days at 7:00 p.m. * May 2010: 27 of 31 days at 6:00 a.m., 21 of 31 days at 1:00 p.m., 23 of 31 days at 4:00 p.m., and 14 of 31 days at 7:00 p.m. * June 2010: 28 of 30 days at 6:00 a.m., 15 of 30 days at 9:00 a.m., and 15 of 30 days at 1:00 p.m. * July 2010: 31 of 31 days at 5:00 a.m., 21 of 31 days at 9:00 a.m., 13 of 31 days at 1:00 p.m., and 13 of 31 days at 7:00 p.m. * August 2010: 26 of 31 days at 6:00 a.m., 23 of 31 days at 9:00 a.m., 20 of 31 days at 1:00 p.m., and 18 of 31 days at 4:00 p.m. * September 2010: 22 of 22 days at 6:00 a.m., 16 of 22 days at 9:00 a.m., 11 of 22 days at 1:00 p.m., and 10 of 22 days at 4:00 p.m. Observation on 09/20/10 at 8:53 a.m. showed a CNA (#7) assisted Resident #4 to the bathroom and removed the resident's brief (soiled with urine and stool). After sitting on the toilet a few minutes, Resident #4 stated, "I'm done." Observation showed Resident #4 did not void. The CNA (#7) stated Resident #4 is "almost always" incontinent, but "we take her to the toilet anyway." Observation on 09/21/10 at 10:00 a.m. showed a CNA (#8) assisted Resident #4 to the bathroom and removed the resident's brief (soiled with urine and stool). The resident sat on the toilet approximately five minutes but did not void. Based on the observations above and review of toileting records, Resident #4's toileting plan failed to promote or maintain her continence. An interview with a nursing staff member (#1) occurred the morning of 09/23/10. The staff	F 315		

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F 315	Continued From page 9 member stated facility staff do not complete toileting/bladder assessments. The times identified on scheduled toileting programs occur as a result of reviewing monthly toileting records. The staff member stated Resident #4's toileting plan has not been changed since July 2009. The staff member agreed Residents #4, #8, and #9's toileting plan needed to be re-evaluated. The lack of complete and accurate assessments does not provide a means of determining Resident #4, #8, and #9's overall continence performance through all shifts and does not provide an accurate baseline data to develop an individualized plan to allow residents to improve/attain maximum bowel and bladder continence.	F 315		