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	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gerard's Community of Care	613 1st Ave SW Hankinson, ND 58041

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 3 of 3 residents (Residents #8, #16, and #23) observed for insulin preparation and administration. Failure to properly prime an insulin pen and administer insulin correctly may result in residents receiving an inaccurate dose of insulin.Findings include:Review of the facility policy titled, Insulin Pen occurred on 07/23/25. This policy, dated 04/09/23, stated, . Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. -Observation on 07/22/25 at 5:30 p.m. showed a nurse (#4) prepared Resident #16's insulin pen for administration. The nurse (#4) dialed the pen to 3 units and with the needle cap on, primed the pen with the needle pointed horizontally. The nurse primed the insulin pen with 3 units instead of 2 units and failed to remove the needle cap and hold the pen upward when priming. -Observation on 07/22/25 at 6:00 p.m. showed a nurse (#4) prepared Resident #23's insulin pen for administration. The nurse (#4) dialed the pen to 3 units and with the needle cap on, primed the pen with the needle pointed horizontally. The nurse primed the insulin pen with 3 units instead of 2 units and failed to remove the needle cap and hold the pen upward when priming. -Observation on 07/23/25 at 11:14 a.m. showed a medication aide (MA) (#6) prepared Resident #8's insulin pen for administration. The MA (#6) dialed the pen to 2 units and with the needle cap on, primed the pen with the needle pointed horizontally. The MA failed to remove the needle cap and hold the pen upward when priming. During an interview on 07/23/25 at 1:30 p.m., an administrative staff member (#5) stated she expected staff to prime an insulin pen with the cap off and the needle pointed upward.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 8 sampled residents (Residents #8 and #15) and 1 supplemental resident (Resident #18) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP) and hand hygiene has the potential to spread infection throughout the facility.Findings include: Review of the facility policy titled Enhanced Barrier Precautions occurred on 07/23/25. This policy, dated 04/08/24, stated, . Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Initiation of Enhanced Barrier Precautions: An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (e.g., central lines, urinary catheters . Implementation of Enhanced Barrier Precautions: . PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . Providing hygiene . Changing briefs or assisting with toileting . device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes . Review of the facility Infectious Disease Control Manual occurred on 07/23/25. This manual, dated May 2007, page 28 stated, . j. Handwashing . when to wash your hands . 2. Should be first thing you do when you enter resident's room and, last thing you do before leaving. 7. After removing your gloves. 8. Before and after handling dressing, catheters, bedpans, specimens, and urinals. Between procedures on the same resident. 9. Before and after assisting residents with any personal needs. -Review of Resident #8's medical record occurred on all days of survey. A physician's order stated, Change ostomy [a surgically created opening in the abdomen, that allows waste to be diverted from its usual pathway] pouch twice weekly and as needed. The current care plan stated, . Staff will use enhanced barrier precautions during the following high-contact activities: . caring for or using an indwelling medical device: colostomy and catheter. -Observation on 07/21/25 at 3:36 p.m. showed a certified nurse aide (CNA) (#1) applied a gown and gloves to change Resident #8's colostomy bag. A nurse (#4) entered the room with additional supplies. The CNA (#1) removed the pouch and placed it in the garbage bag. The nurse (#4), without performing hand hygiene, applied gloves and assisted the CNA by wiping stool from the colostomy stoma (opening) with disposable wipes and placed them in the garbage bag. The CNA tied the garbage bag and gave it to the nurse who exited the room. The CNA (#1) removed the gown and gloves, performed hand hygiene, and exited the room. The nurse (#4) failed to apply a gown before assisting with colostomy cares. During an interview on 07/23/25 at 1:30 p.m., an administrative staff member (#5) stated she expected staff to apply PPE when providing cares to residents on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/21/25 at 1:25 p.m. showed two CNA's (#1 and #3) completed hand hygiene and applied gloves. The CNAs transferred Resident #18 from the wheelchair to the bed using a mechanical sling lift. The CNA (#1) removed Resident #18's soiled brief, performed perineal care, removed the soiled gloves, applied a clean brief, and positioned Resident #18's pants. The CNA (#1) failed to perform hand hygiene after removing the soiled gloves and failed to apply new gloves before applying a clean brief. Observation on 07/22/24 at 3:40 p.m. showed a CNA (#2) assisted Resident #15 to the toilet. The resident voided and performed toileting hygiene. The CNA (#2) applied gloves, provided additional perineal care, removed the soiled gloves, and without performing hand hygiene, applied clean gloves, positioned Resident #15's brief and pants, and assisted Resident #15 to the recliner. The CNA (#2) failed to complete hand hygiene after removing the soiled gloves and before applying clean gloves and failed to offer hand hygiene to Resident #15. During an interview on 07/23/25 at 2:00 p.m., an administrative nurse (#5) stated she expected staff to perform hand hygiene after removing soiled gloves.