STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355126	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gabriel's Community	4580 Coleman Street, Suite 1 Bismarck, ND 58503

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and family and staff interview, the facility failed to notify the resident representative for 1 of 1 closed resident (Resident #1) reviewed for wounds/pressure injuries. Failure to notify the resident representative about new wounds/pressure injuries, changes to existing wounds/pressure injuries, and new/changes in treatment orders for these injuries does not allow the resident representative to be informed and make decisions significant to the resident's health and care. Findings include:Review of the facility policy titled Prevention and Treatment of Skin Breakdown occurred on 02/12/26. This policy, dated 2018, stated, . Weekly skin audits are performed by a licensed nurse. If a . new pressure injury or lower extremity wound develops . Notify attending provider, resident and resident representative. Educate resident/resident representative on skin wound/pressure injury and care plan interventions. Notify the attending provider, resident/resident representative . if the pressure injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Documentation reflects areas as addressed above.Review of Resident #1's medical record occurred on 02/12/26 and identified wounds to the buttocks and right back heel. A comprehensive Minimum Data Set (MDS), dated [DATE], identified a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. Progress notes identified the following wounds/pressure injuries: -Right medial buttock:*09/29/25, Redness and moisture associated skin damage (MASD). *11/05/25, New MASD with excoriation (raw irritated skin lesions).-Right back heel: *11/11/25, New suspected deep tissue injury (SDTI) with different shades of purple discoloration.*11/18/25, The SDTI now an unstageable pressure ulcer with mostly black eschar [dead skin tissue].*11/20/25, Provider orders for an urgent referral to podiatry. Resident #1's medical record lacked documentation the facility notified the resident's representative about the wounds/pressure ulcers to the right buttock and right back heel, treatments, and new orders.During an interview on 02/12/25 at 12:05 p.m., a family member stated they were not aware of the buttock wound and the facility did not notify them about the right back heel ulcer. During an interview on 02/12/25 at 4:09 p.m., a staff nurse (#2) confirmed the facility's policy is to notify resident families of new wounds, changes in existing wounds, and orders/treatments for these wounds.

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