

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER St Gabriel's Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398</p> <p>Based on record review, family interview, and staff interview, the facility failed to notify the physician of a resident's rejection of a prescribed medication for 1 of 1 sampled resident (Resident #2) with a pattern of refusing a medication. Failure to notify the physician of the rejection of Ativan (antianxiety medication) may have prevented the physician from altering the treatment/care provided to the resident.</p> <p>Findings include:</p> <p>Upon request for a policy, on 06/11/24 at 5:30 p.m., an administrative nurse (#4) stated the facility does not have a policy related to notification of the physician.</p> <p>During an interview on the afternoon of 06/10/24, a family member (#1) expressed concern staff failed to administer scheduled Ativan. The family member stated the staff asked Resident #2 if the resident wanted the morning dose of Ativan (May 18) and the resident said no. The family member stated Resident #2 can't make that decision as the resident doesn't know yes from no.</p> <p>Review of Resident #2's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated [DATE], identified no speech, sometimes understood, understands others, severe cognitive impairment, and rejection of cares on one to three days of the look-back period. Diagnoses included aphasia (comprehension and communication disorder), anxiety disorder, dementia, and epilepsy (seizure disorder).</p> <p>A physician's order, dated 03/19/24, stated, lorazepam [Ativan] . 0.5mg [milligrams]; oral. Special Instructions: re [regarding]: anxiety, seizures . Four Times A Day [at] 07:00 AM, 01:00 PM, 07:00 PM, 01:00 AM.</p> <p>The Medication Administration Record (MAR) showed Resident #2 refused Ativan seven times: the 1:00 a.m. dose of Ativan on May 4, 9, 10, 16, 17, and 18, and the 7:00 a.m. dose on May 18.</p> <p>During an interview on 06/11/24 at 3:44 p.m., a supervisory nurse (#12) stated she would inform the doctor if a resident repeatedly refused a medication, but was unaware if staff notified the doctor of Resident #2's refusal of Ativan.</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39211</p> <p>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 18 sampled residents (Resident #13, #55, and #62). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents.</p> <p>Findings include:</p> <p>SECTION N: MEDICATIONS</p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-6 to N-8 stated, . N0415: High-Risk Drug Classes: Use and Indication . Coding Instructions . N0415E1. Anticoagulant (e.g., [for example] warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period . N0415H1. Opioid: Check if an opioid medication was taken by the resident at any time during the 7-day look-back period . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., . clopidogrel) was taken by the resident at any time during the 7-day observation period.</p> <p>- Review of Resident #13's medical record occurred on all days of survey. A physician's order, dated 12/18/23, stated, Tramadol [opioid] 50 mg [milligram] tablet three times a day . re [regarding]: low back pain. The quarterly MDS, dated [DATE], showed staff failed to identify Resident #13 received an opioid.</p> <p>During an interview on 06/12/24 at 2:37 p.m., a nurse manager (#11) stated staff should have coded opioid on the MDS.</p> <p>- Review of Resident #55's medical record occurred on all days of survey. A physician's order, dated 12/31/23, indicated Eliquis (anticoagulant) 2.5 mg twice a day. The quarterly MDS, dated [DATE], showed staff coded N0415I1. Antiplatelet and failed to code N0415E1. Anticoagulant.</p> <p>During an interview on 06/11/24 at 5:15 p.m., an administrative nurse (#4) confirmed Section N of the quarterly MDS was coded incorrectly for Resident #55.</p> <p>SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, page O-7, stated, . Hospice Care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.</p> <p>28398</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Review of Resident #62's medical record occurred on all days of survey. A nurse's note, dated 03/05/24 at 4:54 p.m., stated, Received new order from [name of physician] today: Hospice consult placed and will schedule admission visit for tomorrow. The care plan, dated 03/06/24, stated, . Advance Care Planning: I am receiving Hospice services .</p> <p>The significant change MDS, dated [DATE], showed staff failed to identify Resident #62 received hospice care.</p> <p>During an interview on 06/12/24 at 12:08 p.m., a nurse manager (#11) stated staff missed coding hospice on the MDS.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39211</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 6 of 15 sampled residents (Resident #15, #19, #30, #55, #59, and #65) observed during cares. Failure to practice infection control standards related to use of personal protective equipment (PPE) and hand hygiene has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled Hand Hygiene occurred on 06/12/24. This policy, dated June 2017, stated, . Hand hygiene simply means cleaning hands using either handwashing (washing hands with soap and water), or antiseptic hand rub (i.e. alcohol-based hand sanitizer, including foam or gel). Times to Perform Hand Hygiene are, but not limited to: . Before and after direct resident contact . Before and after entering isolation precaution setting . Before and after assisting a resident with personal cares . Before and after handling peripheral vascular catheters and other invasive devices . Before and after assisting a resident with toileting - wash hands with soap and water . after contact with a resident's mucous membranes and body fluids or excretions . After handling soiled or used linens, dressings, bedpans, catheters and urinals . After removing gloves or aprons .</p> <p>Review of the facility policy titled Enhanced Barrier Precautions occurred on 06/12/24. This policy, dated April 2024, stated, .Enhanced Barrier Precautions (EBP) expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated. Indwelling medical devices (e.g. central lines.) .</p> <p>- Observation on 06/11/24 at 7:59 a.m. showed Resident #55 lying in bed and a PPE cart located outside the room with an Enhanced Barrier Precautions sign on top of the cart. Two certified nurse aides (CNAs) (#5 and #6) donned gowns and gloves and entered the room. The CNA (#5) assisted the resident from the bed to the bathroom and onto the toilet. The CNA assisted the resident to remove her night clothes, removed her gloves, applied new gloves, and offered the resident a washcloth for morning cares. The CNA (#5) placed a paper towel on the floor, obtained a graduated container, emptied Resident #55's urine collection bag into the container, removed her gloves, applied new gloves, applied the resident's knee length socks, secured the urine collection bag to the resident's left leg, assisted the resident with her brief, pants, and shoes, removed her gloves, and applied new gloves. The CNA (#5) placed the resident's walker in front of the resident to stand, completed perineal cares, removed her gloves, applied new gloves, and assisted the resident to pull up her brief and pants. The CNA removed her gloves, applied new gloves, assisted the resident to the sink, handed her a toothbrush/toothpaste, and began combing the resident's hair. The CNA emptied the container of urine into the toilet, removed her gloves, obtained the resident's glasses from the nightstand, gave the glasses to the resident, applied new gloves, and assisted the resident out of the bathroom. The resident ambulated out of the room to the dining room, both CNAs performed hand hygiene and exited the room.</p> <p>The CNA (#5) failed to complete hand hygiene between glove changes, after handling the resident's urine collection bag and graduated container and before touching other surfaces.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Observation on 06/11/24 at 9:08 a.m., showed Resident #59 seated on the toilet. Two CNAs (#8 and #9) entered the room, performed hand hygiene and donned gloves. The CNA (#8) provided perineal care, removed her gloves, and without performing hand hygiene, applied new gloves and transferred Resident #59 to the wheelchair.</p> <p>The CNA (#8) failed to perform hand hygiene between glove changes when performing perineal care.</p> <p>- Observation on 06/11/24 at 9:17 a.m. showed the CNA (#7) donned gloves, assisted Resident #15 onto the toilet, completed perineal cares, removed her gloves, applied new gloves, discarded the wet brief into the garbage, removed her gloves, applied new gloves, assisted the resident with a clean brief and pulled up her pants. With the same gloves, CNA (#7) guided the resident into the recliner chair, placed the call light, applied the oxygen nasal cannula, turned on the oxygen concentrator machine, removed her gloves, hand sanitized, and exited the room.</p> <p>The CNA (#7) failed to complete hand hygiene between glove changes and when toileting a resident.</p> <p>- Observation on 06/11/24 at 12:53 p.m. showed Resident #19 seated in a wheelchair in his room and PPE cart located outside the room with an Enhanced Barrier Precautions sign on top of the cart. Two CNAs (#1 and #2) donned gowns and gloves, entered the room, and transferred Resident #19 from the wheelchair to the bed. The CNA (#2) emptied the contents of the resident's urine collection bag into a graduated container. Without removing the gloves or performing hand hygiene, the CNA (#2) adjusted the resident in bed and placed the call light. The CNAs (#1 and #2) removed their gowns and gloves, performed hand hygiene, and exited the room.</p> <p>The CNA (#2) failed to change gloves and perform hand hygiene after handling the resident's urine collection bag and graduated container and before touching other surfaces.</p> <p>- Observation on 06/11/24 at 1:28 p.m. showed Resident #30 seated in a wheelchair in his room and a PPE cart located outside the room with an Enhanced Barrier Precautions sign on top of the cart. The CNA (#7) donned a gown and gloves, entered the room, applied a gait belt, positioned the walker in front of the resident, and assisted Resident #30 into the bathroom. The CNA lowered the resident's pants and brief and assisted the resident to sit on the toilet. The CNA removed her gloves, applied a new pair of gloves, obtained a graduated container, emptied the resident's urine collection bag into the container, removed her gloves, applied new gloves, and prepared the resident's bed, lowered the covers and adjusted the pillow. The CNA removed her gown and gloves and exited the room to get a package of disposable wipes. The CNA (#7) returned with the package of wipes, failed to hand sanitize, donned a gown and gloves, and entered the resident room. While in the resident's bathroom, the CNA removed the resident's brief, removed her gloves, applied new gloves, assisted the resident with a clean brief, assisted the resident to stand, used the disposable wipes to cleanse the rectal area following a bowel movement, removed the gloves, applied new gloves, secured the brief, pulled the resident's pants up, and held onto the gait belt as the resident walked to the bed. The CNA removed the gloves, applied new gloves, covered the resident with the blanket, placed the TV control and bedside table next to the resident. The CNA removed the gloves, applied new gloves, discarded the urine contents into the toilet, removed the gloves, applied new gloves, removed the garbage bag from the bathroom, removed her PPE, hand sanitized, and exited the room.</p> <p>The CNA (#7) failed to complete hand hygiene between glove changes when toileting a resident, and exiting/returning to a resident room in EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/12/24 at 12:40 p.m. an administrative nurse (#3) stated she expected staff to remove gloves and perform hand hygiene when moving from a dirty to clean task and when changing gloves.</p> <p>Observations on the mornings of 06/10/24 and 06/11/24 showed a PPE cart located outside of Resident #65's room with an Enhanced Barrier Precautions sign and a bottle of hand sanitizer on top of the cart and PPE (i.e., gowns and gloves) located within the drawers of the cart.</p> <p>Observation on 06/12/24 at 8:18 a.m. of an intravenous (IV) antibiotic administration through Resident #65's Peripherally Inserted Central Catheter (PICC) line showed a lack of a PPE cart outside of Resident #65's room. The staff nurse (#10) performed hand hygiene, donned gloves, administered IV antibiotic, removed the gloves, performed hand hygiene, and exited Resident #65's room.</p> <p>During an interview on the morning of 06/12/24, the staff nurse (#10) stated she hadn't worked this unit in a while and was unaware if Resident #65 was on any precautions.</p> <p>The staff nurse (#10) failed to don appropriate PPE when entering Resident #65's room according to the residents' EBP.</p> <p>During an interview on the morning of 06/12/24, an administrative nurse (#3) confirmed Resident #65 continued to be on EBP.</p> <p>42397</p> <p>46964</p>		