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	06/26/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 17 sampled residents (Residents #25). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: Review of Resident #25's medical record occurred on all days of survey and identified hospitalizations from 02/28/25 to 03/03/25 for a urinary tract infection and from 04/09/25 to 04/10/25 for hematuria (blood in the urine). Active diagnosis included malignant neoplasm of the bladder. Medications included Bactrim DS (an antibiotic) for seven days, initiated on 03/03/25. SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, pages I-5 and I-8, stated, . Active Diagnoses in the Last 7 Days - Check all that apply . Coding Instructions. Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . medical treatments, nursing monitoring . during the 7-day look-back period . Resident #25's significant change MDS, dated [DATE], and a quarterly MDS, dated [DATE], showed the facility failed to code the diagnosis of cancer at Section I0100. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages J-29 through J-30, stated, . J1550: Problem Conditions (cont.) . Steps for Assessment 1. Review the medical record, interview staff . for any indications that the resident had . internal bleeding during the 7-day look-back period. Coding Instructions. Check all that apply . J1550D, internal bleeding . Coding Tips . Internal bleeding . Clinical indicators include . hematuria . Resident #25's quarterly MDS, dated [DATE], showed the facility failed to code Section J1550D, internal bleeding. SECTION N: MEDICATIONS (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Long-Term Care Facility RAI User's Manual, revised October 2024, pages N-4 and N-6, stated, . N0415: HIGH-RISK DRUG CLASSES: Uses and Indication . Coding Instructions. Code all high-risk drug class medications . Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period . Resident #25's quarterly MDS, dated [DATE], showed the facility failed to code Section N0415F, antibiotic. During an interview on 06/26/25 at 10:36 a.m., an MDS staff member (#7) confirmed staff failed to accurately code the MDS.

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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, record review, review of facility policy, review of manufacturer's instructions, and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 2 sampled residents (Resident #26) reviewed for insulin use and 1 of 6 sampled residents (Resident #41) observed during insulin preparation. Failure to follow physician's orders for out-of-range blood sugar levels and failure to properly prime insulin pens may result in residents receiving an inaccurate dose of insulin and/or result in adverse health events. Findings include: Review of the manufacturer's instructions for the Humalog [a type of insulin]Kwik Pen occurred on 06/26/25. These instructions, revised May 2025, stated, . Priming your pen . priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly . if you do not prime the pen before each injection, you may get too much or too little insulin . to prime your pen, turn the dose knob to select 2 units . hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top of the cartridge . continue holding your pen with needle pointing up . push the dose knob until it stops . you should see insulin at the tip of the needle . Review of the facility policy titled Diabetic Management occurred on 06/26/25. This policy, dated 2001, stated, . The care and services to manage diabetes mellitus is directed by the providers orders and relevant protocols and guidelines. - Review of Resident #26's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. Physician's orders stated, Blood sugar checks TID [three times a day] Call PCP [primary care provider] if blood glucose is greater than 400 [milligrams per deciliter (mg/dl)] or less than 70 . Review of Resident #26's blood sugar levels from March 26, 2025 through June 24, 2025 identified the following: * 04/16/25 at 7:32 p.m., 455 mg/dl * 05/20/25 at 8:18 p.m., 454 mg/dl * 06/02/25 at 8:04 p.m., 484 mg/dl * 06/04/25 at 7:57 p.m., 459 mg/dl Resident #26's medical record lacked documentation staff notified the physician regarding the blood sugar levels over 400 mg/dl. - Observations on 06/24/25 at 12:10 p.m. and 5:03 p.m. showed a nurse (#5) primed Resident #41's insulin pen horizontally. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 06/26/25 at 11:49 a.m., and 12:28 p.m., administrative nurse (#1), stated she expected nursing staff to prime the insulin pen with the needle pointing up and notify the physician regarding out of range blood sugar levels.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review, policy and procedure review, and staff interview, the facility failed to ensure appropriate care and services for 1 of 1 sampled resident (Resident #117) reviewed for fecal impaction. Failure to follow bowel protocol interventions may have contributed to Resident #117's fecal impaction. Findings include: Review of the facility policy, Bowel Management Protocol, occurred on 06/25/25. This undated policy stated, Purpose: To ensure proper bowel function and management. Procedure: 1. Bowel management report will be pulled daily. Nurse will refer to bowel protocol if no bowel movement unless otherwise indicated. * Day 3 (greater than 48 hours since last BM [bowel movement]) - offer 4 ounces prune juice - if no results - Senna [medication for constipation] 2 tablets PO [per oral] per SHO [Standing House Orders] Utilize SHO for additional Bowel management options. * Day 4 (greater than 72 hours since last BM) - Bisacodyl Suppository [medication for constipation] 10 mg [milligrams] rectally per SHO. If no results - Complete Bowel Assessment and notify Provider of assessment findings that may indicate the need for further intervention. Day 5 (greater than 96 hours since last BM) Complete Bowel Assessment and contract Provider for further instructions. Review of the Standing House Orders for Symptom Management occurred on 06/25/25. This document, dated February 2025, stated, The following Standing House Orders for Symptom Management are to provide support and palliation to patients/residents . Bowel: Constipation (if no bowel movement in [greater than] 48 hours; Perform steps sequentially) * Consider rectal check to determine if impaction is present. * Encourage 2000 ml [milliliters] daily fluid intake . * Consult nutrition services for dietary recommendations. * Give Sennoside 8.6 mg 2 tablets by mouth daily PRN [as needed] . if no BM by day three, offer/give Bisacodyl suppository 10 mg: rectally . * Reattempt Senna or Bisacodyl if no results after 24 hours and notify provider. Review of Resident #117's medical record occurred on all days of survey. The care plan stated, Problem Start Date: 10/02/2024 I am at risk for constipation related to impaired mobility, variable meal intakes, . and hx [history] of constipation. Long Term Goal . I will have a BM [bowel movement] at least every 4 days . Approach Start Date: 10/02/24 Administer meds as ordered, observe for effectiveness and side effects . Follow facility bowel protocol . Monitor my bowel patterns and for s/s [signs/symptoms] of constipation . Review of nurse's notes identified the following: 06/04/25 at 2:30 p.m., CNA [certified nursing aide] reported at shift change that guest requested Prune juice earlier today. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/05/25 10:51 a.m., Guest had an unresponsive episode in the dining room where he became pale and hypotensive. Three staff members attempted to wake him up and he opened his eyes, but he was not able to talk. EMS [emergency medical system] was called and they arrived several minutes later .Guest left with EMS .and guest was then taken to [name of hospital] . 06/05/25 at 4:51 p.m., Guest is being admitted . for UTI [urinary tract infection]/fecal impaction. 06/08/25 at 2:20 p.m., Guest returned . was recently admitted to [name of hospital] r/t UTI and fecal impaction, guest has been having bowel movements, last BM today, received orders for new laxatives . Review of the Physician's History and Physical, dated 06/05/25, stated, . CT [computed tomography] scan [abdominal imaging procedure] showing a large stool burden - continue aggressive bowel regimen and enema . He [resident] states he has been having more trouble with stooling lately . he was given an enema in the ED [emergency department] . Review of Resident #117's bowel movement log showed a medium bowel movement on 06/01/25 and no further bowel movement prior to Resident #117's hospitalization on 06/05/25. The medical record failed to show staff initiated the bowel protocol on 06/04/25 (Day 3 -greater than 48 hours since last bowel movement) and failed to show nursing staff administered Senna or implemented any of the other interventions in the SHO after the resident failed to have a bowel movement after requesting prune juice. During an interview on 06/25/25, an administrative nurse (#1) confirmed the medical record lacked evidence nursing staff implemented the bowel management protocol interventions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a facility reported incident (FRI) investigation, record review, review of facility policy, and staff interview, the facility failed to ensure adequate supervision and/or monitoring for 1 of 1 sampled resident (Resident #49) with an elopement. Failure to identify the resident's risk for elopement and implement, monitor, and modify individualized resident-centered interventions when necessary placed all residents at risk for elopement and injuries.Findings include:The facility reported incident investigation, dated 06/15/25, stated footage showed Resident #49 exited the front doors of the facility at 6:31 p.m. and at 6:40 p.m., resident is seen walking in parking lot using her 4WW [wheeled walker] going east towards [NAME] street . The investigation stated a bystander notified the facility by phone at 8:01 p.m. of Resident 49's elopement and whereabouts. Review of the facility policy titled Elopement occurred on 06/26/25. This policy, dated December 2024, stated, . Purpose . To maintain safety of residents who are at risk of wandering and/or active elopement. Policy: Associates will engage in interventions to prevent wandering and active elopement. The nurse or social services will evaluate each resident's potential for wandering upon admission and as needed.Review of Resident #49's medical record occurred on all days of survey and identified admission to the facility on [DATE]. Diagnosis included dementia. The care plan, dated 06/16/25, stated, . I may wander about in my environment I have been known to exit seek and have a history of elopement.Resident #49's progress notes included the following:* 05/21/25 at 9:25 p.m. Guest is noted to be confused- talking about going 'upstairs' to get her stuff; looking for 'the car' that they used in the party last night; looking for people that her husband brought with him to their house tonight. Guest was reminded that she is currently in the nursing home; agreed to stay and sleep here tonight .* 05/23/25 6:48 at a.m. Presented to nurses station w/ [with] her water cup and a water bottle in her night gown. Said dhe (sic) was looking for water and found it. She is now heading to Bowling, SD [South Dakota]. She says her car is out front and she plans on taking that. I asked her if she would like to get dressed before she left and she agreed to that. Was walked back to her room and was able to be redirected.* 05/23/25 at 2:34 p.m. completed 5 day assessment: triggered severe for cognition .* 05/24/25 at 9:44 p.m. was noted wandering the hall ways, getting inside 151 room.* 5/26/25 at 1:23 p.m. has been noted to be wandering into the therapy room when no staff are in there without her walker.*05/26/25 at 8:41 p.m. was seen wandering around and was seen sitting at room [ROOM NUMBER].* 05/27/25 at 7:19 a.m. was found wandering in the 100's hall this AM after report. Unit doors were closed for safety.* 05/27/25 at 9:56 p.m. was found at 1930 [7:30 p.m.] standing with her walker outside 157's room. Stated she didn't know where she was.* 05/30/25 at 9:08 p.m. Noted to be wandering a lot this evening on the hallways .* 05/31/25 at 12:03 p.m. was found wandering on a neighboring unit . before lunch. Guest was brought back and doors to . unit were shut.* 06/01/25 at 8:42 a.m. has been found wandering off unit, in halls in other guests rooms.* 06/01/25 at 11:50 a.m. found at the end of the 50's hall standing facing the door.* 06/07/25 at 4:25 p.m. has been wandering throughout . halls excessively this afternoon. Occasionally goes to unlocked double doors and looks out. Stated she is 'trying to see where my car is so I can go home' . Has looked into several guests rooms .* 06/14/25 at 9:48 p.m. restless tonight.* 06/15/2025 at 8:45 p.m. exited the building at 6:30 pm with 4WW. Facility staff alerted via a telephone by bystander sitting on her walker off campus. I told bystander to stay with guest until staff got there. Author arrived and found guest sitting on her walker with bystanders. She was communicating with them, but noted to be confused and stated she was in Wisconsin. She appeared calm and not in distressed but fatigued. Resident then transferred into the car without issue. Upon return to facility guest was assessed, she was given a snack and fluids. VS [vital signs] and skin assessed. HS [hour of sleep] cares were done and guest requested her CPAP [continuous positive airway pressure]. Order obtained for a wander guard and the wander guard was placed on her Rt [right] wrist.Resident 49's medical record showed an initial care conference on 06/03/25 but failed to address the wandering. During an interview on 06/26/25 at 11:12 a.m., an administrative staff member (#1) verified the facility lacked documentation of an assessment of Resident #49's elopement risk related to the resident's behaviors after admission. The facility failed to reevaluate Resident #49's elopement risk when she began exhibiting wandering behaviors, looking for her car, and wanting to leave the facility, The facility failed to recognize the behaviors as possible signs of elopement and implement individualized interventions to prevent an elopement.

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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 2 sampled residents (Resident #12 and #117) in Enhanced Barrier Precautions (EBP). Failure to practice infection control standards related to EBP has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Enhanced Barrier Precautions occurred on 06/25/25. This policy, dated 04/01/24, stated, . Procedure: Enhanced Barrier Precautions expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated. It also refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi-drug resistant organisms] to staff hands and clothing. Enhanced Barrier Precautions: Applies to: All residents with any of the following: . Chronic wounds . urinary catheters . PPE used for these situations: During high-contact resident care activities . Transferring . Changing briefs or assisting with toileting . Chronic wound care: any skin opening requiring a dressing . - Review of Resident #12's medical record occurred on all days of survey. The care plan stated, . I require Enhanced Barrier Precautions r/t [related to] presence of indwelling foley catheter . Observation on 06/24/25 at 8:38 a.m. showed a nurse (#5) and a certified nurse aide (CNA) (#6) wore appropriate PPE in Resident #12's room while performing wound cares in bed. After completing the wound cares, the CNA (#6) removed her gown and gloves, performed hand hygiene, and applied new gloves. Without wearing a gown, the CNA assisted the nurse to place a sling underneath the resident and utilized a full body ceiling lift to transfer the resident to a recliner. - Review of Resident #117's medical record occurred on all days of survey. The resident's care plan stated, Problem . I require Enhanced Barrier Precautions r/t presence of indwelling foley . Observation on 06/24/25 at 9:30 a.m. showed two CNAs (#3 and #4) entered Resident #117's room, applied gloves, and without donning a gown, assisted the resident to transfer from his bed to the wheelchair. The CNAs (#3 and #4) failed to apply gowns prior to the transfer. During an interview on 06/26/25 at 8:53 a.m., an administrative staff member (#2) stated she expected staff to wear gowns during high-contact resident cares/transfers for residents on EBP.