STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on June 17, 2013 and completed on June 20, 2013, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	F323 #1) Nursing staff for Residents #6, #10, and #19 re-educated on proper gait belt use. #2) All direct care nursing staff re-educated on proper gait belt use. #3) Gait belt policy reviewed. Education of all direct care nursing staff, including return demonstration of proper gait belt use. #4) On or before July 25, 2013 #5) Quality Director, Clinical Coordinator or Restorative Nursing Coordinator will monitor for proper gait belt use weekly x4, monthly x2. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The Quality Director will submit a report of the audits to the QA committee and necessity of further monitoring will be determined.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident and staff interview, the facility failed to ensure adequate use of assistance devices to prevent accidents for 3 of 7 sampled residents (Resident #6, #10, and #19) observed transferred with a gait belt. Failure to properly use a gait belt placed the residents at risk for sustaining a fall and/or injury. Findings include: Review of the facility policy titled "Gait Belt Use" occurred on 06/20/13. This policy, revised March 2013, stated, "Purpose: Safe transfer and ambulation of residents. Procedure: 1. . . Apply	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Kemble — TITLE: Administrator — (X6) DATE: 7/8/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 the gait belt snuggly around the waist, over the clothing; it is best to position the belt under the abdominal girth if possible." Review of Resident #6's medical record occurred on June 17-20, 2013. The current care plan stated, "Problem: Falls. Approach: . . . transfer with assist of two and gait belt PRN [as needed]. The care plan contained no contraindications to the use of a gait belt. Observations of facility staff providing care for Resident #6 identified the following: *06/17/13 at 5:05 p.m., two CNAs (certified nurse aides) (#4 and #5) assisted Resident #6 to stand and walk to the dining room. A CNA (#4) placed the gait belt around the resident, just below the resident's bust line. The CNAs held onto her gait belt as she stood. The gait belt pulled up beneath Resident #6's breasts and slid up to her upper back as she stood and walked. *06/17/13 at 5:20 p.m. two CNAs (#4 and #5) assisted Resident #6 to transfer to the toilet. The gait belt pulled up beneath Resident #6's breasts and slid up to her upper back as she stood. Resident #6 transferred to the toilet as a CNA (#5) held the gait belt at the back and just below Resident #6's bust line. The Resident commented to the CNAs, "You are cutting off my boobs." *06/18/13 at 12:05 p.m., two CNAs (#4 and #5) assisted Resident #6 to walk to the dining room while holding the gait belt from behind. The gait belt rested just below the resident's bustline when she walked. *06/18/13 at 3:05 p.m., two CNAs (#4 and #5) applied a gait belt to the resident just below the bust line, assisted her to stand and pivot transfer from her bed to her wheelchair. Resident #6	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 stated, "It's cutting into me" as she grabbed at the gait belt. During an interview on 06/18/13 at 4:55 p.m., Resident #6 stated at times the gait belt used by the CNAs is too high and she tells them they are "cutting off my boobs." During an interview on 06/20/13 at 10:40 a.m., an administrative nursing staff member (#3) confirmed properly used gait belts are to be positioned at the waistline. - Review of Resident #10's medical record occurred on June 17-20, 2013. Current diagnoses included dementia. The quarterly Minimum Data Set (MDS), dated 04/02/13, identified the resident required supervision assistance of one person for transfers, the resident was independent in walking, and a fall occurred since the prior assessment. Resident #10's Falls Care Area Assessment, dated 07/05/12, identified the resident wandered, had unsteady balance, and a history of falls. The resident's current care plan also identified poor balance, unsteady gait, and a history of falls. Observations on 06/17/13 at 4:25 p.m. and on 06/18/13 at 9:25 a.m. and at 1:30 p.m. identified Resident #10 seated in an arm chair in his room. A certified nursing assistant (CNA) (#6) assisted him to stand by grasping his arm and pulling him to a standing position. The CNA (#6) guided the resident to his bed, lowered his pants and underwear to his knees, assisted him to lay down on the bed, and completed perineal cares. After perineal cares, the CNA (#6) assisted the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 resident to the edge of the bed, then assisted him to a standing position by pulling on his arm, pulled up his underwear and pants over his brief, and assisted the resident back to his arm chair. Observation on 06/18/13 at 5:50 p.m. identified Resident #10 seated on his bed. A CNA (#6) attempted to assist him to stand by pulling on his arm. After two attempts, the CNA (#6) obtained a gait belt, placed it around the resident's waist, assisted him to stand without pulling on his arm, and assisted him to ambulate out of his room. During interview, on 06/20/13 at 10:45 a.m., an administrative nursing staff member (#3) and a nursing management staff member (#7) confirmed and agreed the CNA (#6) should have assisted Resident #10 to stand with a gait belt instead of pulling on the resident's arm. Pulling on the resident's arm placed the resident and the staff at risk of injury. - Review of Resident #19's medical record occurred on June 19-20, 2013. The resident's medical diagnoses included cerebral vascular accident (CVA) with left side hemiplegia. The quarterly MDS, dated 04/15/13, identified extensive assistance of one person for transfers and toilet use. Resident #19's Falls Care Area Assessment, dated 01/14/13, identified impaired balance during transitions, and "is at high risk for falls; risk factors include intermittent confusion, balance problems while standing, decreased muscular coordination, jerking or unstable when making turns . . ."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 Resident #19's current care plan, identified "Impaired physical mobility: Hx [history] of falls and potential for recurrent falls related to poor balance and unsteady gait, CVA with L [left] hemiplegia, L hip fracture 1/8/12. Approach: . . . Transfer with assist of one. Hemi walker. . . L leg brace in shoe . . ." Observation on 06/20/13 at 8:15 a.m. showed a CNA (#8) assisted Resident #19 to transfer from the bed to the wheelchair. The CNA held the resident around the waist with her arms and did not use a gait belt. After wheeling the resident into the bathroom, the CNA then transferred the resident from the wheelchair to the toilet by holding onto the resident's waist with her arms. After the resident finished using the toilet, the CNA (#8) assisted the resident to his wheelchair by holding onto the belt loops of his jeans. Observations showed Resident #19 unsteady during these transfers.	F 323	F494 #1) Individual A re-educated regarding timely renewal of certification. #2) All licensed and certified nursing staff re-educated regarding timely renewal of licenses and certifications. #3) Upon hiring of staff, license or certificate expiration will be entered into payroll system. Monthly renewal lists will be generated and the staff scheduler will be notified 2 months prior to expiration of a license or certificate. The staff scheduler will communicate with the nursing staff that renewal is due, and then monitor for compliance of renewal.	
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent	F 494	#4) On or before July 25, 2013 #5) Quality Director or Staff scheduler will monitor monthly x2. Results will be reported to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Director will submit a report of the audits to the QA Committee and necessity of further monitoring will be determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 494	Continued From page 5 employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure 1 of 1 nursing assistant (Individual A) working with residents in the facility remained certified. Individual A provided 187.25 hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Review of employee files on 06/18/13 at 3:40 p.m. with an administrative staff member (#1) revealed Individual A's certification expired on 01/30/13. This nursing assistant worked with residents in the facility without certification for a total of 187.25 hours between 02/01/13 and 03/03/13. During an interview on the morning of 06/19/13, an administrative staff member (#2) verified Individual A's certification expired and the facility's process failed to identify the expired certification.	F 494		