

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355058		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2025	
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3400 NEBRASKA DRIVE BISMARCK, ND 58503			
(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			F 000			
F 609 SS=D	An unannounced onsite investigation survey regarding facility reported incidents was completed on 01/23/25. During the investigation the facility was found non-compliant with the regulatory requirements. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced			F 609			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/11/2025

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.

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F 609	Continued From page 1 by: Based on record review, review of the facility reported incident, review of facility policy, and staff interview, the facility failed to report an incident of abuse within 24 hours to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #2) who experienced an injury. Failure to report an event of potential abuse in the required time frame does not comply with regulations established to protect residents. This citation is considered past noncompliance based on review of the corrective action the facility implemented. Findings include: The surveyor determined a deficient practice existed on 11/02/24. The facility implemented and completed corrective action on 11/08/24. Review of the facility policy titled "Vulnerable Adult - ND [North Dakota]" occurred on 01/23/25. This policy, dated 10/14/22, stated, ". . . Report all alleged violations . . . no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the North Dakota Department of Health . . ." The facility investigation report stated, ". . . On Friday 11/01/24, at the afternoon social, resident [Resident #3] grabbed [Resident #2's] finger and bent it back. . . . Health Department . . . notified 11/04/24. . . ." Resident #2's nursing progress note, dated 11/02/24 at 10:18 a.m., stated, "Resident was in activities on Friday. During activities he had a	F 609	Past noncompliance: no plan of correction required.		

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F 609	Continued From page 2 fellow resident pull his right pointer finger. Now today the finger is swollen by the joint . . . He reports mild discomfort to the finger. . . ." During an interview on the afternoon of 01/23/25, an administrative nurse (#1) confirmed the facility failed to report this incident to the SSA within 24 hours. Based on the following information, noncompliance at F609 is considered past noncompliance. The facility implemented corrective actions as follows: * An email was sent to all facility staff on 11/05/24 defining abuse and to report any form of abuse to the manager and the SSA within 24 hours. * On 11/08/24, education related to abuse was assigned to all facility staff to be completed within one week. *Additionally, the facility directors and team leads were required to print off the email sent on 11/05/24, along with the definition of abuse and reporting guidelines, and have staff sign and acknowledge when they completed the education.	F 609			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689			2/14/25

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F 689	Continued From page 3 Based on observation, record review, review of the facility reported incident, review of the facility policy, and staff interview, the facility failed to ensure a resident received adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #1) investigated for a fall. Failure to ensure staff used a mechanical lift properly and verified proper installation of attachments to the Broda chair (specialized wheelchair) resulted in a fall from the mechanical lift. Finding include: Review of the facility policy titled "Floor based, Full Body Sling Lift use" occurred on 01/23/25. This policy, dated 10/27/21, stated, ". . . Transfer resident from chair to bed . . . Push the "UP" button on the hand control for the lift until there is slight tension on the sling loops. PERFORM SAFETY CHECK i. Once there is tension on the loops, double check each loop to be sure each is securely in the hook. ii. Double-check the position and stability of all straps and other equipment. . . . v. Lift the resident about 2 inches off the surface and verify that weight is evenly spread between the straps of the sling. vi. Verify the resident will not slide out of the sling or tip backward or forward. Review of the facility reported incident, stated, ". . . At approximately 1815 [6:15 p.m.] on 1/4/25, a resident, [Resident #1], was involved in a witnessed fall during a transfer with a full body lift. The nurse on duty was promptly notified and called to the resident's room. The CNAs [certified nurse aides] involved in the incident [CNA names], explained that they were transferring the	F 689	1. Targeted training provided to the direct care staff involved in the incident involving resident #1 on 1/4/25 and 1/7/25. Individual competencies completed with the staff members involved on these dates. 2. All residents who utilize full body lifts accompanied by a Broda chair for transfer have the ability to be affected by the same deficient practice. Any resident using a Broda chair has the ability to be affected by the improper installation of the stand assist bars. 3. Floor based, Full Body sling lift use policy and EZ Way Smart Lift (Hoyer) competency Checklist reviewed on 1/4/2025. No changes were necessary. All staff received education regarding proper use of the full body lift via email to all staff on 1/4/25 following the described incident. In addition to reading the email, all staff licensed to perform resident transfers were expected to read the policy titled Floor-based, Full Body Sling Lift Use and also review the competency. Staff were also instructed to sign the email and return to management. On 1/7/25 and 1/9/25, during an all staff survey preparation meeting, staff were once again re-educated on safe transfers using the full body lift. On 1.28.25, the stand assist bars were removed from the Broda Chair in use for resident #1. On 2.11.25, Occupational Therapists reviewed all Broda chairs in		

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F 689	Continued From page 4 resident from a broda wheelchair to the bed using a full body lift per the residents [sic] care plan. During the transfer, the residents [sic] sling became caught on part of the wheelchair. In an attempt to free the sling, the CNA moved the resident's wheelchair, causing the lift to become unbalanced. As a result, the lift struck the CNA in the head, and a portion of the lift subsequently made contact with the residents [sic] face. This impact caused a skin tear above the resident's right eye and on the bridge of his nose. The lift then tipped over on its left side and fell onto the floor causing the resident to fall from a height of about 3 feet onto his bottom while still in the sling. . . . The resident reported no pain, aside from discomfort related to the skin tear. A raised area potentially a hematoma was noted to residents [sic] back. . . ." Resident #1's nursing progress notes stated the following: * 01/04/25 at 8:10 p.m. "After further assessment this nurse found a lump on the resident's right lower back, upon palpation resident said bump was painful. No redness or bruising was found at this time and bump was blanchable. Family was called and updated and consented to sending in. This nurse called on call to get order to send resident in for further assessment. Metro ambulance arrived about 2100 [9:00 p.m.] . . ." * 01/05/25 at 3:15 p.m. "This nurse spoke with resident's wife, [name]. Per [wife's name], the sutures above resident's right eye are dissolvable." An email from the facility's purchasing employee, dated 01/14/25, stated, "[Staff member name] and I met and looked at chair [Resident #1's	F 689	the facility to be sure that none of them had the stand assist bars attached. On 2.12.25, education will be provided to maintenance staff and therapy staff that all new specialty chairs such as Broda chairs must be approved by therapy upon arrival to the facility before being put into service. Therapy will ensure that chairs do not have the stand assist bars on them before putting them into use. 4. Quality assurance nurse or designee will complete random audits of transfers for each Broda chair while using the full body lift per policy and procedure. These audits will also verify the absence of stand assist bars. These audits will be completed weekly times 4 weeks, monthly audits x 4months. Present trends and findings will be reported to QA&A for further guidance on audit needs. 5. Date of Correction 02/14/2025		

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F 689	Continued From page 5 Broda chair]. . . I found the handles at the end of arm rest were placed upside down which could have been where the sling got caught, but I'm not sure. I adjusted them to the proper placement. . . ." An Occupational therapist note, dated 12/09/24 at 5:02 p.m., stated, "Review of broda chair . . . Resident continues using the broda chair for comfort per family request. . . ." (The therapist failed to mention the handles at the end of the arm rests.) During an interview on the afternoon of 01/23/25 while observing Resident #1's Broda chair an administrative nurse (#1) explained that the handles on the resident's Broda chair were turned downwards and therefore the sling could have easily been caught on these handles. This staff member was unsure how long the handles had been on the Broda chair and if the resident utilized the handles.			F 689			