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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 For the standard Medicare/Medicaid recertification survey and complaint survey, started on 01/05/15 and completed on 01/08/15, the sample included five (5) residents for complete review, 16 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	F 309 1) Re-educate staff for resident #10 regarding the necessity of daily documentation of bowel status and following the bowel management policy. Resident #23 is no longer in the facility.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 1 sampled resident (Resident #10) and 1 closed record resident (Resident #23) who did not have a bowel movement (BM) for five to eight days. Failure to follow the facility bowel protocol to relieve constipation has the potential to cause these residents unnecessary discomfort and fecal impaction. Findings include: Review of the facility protocol titled "BOWEL MANAGEMENT" occurred on 01/08/15. This	F 309	2) All residents have the potential to be affected. 3) Review and revise facility policy titled "Bowel Management". Re-educate all nursing staff regarding the necessity of involving Dietary department in bowel management, the necessity of daily documentation regarding bowel status, and any revisions to the bowel management policy. 4) On or before February 12, 2015. 5) Quality Nurse or designee will monitor for appropriate documentation and bowel management interventions weekly x4 and monthly x2. Results will be communicated immediately to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
August People, administrator		02/04/2015

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 309	Continued From page 1 protocol, revised December 2013, stated, ". . . PROCEDURE: 1. Document bowel movement daily. Report any unusual characteristic [sic] to nurse. 2. If no bowel movement by day 3 consider MOM [milk of magnesia] or suppository. 3. If no bowel movement by day 4 consider suppository. 4. If no bowel movement by day 5 consider fleets enema. 4. [sic] Daily Nurse review of bowel report. 5. Bowel Program: A. Notify Dietician *Increase fluid intake *Increase dietary fiber *Other interventions as deemed appropriate . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included constipation. Current medications to manage constipation included scheduled MOM and as needed (PRN), Dulcolax suppository PRN, and a Fleets enema PRN. Discontinued orders included Colace daily from 07/07/14 to 12/18/14 and then twice daily from 12/18/14 to 12/22/14. Resident #10's current care plan stated, "Problem: . . . Alteration in elimination: Constipation . . . Approach: . . . Follow bowel protocol if no BM in 3 days." Review of Resident #10's nutritional assessment, dated 12/23/14, identified dietary interventions to relieve constipation would not be effective due to poor meal intake. Review of Resident #10's bowel records identified a bowel movement (BM) on 11/05/14 and not again until 11/13/14 (seven days without a BM). The medication administration record (MAR) failed to show Resident #10 received any PRN medications to manage constipation until the administration of MOM on 11/12/14 and a	F 309	Quality Nurse will submit a report of the QA monitoring to the QA committee at each scheduled meeting 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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 309	Continued From page 2 suppository on 11/13/14. - Review of Resident #23's closed medical record occurred on January 07-08, 2015. Diagnoses included constipation. Daily medications included Senna for bowel management. PRN medications to manage constipation included Dulcolax tablet and Dulcolax suppository. Resident #23's care plan stated, "Problem: Alteration in elimination: Constipation . . . Approach: . . . Follow bowel protocol if no BM in 3 days." Review of Resident #23's nutritional assessment, dated 10/02/14, failed to identify interventions to prevent constipation. Review of Resident #23's bowel records identified a BM on 11/11/14 and not again until 11/20/14 (eight days without a BM). The MAR showed Resident #23 received PRN Dulcolax tablets on 11/15/14 and 11/18/14. Resident #23's bowel records identified a BM on 12/18/14 and not again until 12/24/14 (five days without a BM). The MAR showed Resident #23 received PRN Dulcolax tablets on 12/21/14 and 12/22/14. During an interview on 01/08/15 at 2:05 p.m., an administrative staff member (#4) provided no further information regarding the above findings. Facility staff failed to administer a bowel stimulant for Resident #10 and #23 according to facility protocol; failed to update dietary; and failed to implement other interventions, such as providing fluids.	F 309		

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 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/procedure review, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 6 sampled residents (Resident #14) and 1 supplemental resident (Resident #25) observed during transfers. Failure to use gait belts properly during transfers, placed residents at risk of injury and/or accidents. Findings include: Review of the facility policy titled "Gait Belt Use" occurred on 01/8/14. This policy, dated 2013, stated, "Purpose: Safe transfer and ambulation of residents Procedure: . . . 1. Apply the gait belt snugly around the waist . . . 3. Bring the resident to a standing position, using one or two hands. Do not lift resident under their arms during transfers. . . ." Review of Resident #14's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's dementia. The current Minimum Data Set (MDS), dated 11/03/14,	F 323	F 323 1) Re-educate staff for resident #14 and #25 on the appropriate use of gait belts per gait belt policy. 2) Any resident that requires the use of gait belts during transfer has the potential to be affected. 3) Review facility policy titled "Gait Belt Use". Educate all nursing staff on the appropriate use of gait belts per gait belt policy. 4) On or before February 12, 2015 5) Quality Nurse or designee will monitor for appropriate gait belt use weekly x4 and monthly x2. Results will be communicated immediately to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Nurse will submit a report of the QA monitoring to the QA committee at each scheduled meeting 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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 323	Continued From page 4 identified extensive assistance of one staff for transfers. The care plan stated, ". . . Problem: . . . Impaired physical mobility: . . . Approach: . . .Pivot transfer with 1 assist, If unable to stand with pivot transfer notify the Nurse for assessment need of standing lift. . . ." Observation on 01/07/14 at 12:04 p.m., showed one CNA (#3) lifted under the resident's right axilla and the other CNA (#2) used gait belt which slid up the resident's back to her shoulders and transferred Resident #14 onto the toilet. While on the toilet, the CNA (#3) tightened the gait belt around Resident #14's waist. Both CNA's (#2 and #3) transferred Resident #14 from the toilet by lifting under the resident's axilla. The CNA's failed to follow Resident #14's care plan and to properly tighten the gait belt and avoid lifting under the resident's arms. - Review of the medical record for Resident #25 occurred on 01/08/15. A quarterly MDS, dated 09/14/14, identified Resident #25 required extensive assistance of one staff member for transfers, walking in the corridor, and locomotion on the unit. The current care plan stated "Problem: Impaired physical mobility . . . Transfer with assist of 1 and front wheeled walker (FWW). Walk to Dine with FWW and assist of 1. . . ." Observation, on 01/06/15 at 9:30 a.m., showed a CNA (#1) assisted Resident #25 from a sitting to standing position by pulling on her arm. The CNA (#1) failed to use the gait belt around the resident's waist. The resident did not stand on the first attempt. The CNA (#1) then held the gait belt and Resident #25's arm and assisted her to stand.	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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 323	Continued From page 5 The CNA (#1) failed to assist Resident #25 to stand using the gait belt as per facility policy. During an interview on 01/07/15 at 4:30 p.m., an administrative staff member (#4) confirmed staff failed to properly use the gait belt and should not lift under a resident's arm when assisting them to transfer.	F 323	F 329 1) Re-educate staff for resident #14, 17, & 18 regarding the use of non-pharmacological behavioral interventions prior to administering PRN psychotropic medications. Resident #21 is no longer in the facility.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	2) Any resident that requires the use of PRN antipsychotics has the potential to be affected. 3) Review and revise facility policy titled "Psychotropic Drug Use". Educate all staff on the policy and the necessity of using non-pharmacological behavioral interventions prior to administering PRN antipsychotic medications. 4) On or before February 12, 2015 5) Quality Nurse or designee will monitor for appropriate use and documentation of non-pharmacological behavioral interventions prior to administering PRN antipsychotic medications weekly x4 and monthly x2. Results will be communicated immediately to the Director of Nursing. If	

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 329	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, and review of facility policy, the facility failed to ensure a medication regimen free from unnecessary medications for 4 of 10 sampled residents (Resident #14, #17, #18, and #21) who received as needed (PRN) antianxiety medications. Failure to provide non-pharmacological interventions prior to the use of medications may result in residents receiving unnecessary medication and possible adverse reactions. Findings include: Review of the facility policy titled "Psychotropic Drug Use" occurred on 01/08/15. This policy, undated, stated, ". . . Antipsychotics are not used unless necessary to treat a specific condition as diagnosed and documented in the record, based on the comprehensive assessment. . . . behavioral interventions are attempted unless contraindicated. . . . Each resident's record will include behavior monitoring and a description of the behavior to be modified. . . ." - Record review for Resident #21 occurred January 07-08, 2015. Diagnoses included Alzheimer's disease, dementia with behavioral disturbances, depression, and anxiety. A quarterly Minimum Data Set (MDS), dated 12/03/14, identified the resident with severely impaired cognition, and exhibited no behavioral symptoms. Current physician orders included an order for PRN Ativan (an antianxiety medication) 0.5 mg (milligrams) every four hours for restlessness and/or complaints of agitation.	F 329	concerns are identified immediate corrective action will be implemented. The Quality Nurse will submit a report of the QA monitoring to the QA committee at each scheduled meeting 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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 329	Continued From page 7 The current care plan, stated: "Problem . . . Mood and behavioral symptoms related to anxiety and depression. . . . Approach . . . Encourage [Resident #21] to share her feelings, concerns, inability to sleep and unusual lethargy and frustrations re [regarding]: her care and routine. Provide support and encouragement and work to build a trusting relationship and rapport with her. [Resident #21] enjoys visiting about her family and especially loves receiving compliments. Encourage her to come to the DR [dining room] for lunch and supper meals allowing adequate time for applying make-up. Responds well to compliments. Encourage [Resident #21] to share her feelings, . . . provide support and reassurance as needed. Reassure resident when she is exhibiting anxiety." Review of Resident #21's medication administration record (MAR) from 10/01/14 through 01/08/15 showed nursing staff administered PRN Ativan without identifying attempted non-pharmacological interventions on the following occasions: * 11 of 11 times in October; * 6 of 8 times in November; * 6 of 11 times in December; and * 1 of 1 time in January. - Review of Resident #14's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and agitation. The current MDS, dated 11/03/14, identified severely impaired cognition with behaviors occurring daily. Resident #14's medications included Ativan 0.5 mg every four hours as needed for severe agitation. Resident #14's care plan stated, ". . . Problem: . .	F 329		

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 329	Continued From page 8 . Agitation and Anxiety . . . Approach . . . Staff will attempt to divert her attention through visitation over her photo albums, reading devotionals, taking her outdoors, swinging in the glider, offering snacks, offering exercises to do, engaging in conversation, putting puzzles together, folding laundry . . ." Review of Resident #14's MAR from 10/01/14 through 01/06/15 showed nursing staff administered PRN Ativan without attempting non-pharmacological interventions on the following occasions: * 7 of 11 times in October (given once for sleep) * 4 of 6 times in November * 5 of 8 times in December * 2 of 4 times in January - Review of Resident #17's medical record occurred on January 08-09, 2015. Diagnoses included Alzheimer's dementia and anxiety. The current MDS, dated 11/09/14, identified the resident with moderately impaired cognition. Resident #17's medications included Ativan 0.5 mg every four hours as needed for anxiety. Resident #17's care plan stated, ". . . Problem: Mood and behavioral symptoms related to dementia and anxiety. . . Approach: . . . Attempt to distract him to another topic of conversation (for example, he enjoys visiting about the family picture in his room and the picture of his home . . . When fidgeting or restless, take him for a wheelchair ride around the neighborhood or facility to provide distraction. Attempt to address his need . . . He enjoys watching sports in this room . . ." Review of Resident #17's MAR from 11/07/14	F 329		

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 329	Continued From page 9 through 01/08/15 showed nursing staff administered PRN Ativan without attempting non-pharmacological interventions on the following occasions: * 2 of 5 times in November * 12 of 13 times in December (given six times for sleep) * 2 of 2 times in January (1 time given for sleep) - Review of Resident #18's medical record occurred on 01/08/14. Diagnoses included dementia and agitation. The current MDS, dated 10/15/14, identified severely impaired cognition. Resident #14's medications included Ativan 0.25 mg every six hours as needed for anxiety. Resident #18's care plan stated, " . . . Problem: . . . Mood and behavioral symptoms related to dementia, anxiety . . . Approach: . . . Monitor for [Resident #18's] sleep at night and offer reassurances and other non-pharmacological approaches such as toileting her, offering hot milk, back rub, reading the Bible, visiting with her about her family . . . " Review of Resident #18's MAR from 10/01/14 through 01/08/15 showed nursing staff administered PRN Ativan without attempting non-pharmacological interventions on the following occasions: * 3 of 7 times in October * 5 of 7 times in November (given three times for sleep) * 2 of 3 times in December (given once for sleep) * 1 of 1 time in January Nursing staff failed to consistently attempt non-pharmacological, person-centered interventions prior to the administration of a PRN	F 329		

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 329	Continued From page 10 antianxiety medication which placed Resident #14, #17, #18, and #21 at risk of receiving unnecessary psychoactive medication.	F 329	F 333 1) The nurse for resident #26 immediately re-educated regarding "Insulin Injection Guidelines" found within the policy titled "Diabetes Management". 2) Any resident that receives rapid acting insulin has the potential to be affected. 3) Review "Diabetes Management" policy. Re-educate all nursing staff on the policy titled "Diabetes Management". 4) On or before February 12, 2015. 5) Quality Nurse or designee will monitor that residents receiving rapid acting insulin have a meal or nourishment provided within 15 minutes. The Quality Nurse or Designee will monitor weekly x4 and monthly x2. Results will be communicated immediately to the Director of Nursing. If concerns are identified immediate corrective action will be implemented. The Quality Nurse will submit a report of the QA monitoring to the QA committee at each scheduled
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure administration of insulin occurred within the ordered/recommended times for 1 of 2 sampled resident (Resident #26) observed during insulin administration. Failure to administer Humalog (a rapid-acting insulin) at the correct time may result in low blood sugar levels (hypoglcyemia). This practice may negatively impact all diabetic residents residing at the facility. Findings include: "Nursing 2015 Drug Handbook," 35th edition, Wolters Kluwer, Philadelphia, pages 756-757, reviewed on 01/08/15, stated the following, ". . . Humalog . . . Inject subcutaneously within 15 minutes before or after a meal. . . ." Review of the facility policy titled "INSULIN INJECTION GUIDELINES" occurred on 01/08/15. This policy, revised June 2014, stated, ". . . When a resident has scheduled rapid acting insulin the injection may be held if there is reason to believe resident's meal consumption may be delayed. If	F 333		

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 _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	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 333	Continued From page 11 insulin has been given and meal consumption is delayed for more than 10-15 minutes, staff should consider offering resident carbohydrates such as 1/2 glass of juice or milk. . . ." Observation of medication pass on 01/06/15 at 5:25 p.m. showed a nurse (#6) administered six units of Humalog insulin to Resident #26. The resident received her meal at 5:55 p.m. (30 minutes after the insulin administration). Facility staff failed to ensure Resident #26 received a nourishment (carbohydrate) or meal within 15 minutes of rapid-acting insulin administration. This may result in unstable blood sugar levels for Resident #26 and other insulin dependent residents in the facility. During an interview on 01/08/15 at 11:18 a.m., an administrative nurse (#4) confirmed a meal or nourishment should be offered after the administration of a rapid-acting insulin.	F 333	meeting and necessity of further monitoring will be determined.	