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 _____	03/08/2018

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 The standard Medicare/Medicaid recertification survey started on 03/06/18 and concluded on 03/08/18.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 1 supplemental resident (Resident #48) observed during medication administration. Failure to crush medications as ordered by the physician has the potential to affect Resident #48's safety and placed her at risk for aspiration. Findings include: Review of facility policy titled "Medication Administration and Documentation" occurred on 03/08/18. This policy, dated 10/2017, stated, " . . . If the resident is unable to swallow a pill, obtain an order from the resident's physician and document on the care plan that the pill may be crushed or capsule opened and placed in some other medium to facilitate swallowing; OR nurse may consult with consulting pharmacist to consider the use of alternative forms that may be available for this medication. Contact Physician for applicable order. . . ."	F 658	1. A. Added "May crush all medications, except for Potassium which may be dissolved or crumbled" to Resident #48'□s electronic Medication Administration Record Administration Notes. B. Already had a physician'□s order, dated 01/11/18, which stated "If OK with pharmacy, OK to crush all medications." Our consultant pharmacist reviewed this resident□'s medications on 01/22/18 and wrote a progress note identifying all meds may be crushed and combined as needed except for Potassium (should be crumbled or dissolved). C. Resident'□s care plan, dated 01/30/18, already identified the resident'□s medications were crushed. D. During the week of survey, it was verbally communicated to Prairie View CMAs to crush this resident□'s medications. 2. All residents who need their	4/12/18

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

Electronically Signed | 03/30/2018

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F 658	Continued From page 1 Review of Resident #48's medical record occurred on 03/08/18. Diagnoses included Alzheimer's disease, dementia, and generalized anxiety disorder. A physician's order, dated 01/11/18, stated, "If OK with pharmacy, OK to crush all medications." A pharmacy review, dated 01/22/18 stated, ". . . All medications . . . may be crushed and combined as needed to meet the resident's needs . . . Do Not crush potassium tablet . . ." Resident #48's care plan stated, "Problem . . . Crushed medication administration due to resident's dx [diagnosis] of Alzheimer's and dementia with behavioral disturbances . . . Approach . . . Combine crushed medications together and give all at once to increase medication consumption. . . . " During the medication pass on 03/08/18 at 10:04 a.m., observation showed a certified medication assistant (CMA) (#8) administered Resident #48's medications whole, not crushed. The resident started to chew her medications, had a difficult time swallowing them and started to gag, cough and spit them out. The CMA (#8) collected the unconsumed medications, and reported the incident to the licensed nurse (#4). The CMA (#8) documented the resident refused her medications. During an interview on 03/08/18 at 2:52 p.m., an administrative nurse (#2) stated she expected staff to crush Resident #48's medications. Another administrative nurse (#4) agreed, stating the resident has a history of attempting to chew	F 658	medications crushed have the potential to be affected by the same deficient practice. 3. A. We reviewed the following for all residents in our facility who need their medications crushed to ensure compliance: physician orders, Administration Notes on eMAR, care plan, pharmacy review and ensured staff were correctly crushing with administration. B. All CMAs and nurses will be re-educated on the aspects of crushed medication administration on April 10 and 11th, 2018. 4. Audits on all residents with crushed medications will be completed by the Quality Assurance Nurse or a designee. The audits will begin on 04/03/18 and will be done three times a week for one month, three per month for two months and then three per quarter for three quarters. Results will be reported to the QA Committee quarterly. 5. Compliance date 04/12/18.	

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F 658	Continued From page 2 her medications.	F 658		
F 689 SS=D	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: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #57) observed during a gait belt transfer. Failure to utilize the gait belt during transfers placed Resident #57 at risk of an accident and/or injury. Findings include: Review of the facility policy titled "Gait Belt Use" occurred on 03/08/18. This policy, dated January 2015, stated, "Purpose: Safe transfer and ambulation of residents. Procedure: 1. Apply the gait belt snugly around the waist . . . 3. Do not lift resident under their arms during transfers. . . ." Observation on 03/06/18 at 5:01 p.m. showed a certified nursing assistant (CNA) (#5) placed a gait belt around Resident #57's waist. The CNA (#5) and an unidentified CNA transferred Resident #57 from the bed to the wheelchair. As the CNA (#5) lifted the resident under the	F 689	1. Resident #57 requires assistance of one staff member and a gait belt for transfers. 2. All residents who require a gait belt for transfers have the potential to be affected by the same deficient practice. 3. All nursing staff, restorative nursing staff and activity staff will be re-educated on the proper use of gait belts on 04/10/2018 and 04/11/2018. 4. Audits on gait belt transfers will be completed by the Quality Assurance Nurse or a designee starting on 04/03/2018. Audits will be done five times weekly for 4 weeks, five times monthly for two months and then five times quarterly for 3 quarters. Results will be reported to the QA Committee quarterly. 5. Compliance date: 04/12/2018.	4/12/18

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F 689	Continued From page 3 resident's right arm and the resident yelled, "Don't pull so hard." A few minutes later both CNAs assisted Resident #57 off of the toilet and CNA (#5) lifted the resident under his left arm. The CNA (#5) failed to use the gait belt when transferring Resident #57. Observation on 03/07/18 at 8:31 a.m. showed a CNA (#6) placed a gait belt around Resident #57's waist. As the CNA (#6) transferred Resident #57 off of the toilet she lifted under the resident's left arm and failed to use the gait belt during the transfer. During an interview on 03/08/18 at 9:15 a.m., an administrative nurse (#2) stated she expects staff to use the gait belt during a transfer and not to lift under the resident's arm.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		4/12/18

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F 812	Continued From page 4 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store food under safe and sanitary conditions in 1 of 1 walk-in coolers in the facility kitchen. Failure to store foods properly increase the risk of cross-contamination of food items that may result in a food borne illness. Findings include: Review of the facility policy titled "Refrigerator/Cooler and Freezer Storage" occurred on 03/08/18. This policy, revised November 2017, stated, ". . . Store foods in ways that prevent cross-contamination. Store refrigerated raw meat, poultry and seafood separately from ready-to-eat-foods. If raw and ready-to-eat foods cannot be stored separately, store foods in the following top to bottom order. Ready-to-eat foods, Seafoods, Whole cuts or beef or pork, Ground meat and ground fish, Whole and ground poultry . . ." Observation of the walk-in cooler on the afternoon of 03/06/18 showed 3 raw turkey roasts in one tub stored on a shelf above raw ground meats. Later in the afternoon, observation showed the tub of turkey roasts moved to the correct shelf (a shelf below raw ground meat). During an interview on 03/08/18, a dietary supervisor (#3) confirmed the turkey roasts should have been stored on the bottom shelf of	F 812	1. The raw turkey roasts were moved to the correct bottom shelf on 03/06/18 and staff working were immediately educated. 2. All residents who eat food stored and prepared from the kitchen have the potential to be affected by the same deficient practice. 3. A sign was already posted in the kitchen prior to survey identifying the proper order to store meat in the walk-in cooler. All dietary staff were verbally informed on 3/07/2018. Formal education will occur at the all staff meeting on 04/10/2018 and 04/11/2018. 4. Audits will be conducted by the Dietary Manager or a designee starting on 04/03/2018. Audits will be conducted twice a week for four weeks, twice a month for two months and twice a quarter for three quarters. Results will be reported to the Quality Assurance Committee quarterly. 5. Compliance date 04/12/2018.	

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F 812	Continued From page 5 the rack in the refrigerator. Failure to store foods in a clean and sanitary manner placed residents, visitors, and staff at risk for foodborne illness.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		4/12/18

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F 880	Continued From page 6 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 880	1. Resident #12, #38, #40, #41, #52,	

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F 880	Continued From page 7 facility policy/procedure, and staff interview, the facility failed to follow infection control practices for 8 of 26 sampled residents (Resident #38, #40, #41, #52, #57 #73, #77, and #533), and 1 supplemental resident (Resident #12). Failure to follow infection control practices of hand hygiene during toileting/personal care (Resident #38, #40, #41, #52, #73, and #533), medication administration (Resident #12), foley catheter care (Resident #57), and when using medical equipment (Resident #77) has the potential to spread infection to other residents, personnel, and visitors. Findings include: HAND HYGIENE Review of the facility policy titled "Hand Hygiene" occurred on 03/08/18. This policy, dated January 2014, stated, "It is the policy of the facility that hand washing/alcohol based rub be regarded as the single most important means of preventing the spread of microorganisms and transmission of infection. All personnel shall follow hand hygiene policies and procedures to prevent the spread of infection and disease to residents, visitors, and other personnel . . . perform hand hygiene . . . Before and after assisting a resident with toileting; After performing peri-care and resident is safe, remove gloves and complete hand hygiene . . . After removing gloves or aprons. . . ." - Observation on 03/07/18 at 7:32 a.m. showed a nurse (#15) performed a head to toe skin assessment of Resident #533 during her morning cares. The nurse (#15) cleansed, dried and	F 880	#57, #73, #77 and #533 had the potential to be affected during the deficient practice found during survey. 2. All residents in the facility have the potential to be affected by improper infection prevention and control practices. 3. All nursing staff will be re-educated on hand hygiene after toileting/personal cares, glove usage, medication administration, indwelling urinary catheter care and dating and timing all enteral feedings when hung. This in-service is scheduled for 04/10/2018 and 04/11/2018. 4. Random audits observing all areas identified by the survey team will be conducted starting on 04/03/2018. Audits will be conducted ten times a week for four weeks, ten times a month for two months and ten times per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or a designee and results will be reported to the Quality Assurance Committee quarterly. 5. Compliance date: 04/12/2018.	

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F 880	Continued From page 8	F 880		

bandaged the resident's right great toe and then removed her gloves. The nurse (#15) failed to perform hand hygiene after removing her gloves and prior to applying new ones.

- Observation on 03/07/18 at 8:00 a.m., showed a certified nursing assistant (CNA) (#16) entered Resident #38's room to assist an unidentified CNA with peri cares. One of the CNAs (#16) provided Resident #38's incontinent bowel movement (BM) cares, removed her visibly soiled gloves, and applied new gloves. The CNA (#16) failed to perform hand hygiene after removing her gloves and prior to applying new ones.

- Observation on 03/07/18 at 10:46 a.m., showed a CNA (#11) provided Resident #73 incontinent (BM) cares, and then applied an ointment to her buttocks. The CNA (#11) removed her gloves and assisted another CNA (#12) in transferring the resident to her wheelchair. The CNA (#11) failed to perform hand hygiene after removing her gloves and prior to the transfer.

- Observation on 03/07/18 at 10:56 a.m. showed two CNAs (#9 and #10) provided Resident #41's incontinence (BM) cares. Both CNAs gloves became soiled with BM during the observation. The CNAs removed their soiled gloves, applied new ones, and continued to assist Resident #41 with additional morning cares. The CNAs (#9 and #10) failed to perform hand hygiene after removing their soiled gloves and prior to applying new ones.

- Observation on 03/07/18 at 11:40 a.m. showed a CNA (#13) provided Resident #52 incontinence (BM) cares while another CNA (#11) assisted in

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F 880	Continued From page 9	F 880		

rolling the resident side to side. Both CNAs removed their gloves. One of the CNAs (#13) washed her hands while the other CNA (#11) transported Resident #52 to the dining room via wheelchair. The CNA (#11) failed to perform hand hygiene prior to exiting the resident's room.

- Observation on 03/07/18 at 3:38 p.m. showed a CNA (#14) removed Resident #40's brief, wet with urine, provided peri care, applied a new brief, and removed her gloves. The CNA (#14) then transferred Resident #40 to his wheelchair utilizing a sit-to-stand lift, applied foot pedals to his wheel chair, removed his nasal cannula, placed the tubing in a bag by the oxygen concentrator, retrieved a different nasal cannula from the bag hanging on the back of the wheelchair and applied the cannula to the resident. The CNA (#14) failed to perform hand hygiene after removing her gloves and prior to performing other tasks.

During an interview on the afternoon of 03/07/18, an administrative staff member (#7) stated she expected CNAs to perform hand hygiene after removing their gloves and prior to providing other resident cares.

MEDICATION ADMINISTRATION

- Observation on 03/07/18 at 8:44 a.m. showed a CMA (certified medication aide) (#1), preparing Resident #12's medication. The CMA (#1) stuck her bare finger into the medication envelopes to open them, dispensed medications into the envelopes, crushed the medications, stuck her bare fingers into the envelopes to open them and poured the contents into medication cups. The

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F 880	Continued From page 10 CMA (#1) performed this action with four different medications. During an interview on 03/08/18 at 1:50 P.M., two administrative nurses (#2 and #4) indicated it is not acceptable infection control practice for staff to stick their bare fingers in the medication envelopes. FOLEY CATHETER CARES - Observation on 03/07/18 at 8:31 a.m. showed Resident #57 sitting on the toilet with his Foley catheter disconnected from the leg bag. The tip of the leg bag extended downward, touching the back of the resident's leg. After donning gloves and without cleaning the tip of the leg bag, the CNA (#6) reconnected the leg bag to the Foley catheter. During an interview on 03/07/18 at 9:31 a.m., an administrative nurse (#7) stated she would expect staff to clean the port of the bag with an alcohol swab before reconnecting it to the Foley catheter. MEDICAL EQUIPMENT Review of the policy titled, "Enteral Feeding Tube (EFT) Use and Care" occurred on 03/07/2018. This policy, revised October 2017, stated, ". . . Mark with the date they were first opened. . . ." - Observation on 03/06/18 at 11:29 a.m., showed staff failed to label Resident # 77's enteral tube feeding, with the date and start time of her feeding. Failure to label the tube feeding with the start date increased the risk of loss of nutritional	F 880		

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F 880	Continued From page 11 value, bacterial growth, and or contamination During an interview on the afternoon of 03/07/18, an administrative staff member (#7) stated she expected staff to label enteral tube feedings with the date and start time of the feedings.	F 880		