| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355058 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/22/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BAPTIST HEALTH & REHAB | 3400 NEBRASKA DRIVE , BISMARCK, North Dakota, 58503 |

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| F0000 | INITIAL COMMENTS<br><br>An unannounced onsite investigation survey regarding a facility reported incident (FRI) and a complaint was completed on July 16-22, 2025. During the FRI investigation, the facility was found noncompliant with regulatory requirements. During the complaint investigation the facility was found in compliance with regulatory requirements.<br><br>Based on the results of the investigation survey, an extended survey was conducted on July 22, 2025. | F0000 | | |
| F0695<br>SS = SQC-J | Respiratory/Tracheostomy Care and Suctioning<br><br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br><br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on review of a facility reported incident (FRI) investigation, record review, policy review, and staff interview, the facility failed to provide appropriate respiratory care for 1 of 1 closed resident record (Resident #1) who required respiratory support from a ventilator. Failure to provide care consistent with professional standards of practice and the physician's orders may have resulted in or contributed to Resident #1's death and placed all other ventilator-dependent residents at risk of injury or death. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following discovery of the incident.<br><br>The State Survey Agency (SSA) conducted an on-site investigation and determined an Immediate Jeopardy (IJ) situation existed on 07/15/25 when a nurse (#3) delegated a non-qualified staff member (#2) to turn off | F0695 | "Past Noncompliance - no plan of correction required" | |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0695 SS = SQC-J | Continued from page 1<br>Resident #1's ventilator, and the nurse (#3) failed to disconnect the resident from the ventilator and deflate the tracheostomy cuff. The survey team notified the administrator and the director of nursing (DON) of the IJ, provided the IJ template, and requested a plan for removal of the IJ on 07/21/25 at 12:52 p.m. The SSA received the removal plan on 07/21/25 at 1:16 p.m. and accepted the removal plan and verified implementation at 2:40 p.m. The survey team confirmed by interview and record review the facility removed the IJ on 07/15/25 and corrected the deficient practice prior to the start of the survey on 07/16/25, therefore considered past non-compliance. The deficient practice remained at a "G" scope and severity following the removal of the IJ.<br><br>Findings include:<br><br>Review of the facility policy titled "Tracheostomy [surgically created opening in the neck into the windpipe] Care and suctioning of resident with tracheostomy" occurred on 07/16/25. This policy, dated 03/10/25, stated, ". . . [Tracheostomy] Tubes can come with or without a cuff. These cuffs can be filled with air or foam. . . ."<br><br>Review of the facility policy titled "Trilogy Non-Invasive Ventilator (NIV)" occurred on 07/16/25. This policy, dated 03/10/25, stated, ". . . Responsibility: Licensed nurse . . . Cuffed tracheostomies should always have the cuff inflated during NIV use unless otherwise ordered by the physician. . . . Monitor alarms as needed . . ."<br><br>Review of Resident #1's medical record occurred on 07/16/25. Diagnoses included chronic respiratory failure with hypoxia (low level of oxygen in body tissues). The care plan stated, "Alteration in comfort related to Chronic respiratory failure with hypoxia, trach [tracheostomy], . . . pneumonia, and URI [upper respiratory infection] . . . apnea [cessation of breathing] . . . Approach: . . . Trach cares per facility protocol and physician orders. . . . Trilogy machine per physician orders . . ." A physician's order, dated 10/09/17, included a ventilator used daily at bedtime from 8:00 p.m. to 7:00 a.m. An order, dated 01/15/18, stated, "Inflate cuff with 8 ml [milliliter] of STERILE WATER while on the Trilogy. Deflate cuff when not on the trilogy, twice a day."<br><br>A nurse's note, dated 07/15/25 at 8:21 a.m., stated, "Nurse went to resident's room and found resident to be unresponsive and without a pulse. 2 nurses confirmed death. . . ." | F0695 | | |

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| F0695 SS = SQC-J | Continued from page 2<br>On 07/15/25, the facility initiated a root cause analysis (RCA) of the event as part of their investigation. The RCA, completed 07/16/25, stated, "Resident's [#1] trilogy was alarming so [name of medication aide (MA) (#2)] entered the resident's room to check on resident. Resident did not appear in distress. He asked the nurse what to do about the alarming trilogy machine. [Name of nurse (#3)], LPN [licensed practical nurse] told [name of MA (#2)] to turn the machine off and that he would be in to take care of it in a minute. [Name of MA (#2)] turned the machine off. Approximately an hour later, when [name of nurse (#4)], LPN entered the room to do [name of Resident #1]'s breathing treatments, [name of Resident #1] had passed away."<br><br>During an interview on 07/16/25 at 3:14 p.m., a MA (#2) stated on 07/15/25 at about 7:05-7:10 a.m., he heard an alarm beeping from Resident #1's "breathing machine" (ventilator). The MA (#2) went to the desk and observed the night nurse (#3) giving report to the day nurse (#5) and asked them if he should turn the machine off and one nurse (#3) said yes. "I asked how do you do that, push the button? The nurse [#3] said 'yes.' I returned to the room, selected the power button, and pushed it off." The MA (#2) stated after he turned the ventilator off, "I made sure she was breathing, and she looked like she was. Then I asked the nurse, 'Being she still has that breathing apparatus on, she can still breathe, right?'" The MA (#2) stated the nurse (#3) said "yes."<br><br>During an interview on 07/16/25 at 6:02 p.m., a nurse (#5) stated she received report from the night nurse (#3) on 07/15/25 starting at 7:00 a.m. During the report, the nurse (#5) stated two certified nurse aides (CNAs) reported they thought Resident #1's "respirations were increased." The nurse (#5) stated about 5-10 minutes later, the MA (#2) came and asked, “Can I turn that machine off, it’s beeping – [Resident #1]'s vent. [Nurse #3] said 'yes.' [MA #2] asked, 'Where is the button to turn it off' and [nurse (#3)] said, 'If you look at the front of the machine, it is the power button.'" The nurse (#5) stated the night nurse usually removed the ventilators from residents by the time her shift started, "So, this was unusual to still be on." She stated the MA (#2) returned to the desk and asked, “Are you sure she can breathe with that machine turned off. [Nurse #3] said 'yes.'"<br><br>During an interview on 07/16/25 at 2:21 p.m., a nurse (#4) stated she found Resident #1 unresponsive with no breathing or circulation on 07/15/25 at about 8:15 a.m. The nurse observed Resident #1's trach tube connected | F0695 | | |

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| F0695 SS = SQC-J | Continued from page 3<br>to the ventilator, which was turned off. When asked who is responsible to turn on/off the ventilator, the nurse (#4) stated, "A nurse should be doing everything with the vents."<br><br>During an interview on 07/16/25 at 1:50 p.m., a nurse (#1) explained a nurse deflated the trach cuff when removing a resident from the ventilator and inflated the cuff when connecting to the ventilator. She stated, "Only nurses are allowed to connect or disconnect the vent from the trach or inflate/deflate the cuff. Only nurses check on the vent alarm to see if there is a concern."<br><br>The facility failed to ensure only nurses or other qualified staff turned off a resident's ventilator.<br><br>The facility completed the following steps to remove the immediacy and correct the deficient practice:<br><br>* Completed an investigation of the incident by interviewing staff working the shift prior to and following the incident.<br><br>* Placed the MA (#2) and the nurse (#3) on administrative leave during the investigation and then terminated the nurse (#3).<br><br>* Education provided to all facility staff who worked on 07/15/25. Provided the policy on “Change in Condition and Delegation,” along with education on tracheostomies and ventilators, and providing care within your scope of practice to all staff on 07/15/25 to read and sign before their next shift. Nursing management staff assigned to be on site and provide education to all nurses prior to their next shift.<br><br>* Provided the policies on the Trilogy Non-Invasive Ventilator, tracheostomy site care, and suctioning on 07/15/25, and information on the importance of acting quickly to assess alarms and change in conditions to all nurses on 07/16/25 to review and sign prior to providing patient care.<br><br>* Started a Root Cause Analysis (RCA) of the incident on 07/15/25 and completed it on 07/16/25. | F0695 | | |