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 07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	**3400 NEBRASKA DRIVE BISMARCK, ND 58503**

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F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on July 6, 2021. The sample included one (1) closed record for focused review and eight (8) supplemental residents for observations. Based on observation, record review, facility policy review, staff interview, and review of provider notes the complaint issues investigated were substantiated.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		7/20/21

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

Electronically Signed | 07/16/2021

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F 609	Continued From page 1 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 by: Based on record review, review of State Survey Agency reports, review of facility policy, and staff interview, the facility failed to report to the State Survey Agency a potential incident of neglect with serious bodily injury for 1 of 1 closed records reviewed (Resident #1). Failure to report all alleged incidents of neglect with injury placed all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled "Vulnerable adult-ND [North Dakota]" occurred on 07/06/21. This policy, revised 06/14/21, stated, ". . . Alleged violation: Is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse . . . Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . . . Report all suspected/alleged violations immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury . . . to the state agency . . ." Review of Resident #1's medical record occurred on 07/06/21. Nursing notes identified:	F 609	1. Facility self-reported to North Dakota Department of Health on 7/01/2021. Final report submitted to the North Dakota Department of Health on 7/02/2021. 2. Any resident who experiences serious bodily injury or has alleged violations related to mistreatment, exploitation, neglect or abuse, including injuries of unknown source, and misappropriation of resident property has the potential to be affected. 3. Vulnerable Adult- facility policy reviewed on 7/7/2021 at this time. Written and electronic education regarding mandatory reporting of possible allegations of abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property provided to all employees on 7/15/21. All staff continue to complete mandatory annual education via compliance training platform (Relias) on abuse and neglect. Training is assigned to individual employee to be completed upon hire, the month of July and annually. 4. Interdisciplinary team will meet daily Monday through Friday to review any potential allegations and to assure reporting requirements have been met.	

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F 609	Continued From page 2 * 06/24/21 at 5:00 p.m., ". . . fell during transport via Hoyer lift/ hourglass sling [full body mechanical lift and sling] from bed on way to WC [wheelchair]. Resident was in doorway of room. CNAs [certified nursing assistants] noted hearing a loud snap and top left sling hook off and resident fell to floor head first and laceration to left temporal area, possible laceration and hematoma to back of head. . . . Sling inspected and intact, Hoyer lift functional, no equipment issues noted." * 06/25/21 at 2:49 a.m., ". . . Informed that resident is being admitted for a comminuted [broken into more than two pieces] right Femur fracture. . . ." The facility failed to report the fall with serious bodily injury to the State Survey Agency. During an interview on 07/06/21 at 2:21 p.m., an administrative staff (#1) stated the facility completed an investigation on the incident immediately, and had not reported the incident within 2 hours, the investigation, or the serious bodily injury (comminuted femur fracture) to the State Survey Agency. See F689	F 609	Information regarding investigations will be recorded and retained for record by interdisciplinary team. All allegations will be reviewed at the quarterly quality assurance performance improvement(QAPI)meeting. 5. Date of Correction 7/20/21.	
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	F 689		7/20/21

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F 689	Continued From page 3 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide appropriate and sufficient supervision to prevent accidents for 1 of 1 closed resident record reviewed (Resident #1). Failure to safely utilize an mechanical lift with a sling resulted in a fall with serious injury for Resident #1, and placed all residents requiring this type of transfer at risk for accidents and/or injury. Findings include: Review of the facility procedure titled "Ez Lift (Full Body Lift or FBL)" occurred on 07/06/21. This procedure, revised November 2013, stated, ". . . The EZ Lift (Full Body lift/FBL) was designed primarily to lift residents from the bed, chair toilet and floor. . . . Transferring a resident from bed to chair . . . position sling under resident . . . Position EZ Lift . . . Attach sling to lift. Attach the loops by the resident's shoulders to the lift. Take the wing that is lying over the left leg and hook it on the right hook. Then take the wing lying over the right leg, cross it over and hook it on the left hook . . . Lifting the resident. Push "UP" button on hand control. Once there is tension on loops, double check the loops to make sure that they are securely in the hooks. . . ." Review of Resident #1's medical record occurred on 07/06/21. Resident #1's care plan identified ". . . Impaired physical mobility: persistent vegetative state, left arm contracture, spasticity . . . Transfer with full body lift and assist of two. . . ."	F 689	1. Education provided on 06/24/2021 and 06/25/2021 to direct care staff caring for resident #1 affected by fall during transfer. Individual competencies completed with the staff members involved. 2. Resident care plans reviewed to identify any residents requiring use of Ez Lift(Full Body Lift or FBL). Upon admission residents will be evaluated to determine need for use of full body lift by licensed therapist and will be reflected in resident's plan of care. 3. Ez Lift policy and Ez Lift competency evaluation were reviewed on 6/25/21. All direct care new hire staff will complete Ez Lift competency prior to providing direct care starting 6/25/2021. Electronic education provided regarding safe use of Ez Lift on 6/25/2021 to all direct care staff. Verbal education provided regarding policy and appropriate use of Ez Lift on 6/29/2021 and 07/01/21. All staff who provide direct care will be educated and competencies will be completed and evaluated regarding use of Ez Lift starting on 6/28/21 and to be completed by 7/20/21. 4. Ez Lift competencies will be completed by all direct caregiver staff by 7/20/2021. Random audits will be conducted observing 10% of all direct care staff	

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F 689	Continued From page 4 Review of Resident #1's nursing notes identified: * 06/24/21 at 5:00 p.m., ". . . fell during transport via Hoyer lift [mechanical full body lift]/hourglass sling from bed on way to WC [wheelchair]. Resident was in doorway of room. CNAs [certified nursing assistants] noted hearing a loud snap and top left sling hook off and resident fell to floor head first and laceration to left temporal area, possible laceration and hematoma to back of head. Pressure held to laceration while assistance of other nurses obtained. Resident did not lose consciousness, VS [vital signs] WNL [within normal limits] and pupils equally round, 5mm [millimeter] and reactive. Transported to [name of hospital] via [name of ambulance]. Sling inspected and intact, Hoyer lift functional, no equipment issues noted." * 06/24/21 at 5:41 p.m., ". . . report from ER [emergency room] Nurse and resident will return to facility. Transport called and on way. No fractures determined . . . Adhesive to laceration and steri strips. Family elected not to CT [computerized tomography - series of X-ray images provide more-detailed information] scan or x-ray." * 06/24/21 at 6:50 p.m., ". . . Resident returned via facility van and has no adhesive dressing to linear shaped laceration that is 1.5 cm [centimeter] x 3mm. No bruising surrounding area at this time. Does make eye contact and pupils are equal and reactive. ROM [range of motion] is unchanged. Tissue adhesive will gradually peel off and the steri strips will come off within next week. BP [blood pressure] 88/ 59, Pulse 109, Resp [respirations] 15 and sats [oxygen saturation] 93% [percentage]. . . ." * 06/24/21 at 10:08 p.m., ". . . BP 86/54, pulse 122, resp. 14, temp. 98.9. Resident makes eye	F 689	performing Ez Lift transfers to monitor safe use of full body lift according to policy. Audits will be completed weekly for four weeks, monthly for three months and quarterly for three quarters. Audits will be started by 7/10/2021 and will be completed by the Quality Assurance nurse or designee. 5. Date of correction 07/20/2021.	

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F 689	Continued From page 5 contact. Resident is nonverbal. Face pale. Additional 1cm laceration to left back of head cleansed. Left temple laceration intact. At 2100 [9:00 p.m.] resident is transferred into bed per Hoyer and 3 [staff] assist. When pants removed noted large deformity with swelling and bruising to right hip. Resident grimaces with movement. Brief changed while trying to keep leg stable . . . Call to Physician on call [name]. Ordered send [him/her] back to ER for evaluation right hip. . . ." * 06/25/21 at 2:49 a.m., ". . . phone call from [hospital name] ER Nurse [name]. Informed that resident is being admitted for a comminuted right Femur fracture. . . ." * 06/25/21 at 9:36 a.m., ". . . The hospital SW [social worker] called a short time later to indicate that [Resident #1] would be returning to the facility on hospice/comfort care today." * 06/25/21 at 3:36 p.m., ". . . Resident returned to the facility via ambulance from [hospital name] . . . Resident returned from injury due to previous fall on 06/24/2021 and fx [fracture] to R [right] femur and laceration to L [left] temporal area. Resident was admitted to hospice care . . ." * 07/01/21 at 5:16 p.m., ". . . Resident expired this shift, on 07/01/2021. . . ." Review of Resident #1's physician notes identified: * 06/25/21 at 4:06 a.m., ". . . Initially patient was brought in around 5 PM yesterday after falling from a Hoyer lift . . . had a small scalp laceration to the left . . . no other injuries were reported at the time. . . . head laceration was repaired . . . Long discussion between family and ER provider, resulted in family choosing not to go ahead with imaging, as this would not change treatment, as well as a head trauma being relatively minor.	F 689		

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F 689	Continued From page 6 Patient was transported to [name of nursing home] . . . returned to our ER several hours later . . . found to have fracture of right femur. . . . met with [Resident #1] . . . sister is in the room . . . States that [Resident #1] appears a little more comfortable now, and they would not like extreme measures or treatments or imaging performed. Orthopedic surgery on-call was contacted from the ED, and given patient's significant history, and severe osteoporosis due to immobility, surgical repair of the fracture is most likely impossible. . . ." Review of the facility's investigation of the fall, dated 06/25/21, stated, "During a hoyer transfer on 06/24/21 at approximately 1540 [3:40 p.m.], with a hour glass sling, two CNAs present, as they moved from the bed . . . they reported hearing a loud snap and resident fell head first to floor. Top loop of sling was off and feet were in air. Resident was lowered to floor . . . Resident found lying on the floor just outside of doorway to room with . . . legs out in front . . . and lower back on leg of Hoyer . . ." The facility failed to ensure the necessary care and services to promote safety for Resident #1. The failure resulted in an avoidable fall from the full body lift resulting in head laceration, femur fracture, and pain.	F 689		