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 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH & REHAB	**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 An unannounced onsite investigation survey regarding facility reported incidents was completed on January 31, 2024. During the report investigation the facility was found noncompliant with regulatory requirements.	F 000		
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: Based on record review, review of the facility reported incident investigation, review of facility policy, and staff interview, the facility failed to ensure an environment free of hazards for 1 of 2 sampled residents (Resident #1) injured while consuming a hot beverage. Failure to provide the appropriate adaptive drinking aids with a mug for hot beverages contributed to Resident #1's injuries This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: The surveyors determined a deficient practice existed on 09/30/23. The facility implemented corrective action and completed all staff education on 10/06/23.	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/19/2024

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F 689	Continued From page 1 Review of the facility policy titled "Hot Liquid Screen" occurred on 01/31/24. This policy, updated 01/26/24, stated, "Policy: The purpose of the hot liquid screen is to assess the Resident's ability to safely drink hot liquids independently. Procedures: 1. Each resident will be assessed at their initial nutritional assessment, at their quarterly nutrition assessment and as needed. 2. Modifications and/or adaptive equipment will be provided per assessment if resident is not able to drink hot liquids independently. . . ." Review of Resident #1's medical record occurred on 01/31/24 and included the diagnoses of Parkinson's disease, muscle weakness, and reduced mobility. Review of Resident #1's care plan stated, ". . . Nutrition/Hydration: . . . Resident needs close supervision for safety with eating and drinking foods and liquids. . . . Approach Start Date: 08/30/2023 Diet per MD [physician] order. Close Supervision . . . liquids in plastic mugs w/ [with] lids and straws . . ." Review of Resident #1's progress notes identified the following: *09/30/23 at 9:00 a.m. "NUTRITION: Request by nursing was made Friday morning 09/29/23 after breakfast as resident had spilled coffee on her hand and leg during breakfast meal. It was agreed upon that we would place all liquids in plastic mugs with lids and straws to prevent further mishaps and spilling from resident. I will update her meal card to reflect this and will update her supervision to close supervision. Dietitian will monitor and follow up." *10/01/23 at 11:12 a.m. ". . . 09/30/23 resident spilled hot liquids on her at supper time. Lids and	F 689		

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F 689	Continued From page 2 straws were not in place at this time. Resident was noted to have burns on inner thighs. Cold wash cloths was [sic] put in place. Nurse assessed an hour later. Two burns were noted on the R [right] inner thigh but the redness to the surrounding area was no longer visible. Bacitracin [antibiotic ointment] was applied along with cold ice pack. See wound management for details. Provider and family aware. CNAs [certified nurse aides] were educated that resident is needing more help with drinks as she is shaky at times and is more at risk for spilled [sic] even with lids and a straws." Review of "Wound Management Detail Report" identified the following: *09/30/23 at 6:57 p.m. Both burn areas described as "Partial thickness: redness, blistered, moist, painful". The burn measurements identified as follows: one the length of four centimeters (cm) and width of five cm. the second burn the length of one cm and width of one cm. *10/01/23 at 1:44 p.m. Both burn areas described as "Superficial: painful, no edema, redness, blanches with pressure". The burn measurements identified as follows: one the length of two centimeters (cm) and width of one cm. the second burn the length of one cm and width of one cm. *10/03/23 at 12:00 p.m., Indicated, "only one blister remains to right inner thigh." The burn described as "partial thickness: redness, blistered, moist, painful . . . Comments: Fluid filled blister remains to right inner thigh. Surrounding skin is intact with no further erythema or concerns." Burn measurement identified as a length of 0.6 cm and width of 1.2 cm.	F 689		

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F 689	Continued From page 3 The facilities investigation report dated 10/05/23 included the following documentation: ". . . On 09/29/23, Resident spilled coffee on her hand and leg during the breakfast meal. The team lead, [name of staff] and dietician, [name of staff] met to discuss the situation. [name of staff] completed a hot liquid screen on [Resident #1] and decided that we would place all liquids for resident in plastic mugs with lids and straws in hopes to prevent further mishaps and that resident should be close supervision. . . . Resident's meal cards were updated to reflect liquids in plastic coffee mugs with lids, straws and close supervision. Supervision and adaptive equipment lists were also updated. On Saturday, 09/30/23, resident was eating supper and accidentally spilled her hot chocolate on herself. . . . A CNA that usually does not work that neighborhood, was helping on [name of neighborhood] that day. She was assisting residents and serving liquids to them before mealtime. . . . The CNA served [Resident #1] a cup of hot chocolate. However, the root cause analysis revealed that the CNA was not aware that [Resident #1] was supposed to have lids/straws with all liquids. So, the hot chocolate did not have a cover/lid on it, nor was there a straw in it. . . . [Resident #1] states that she went to set down her cup of hot chocolate and she set the glass to close to the edge of the table. The liquid spilled on her lap causing redness and irritation. . . ." During an interview on 01/31/24 at 1:45 p.m. an administrative staff member (#1) stated she expects facility staff to follow the dietary's list of adaptive equipment for the specific residents.	F 689		

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F 689	Continued From page 4 Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for the deficient practice by: *The facility completed an investigation with interviews of staff that determined the cause of the incident (lack of lid on mug). *Provided immediate staff education regarding resident safety with hot liquids and reminder to follow the resident's menu card list of adaptive equipment. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: *On 10/02/23 Implemented the use of a dining information binder located in each kitchenette for staff to follow the specific adaptive equipment needs for a resident. *On 10/06/23 provided all staff education via written information e-mailed to all unit managers/charge nurses who then provided verbal and written education to all staff on individual units to include staff initials to acknowledge education received. *Implemented weekly temperature taking of brewed coffee and hot water in all kitchenettes. *Implemented audits to verify resident specific adaptive equipment lists are consistent in the dining information binder and resident care plan, and complete observations to ensure the appropriate adaptive equipment in place for the resident. *Implemented random staff interviews to ensure staff members are aware of the location of the adaptive equipment binder and supplies, with immediate education provided to staff when	F 689		

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F 689	Continued From page 5 needed.	F 689		