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 03/23/2023

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 The standard Medicare/Medicaid recertification and complaint survey started on 03/20/23 and concluded 03/23/23. The concerns identified by the complainants were unsubstantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 27 sampled residents (Resident #101). Failure to accurately complete the MDS results in an inaccurate reflection of the resident's current status and may affect the development of the comprehensive care plan and the care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page N-6 states, ". . . N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period . . ." Review of Resident #101's medical record occurred on all days of survey. The quarterly MDS, dated 02/12/23, identified staff coded Section N410B anti-anxiety use on 7 of 7 days of	F 641	1. Department of Health statement of deficiencies addresses resident 101's MDS with ARD 2/12/23 as being inaccurately coded. This MDS was corrected to accurately reflect zero of seven days this resident received antianxiety medication in the observation period. The MDS modification was completed on 3/22/23 and submitted to CMS on 3/22/23. 2. On 4/5/23 the facility ran a MDS Anti-anxiety, N410B software report and identified 30 residents for a total of 51 MDS's coded with use of anti-anxiety medications from time period of Quarter 1, 2023. 3. The MDS coding error found in survey was determined to be an isolated error. Facility has a RAI Policy in place reflective of the CMS RAI guidelines with no updates needed. The MDS Coordinator that completed the MDS with the error noted was provided education.	4/27/23

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

Electronically Signed | 04/07/2023

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F 641	Continued From page 1 the look-back period. The record failed to show an order for an anti-anxiety medication. During an interview on 03/22/23 at 2:55 p.m., a nurse (#1) confirmed Resident #101 "has never received an anti-anxiety medication" and confirmed the 02/12/23 quarterly MDS "was marked in error."	F 641	All current MDS coders for the facility were provided education to ensure understanding of definition of coding N410B was understood. 4. Facility Quality Nurse or designee will identify MDS's completed in the audit time frame to ensure anti-anxiety medications are coded correctly. Audits will be performed weekly for four weeks and monthly for four months. Trends will be reported to QA&A Committee for further recommendation needs for auditing. 5. Correction Date: April 27th, 2023.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced	F 644		4/27/23

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F 644	Continued From page 2 by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #44) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, revised December 2020, page 13, states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC [mental illness, intellectual disability, and conditions related to intellectual disability referred to in regulatory language as related conditions or RC] was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #44's medical record occurred on all days of survey and identified an original PASARR completed on 08/11/20. Upon admission to the facility on 03/09/21, the resident was prescribed Seroquel (an antipsychotic	F 644	1. The resident found to be impacted in survey had an updated PASRR completed and submitted on 3/23/23. The updated PASRR included the new diagnosis of psychotic disorder with delusions and addition of new medication Seroquel. Upon submission of new level 1 screening a level 2 screen was not triggered. 2. Facility identified all Level 1 and Level 2 PASRR residents residing in the facility on 4/5/23. A review was completed for all residents currently in the facility to determine need of an updated Level 1 screen due to a newly diagnosed mental illness since the prior Level 1 screen was completed that could result in the change in delivery of care and services in support of resident needs. PASRR policy reviewed and determined to be up to date at this time. 3. Designated staff that work with PASRR practices reviewed information from the ND PASRR Provider Manual, specifically related to change in the status assessments in relation to the need for a new Level 1 screen. Health information manager will begin to routinely run a new diagnosis report to identify residents with new diagnosis classifications found in the North Dakota PASRR Provider Manual that would trigger the need for a new Level 1 assessment. 4. Quality nurse or designee will complete	

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F 644	Continued From page 3 medication) and received a new diagnosis of psychotic disorder with delusions due to known physiological condition. The record lacked evidence of an updated PASARR being completed which included the new diagnosis and medication. During an interview on 03/23/23 at 2:20 p.m., an administrative staff member (#2) confirmed the facility failed to complete a new PASARR for Resident #44.	F 644	the audits ensuring PASRRs are completed per regulatory compliance weekly for four weeks, and monthly for four month and present trends of findings at QA&A for further guidance on audits needs. 5. Correction Date: April 27th, 2023	
F9999	FINAL OBSERVATIONS The complaints investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		