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 _____	01/23/2020

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 01/21/20 and concluded 01/23/20.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care	F 657	F-657 It is the intent of this facility to remain in compliance with F-657 as evidenced by the following:	2/27/20

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

Electronically Signed | 02/14/2020

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F 657	Continued From page 1 plan to reflect the residents' current status for 4 of 28 sampled residents (Resident #21, #27, #116, and #188). Failure to review and revise the care plans to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan and baseline care plan" occurred on 01/22/20. This policy, dated 01/25/19, stated, ". . . The resident care plan is constantly changing. It is to be updated routinely in the electronic record to reflect resident's current condition. . . ." - Observation throughtout the day on all days of survey identified Resident #116 with hand splints on both hands. Review of Resident #116's medical record identified a physician's order that stated, " Ensure bilateral hands are clean/dry. Palmar guards to be in place. Special Instructions: Inform therapy if any redness/irritation arises from palmar guards Twice A Day . . ." The resident's care plan failed to reflect the use of the palmar hand splints. - Review of Resident #188's medical record occurred on 01/22/20. Diagnosis included ischemic cardiomyopathy (narrowing of the coronary arteries). A physician's order, dated 01/15/20 identified a resident on Coumadin (anticoagulant). The resident's care plan failed to reflect the use of an anticoagulant. - Review of Resident #21's medical record	F 657	1. Resident #21, #27, #116, and #188 had the potential to be affected by the deficient practice found during survey. Care plans for the noted residents were updated to reflect current adaptive devices, diagnoses, and medication use. 2. All resident have the potential to be affected. 3. All residents will have a current comprehensive care plan in place and reviewed by the interdisciplinary team. Care plan policy has been reviewed. Comprehensive care plans will be reviewed, revised and reflect resident's current status. All staff education provided on 1/25/2020, and will be provided again on 2/25/2020, 2/26/2020, and 2/27/2020. 4. Random audits observing areas identified by the survey team will be conducted starting on 02/17/2020. Audits will be conducted on 10% of the residents a week for four weeks, 10% of the residents for a month for two months and 10% of the residents per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: 02/27/2020.	

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F 657	Continued From page 2 occurred on all days of survey. A quarterly Minimum Data Set (MDS) dated 10/28/19, identified the resident does not have hearing aids. Observation during all days of survey showed Resident #21 without hearing aids. The current care plan stated, ". . . COMMUNICATIONS HEARING . . . Assist with insertion and removal of hearing aides, as resident tolerates. Lock hearing aides in cabinet at night. . . . During an interview on 1/21/20 at 11:30 a.m., a medication assistant (MA) (#3) confirmed Resident #21 does not have hearing aids. - Review of Resident #27's medical record occurred on all days of survey. An MDS, dated 11/05/19, identified the resident has a diagnoses of diabetes with insulin (a glucose controlling medication) use. The resident's care plan failed to reflect current the diagnoses of diabetes with insulin use.	F 657		
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: 1. Based on record review, review of facility policy, and staff interview, the facility failed to	F 658	F-658 It is the intent of this facility to remain in compliance with F-658 as	2/27/20

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F 658	Continued From page 3 follow professional standards of practice regarding medication administration for 3 of 3 residents (Resident #27, #83, and #130) with medications administered late. Failure to ensure staff administered medications in a timely manner may result in adverse reactions and jeopardize residents' health. Findings include: Review of the facility policy titled "Medication Management" occurred on 01/23/20. This policy, revised July 2019, stated, ". . . Medications may be given 1 hour before or 1 hour after scheduled administration time . . . Facilities using liberalized medication pass times [a range of time example 0700-1000] will administer meds [medications] during the ranges given in the liberalized medication pass times and will not have an additional hour before or after those times. . . ." Review of the facility's medication administration record (MAR) for Residents #27, #83, and #130 showed the facility used a liberalized and standard medication pass. - Review of Resident #27's medical record occurred on all days of survey. The resident's MAR from 01/01/20 to 01/23/20 showed staff administered medications late on 13 occasions in the last 23 days. - Review of Resident #83's medical record occurred on all days of survey. The resident's MAR from 01/01/20 to 01/23/20 showed staff administered medications late on 20 occasions in the last 23 days.	F 658	evidenced by the following: 1. Resident #27, #83, and #130 had the potential to be affected by the deficient practice found during the survey. Education provided to staff to assure residents will receive medications during appropriate time frames and prepared according to the professional standards and procedure. 2. All residents who receive medication have the potential to be affected. 3. All resident's receiving medication will receive scheduled medication following professional standards of practice and according to facility's policy and procedure. Medication administration policy reviewed. Staff will be re-educated regarding medication administration times, ranges, proper preparation and appropriate late administration documentation. All staff education provided on 01/25/2020 and will be provided again on 02/25/2020, 02/26/2020, and 02/27/2020. New hire orientation checklist revised including review of proper preparation of medications. 4. Random audits observing areas identified by the survey team will be conducted starting 02/17/2020. Audits will be conducted on 10% of the residents a week for four weeks, 10% of residents a month for two months, and 10% of the residents per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance	

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F 658	Continued From page 4 - Review of Resident #130's medical record occurred on all days of survey. The resident's MAR from 01/01/20 to 01/23/20 showed staff administered medications late on 11 occasions in the last 23 days. During an interview on 01/23/20, an administrative nurse (#1) stated she expected staff to administer medications within ordered timeframe's. 2. Based on observation, facility policy and staff interview, the facility failed to follow professional standards of practice for 1 of 5 observations of medication administration. Failure to properly prepare medications may place residents at risk for medication errors. Findings Include: Review of the facility policy titled "Medication management - Medication storage" occurred on 01/23/20. This policy, revised August 2019, stated, ". . . Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. . . ." Observation on the morning of 01/21/20 showed two unlabeled medication cups containing medications in the top drawer of the medication cart. A medication assistant (MA) (#3) stated she placed the medications for two residents in the unlabeled containers in the drawer. During an interview on 01/23/20 at 11:35 a.m., an administrative nurse (#1) confirmed she expected staff to follow facility policy regarding medication administration.	F 658	Committee quarterly. 5. Date of correction: 02/27/2020	
F 676	Activities Daily Living (ADLs)/Mntn Abilities	F 676		2/27/20

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F 676 SS=D	Continued From page 5 CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.	F 676		

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F 676	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services to maintain or improve abilities in activities of daily living (ADLs) for 1 of 1 sampled resident (Resident #21) care planned for hearing, communication, and understanding deficits. Failure of staff to effectively communicate with Resident #21 may result in frustration, behaviors, and decreased quality of life. Findings include: Review of Resident #21's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated 10/28/19, identified a Brief Interview Mental Status (BIMS) score of 9, (moderately impaired cognition) and adequate hearing. The current care plan stated, ". . . COMMUNICATIONS HEARING/SPEECH "Ask questions that can be answered with yes, no, or a short response. Speak in clear, simple, short messages. Devote your full attention to resident. Allow resident plenty of time to respond to questions. Face resident when speaking to her. Speak slowly in low, clear tones. Ask resident if she heard or understood you, repeat PRN [as needed]. . . ." - Observation on 01/21/20 at 7:50 a.m., showed Resident #21 seated in her room faced opposite of the door. The surveyor knocked on the door several times, the resident did not respond, the surveyor entered the room and introduced myself three times. "I can't understand you, I can not hear," Resident #21 stated. The surveyor wrote her name on a sheet of paper, handed it to the	F 676	F-676 It is the intent of this facility to remain in compliance with F-676 as evidenced by the following: 1. Resident #21 had the potential to be affected by the deficient practice found during survey. Care plan was updated immediately to reflect resident no longer uses hearing aids. A "pocket talker" hearing amplifier is available for the resident's use. It is resident's preference to utilize the white board and marker to aid in communication. This has been added to the care plan. Direct care staff educated immediately regarding the use of updated interventions via discussion at daily stand up meetings. 2. All residents who have a hearing impairment have the potential to be affected. 3. All residents who have a noted hearing impairment will have documented interventions to improve quality of life and activities of daily living in the comprehensive care plan. All staff were educated on 01/25/2020 to review and update care plans for any changes. Further education will be provided on 2/25/2020, 2/26/2020 and 2/27/2020 regarding reviewing and updating care plans as an interdisciplinary team monthly and as needed to ensure accuracy of interventions provided for hearing impairment and to have therapy evaluate when necessary and as appropriate. 4. Random audits observing areas	

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F 676	Continued From page 7 resident, and she responded, "Hi [surveyors name]." - Observation on 01/21/20 at 8:03 a.m., showed a certified nursing assistant (CNA) (#7) and medication assistant (MA) (#3) entered Resident #21's room, stated "I am here with your Tylenol," three times. Resident #21 stated, "I don't know what you are talking about." The MA (#3) wrote on a paper, "Do you have a headache?", Resident #21 accepted the Tylenol. When asked if Resident #21 had hearing aids the MA stated no. The MA (#3) asked Resident #21 if she needed anything else and the resident responded "What ? The MA (#3) then communicated on paper, the resident shook her head no. The CNA (#7) shouted from across the room "Do you need to use the bathroom?" The Resident #21 did not respond. The CNA (#7) again shouted from across the room. "Do you want to use the bathroom?" Resident #21 did not respond and the CNA (#7) assisted her to the bathroom. "I wish you guys would talk out loud so I can understand you" stated Resident #21. The CNA (#7) exited the bathroom to make the bed. The CNA (#7) shouted from the bed side "Are you finished?" Resident #21 did not respond. The CNA (#7) continued to make the bed. When asked about communication with Resident #21 the CNA (#7) stated, "Some days she hears a lot better and sometimes she won't." The CNA (#7) entered the bathroom with a gait belt, applied gloves and shouted "Are you finished?" The Resident #21 stood with CNA (#7's) assistance, and exited the bathroom. - Observation on 01/22/20 at 1:57 p.m., showed a CNA (#8) entered Resident #21's room, and	F 676	identified by the survey team will be conducted starting on 02/17/2020. Audits will be conducted on 10% of the residents a week four weeks, 10% of the resident a month for two months, and 10% of the residents per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: 02/27/2020.	

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F 676	Continued From page 8 asked if she would like to use the bathroom or have something to eat. Resident #21 stated, "I don't know what you said." The CNA (#8) again asked Resident #21 if she would like to use the bathroom or have something to eat. The resident did not respond. When asked about communication with Resident #21, the CNA (#8) stated, "Yes, she is hard of hearing." During an interview on the afternoon of 01/23/20 at 9:05 a.m., when asked about communication with Resident #21, a MA (#3) stated, "yes she is very hard of hearing and it can be very difficult." The facility failed to use interventions developed for the resident to improve communication with the resident, thus improving quality of life and well being.	F 676		
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, and record review, the facility failed to provide adequate assistance for 1 of 1 supplemental resident (Resident #90) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift placed Resident #90 at risk for pain/discomfort and/or accidents with/without	F 689	F-689 It is the intent of this facility to remain in compliance with F-689 as evidenced by the following: 1. Resident #90 had the potential to be affected by the deficient practice found during the survey. Education provided to	2/27/20

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F 689	Continued From page 9 injury. Findings include: - Review of Resident #90's medical record occurred on 01/21/20. The significant change Minimum Data Set (MDS), dated 12/18/19, identified extensive assistance of two or more people for transfers and toilet use. Observation on 01/21/20 at 9:15 a.m., showed a certified nursing assistant (CNA) (#6) attempted to raise Resident #90 off the toilet using a sit-to-stand mechanical lift. As the CNA (#6) started to raise the lift, it stopped and left Resident #90 suspended in the sling in a seated position to the right side of the toilet with his elbows extending toward the ceiling. The CNA (#6) stated the lift battery "ran out." The CNA called for assistance using her two-way radio, did not receive a response, removed the battery from the lift and left the bathroom. At 9:17 a.m. the CNA (#6) returned with a new battery, placed it in the lift, raised Resident #90 to a standing position, performed perineal cares, and transferred him to his wheelchair. When asked why she left Resident #90 alone hanging in the harness, she stated she did not know what else to do.	F 689	staff regarding safe operation of transfer equipment. 2. All residents who are care planned as requiring mechanical assistance with transfer equipment have the potential to be affected. 3. All residents will receive adequate supervision and assistance devices to prevent accidents. Sit-to-Stand Lift use policy was reviewed no update needed. All staff upon hire an annually will complete a competency checklist for each mechanical lift. All staff education regarding Sit-to-Stand lift provided on 01/25/2020 and will be provided again on 02/25/2020, 02/26/2020, and 02/27/2020. 4. Random audits observing areas identified by the survey team will be conducted starting on 02/17/2020. Audits will be conducted on 10% of the residents a week for four weeks, 10% of the residents a month for two months, and 10% of the residents per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: 02/27/2020.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		2/27/20

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F 758	Continued From page 10 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 11 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 2 sampled residents (Resident #2) who received an as-needed (PRN) psychotropic medication. Failure to ensure the physician limited the use of PRN psychotropic medications to 14 days or extended the order including the rationale for the PRN psychotropic medications may result in residents' receiving an unnecessary medication and experiencing adverse effects related to its use. Findings include: Review of the facility policy titled "PRN medication" occurred on 01/23/20. This policy, dated 07/15/18, stated " . . . PRN orders for psychotropic medications are limited to 14 days unless the attending or prescribing physician believes it is appropriate for the PRN order to be extended beyond 14 days, he or she would document the rationale in the resident's medical record . . ." Review of Resident #2's medical record occurred on all days of survey. A physician's order for Zanax (antianxiety medication), dated 10/21/19, stated, "Give 0.5 mg [milligrams] by mouth every 6 hours as needed for anxiety." The record lacked an order to extend the Zanax beyond 14 days.	F 758	F-758 It is the intent of this facility to remain in compliance with F-758 as evidenced by the following: 1. Resident #2 had the potential to be affected by the deficient practice found during survey. This resident received physician order for anti-anxiety medication beyond fourteen days. 2. All residents who receive psychotropic medication PRN have the potential to be affected. 3. All residents who receive psychotropic medication PRN will avoid unnecessary use by limited use to 14 days unless re-evaluated and reviewed for appropriateness by provider. Psychotropic medication monitoring and PRN medication policy reviewed at this time. All staff education provided on 01/25/2020 and will be provided again on 02/25/2020, 02/26/2020, and 02/27/2020. 4. Random audits observing areas identified by the survey team will be conducted starting on 02/17/2020. Audits will be conducted on 10% of the residents for four weeks, 10% of the residents a month for two months, and 10% of the residents per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: 02/27/2020.	

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	355058	A. BUILDING _____ B. WING _____	01/23/2020

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F 758	Continued From page 12 Review of Resident #2's medication administration records, 10/21/20 to 01/23/20, showed continued administration of PRN Zanax. During an interview on 01/23/20 at 11:40 A.M., an administrative nurse (#1) agreed Resident #2 received PRN Zanax beyond 14 days and confirmed the provider failed to indicate the rationale and duration for the PRN Zanax.	F 758		
F 770 SS=B	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired laboratory supplies for 1 of 3 medication rooms (Morning Star). Failure to discard expired laboratory supplies increased the risk of staff utilizing outdated laboratory supplies with reduced efficacy. Findings include: Observation of the Morning Star medication storage room on the afternoon of 01/21/20 with a licensed staff nurse (#2) identified the following expired laboratory supplies: * Six vacutainers - four expired 11/30/19 and two	F 770	F-770 It is the intent of the facility to remain in compliance with F-770 as evidenced by the following: 1. Residents on Morning Star had the potential to be affected during the deficient practice found during survey. Expired laboratory supplies discarded in this area immediately. 2. All residents receiving laboratory services have the potential to be affected by outdated laboratory supplies. 3. Expiration dates of laboratory supplies	2/27/20

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F 770	Continued From page 13 expired 12/31/19. During an interview on 01/23/20 at 11:35 a.m., an administrative nurse (#1) agreed the above items had expired and staff needed to discard the items.	F 770	in all medication rooms will be reviewed monthly and documented accordingly. 4. Random medication room audits will be conducted on one neighborhood a week for four weeks, two neighborhoods a month for two months, and each neighborhood each quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of Correction: 2/27/2020	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by:	F 802		2/27/20

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F 802	Continued From page 14 Based on observation, review of facility policy, resident group interview, and staff interview, the facility failed to ensure sufficient staff for meal service on 4 of 6 units (Prairie View, Western Skies, Meadow Lark, and Northern Lights). Failure to serve resident meals in a timely manner did not enhance the dining experience for the facility's residents. Findings include: Review of the facility policy titled "Open Dining Frequency of Meals" occurred on 01/21/20. This policy, revised 11/26/19, stated, ". . . Breakfast 7:30 am [morning] to 10:30 am . . . Lunch 11:00 am to 3:00 pm [afternoon] . . . Dinner 3:30 pm to 6:00 pm . . . All residents may choose from the restaurant menu for all 3 meals. There will be a Special of the Day available from 4:30 pm to 6:00 daily . . . Every effort will be made to serve all residents together who are sitting at the same table, however orders will also be filled on a first come first serve basis with the exception of those who require priority serving . . ." - Observation of the noon meal on 01/21/20 of Prairie View dining room showed the following: * At 11:50 a.m. - 15 residents sitting at tables in the dining room. An unidentified CNA stated the meal ticket orders for these residents had been placed at 11:30 a.m. * 12:15 p.m. - Three residents sitting at Table #1, with only one of the three residents receiving their meal. The last resident was served his/her meal at 12:30 p.m., 45 - 60 minutes after placing the order. * 12:04 p.m. - Four residents sitting at Table #2, with only one of the four residents receiving their	F 802	F-802 It is the intent of the facility to remain in compliance with F-802 as evidenced by the following: 1. Residents #7, #15, #119, and #126 had the potential to be affected by the deficient practice found during survey. Regulation 483.60 states that meals or nutritional supplements are to be provided to residents within 45 minutes of residents request or less depending on facility's scheduled time for meals. Staff educated immediately regarding extended wait times on the affected residents along with the regulation expectation for all residents. 2. All residents coming to the dining room for meals have the potential to be affected by this deficiency. 3. On 01/25/2020 all staff education provided with the expectation that the affected and all residents are to be taken to the dining room one by one and putting their orders in one by one to prevent many orders being sent to the cook at the same time. Also to watch for residents that have independently taken them selves to the dining room and assure that their order has been taken. All staff education provided regarding the 45 minute regulation, revised open dining processes which includes the new process of taking a resident's order, and assisting with serving prepared trays. Dietary staffing hours have been modified to reflect the need for additional staffing coverage. Dietary staff received education regarding working to expedite	

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F 802	Continued From page 15 meal. The last resident was served his/her meal at 12:25 p.m., 34 - 55 minutes after placing the order. * 12:30 p.m. - Three residents sitting at Table #3, with only one of the three residents receiving their meal. The last resident was served his/her meal at 12:50 p.m., 60 - 80 minutes after placing the order. * 12:30 p.m. - Three residents sitting at Table #4, with only one of the three residents receiving their meal. The last resident was served his/her meal at 12:41 p.m., 60 - 70 minutes after placing the order. - Observation of the noon meal on 01/21/20 of Western Skies dining room showed the following: * Resident #7 arrived at 11:48 a.m., placed her lunch order with staff, and received her meal at 12:14 p.m., 26 minutes later. * Resident #15 arrived at 11:54 a.m., placed his lunch order with staff, and received his meal at 12:19 p.m., 25 minutes later. * An unidentified resident arrived at 11:57 a.m., placed her order with staff, and received her meal at 12:27 p.m., 30 minutes later. - Observation of the evening meal on 01/21/20 of Meadow Lark dining room showed the following: * 5:08 p.m. - An unidentified residents observed sitting at the dining room table. The resident received her meal at 5:39 p.m. (31 minutes later). - Observation on 01/21/20 of Northern Lights dining room identified the following: *8:15 a.m. - Resident #119 arrived to the dining room table and received her meal at 8:57 p.m. (42 minutes later). * 4:18 p.m. - identified Resident #126 arrived to	F 802	and serve simultaneously, and serving each tray individually. Although it is our goal for residents to be provided their meals within 30 minutes, our policy has been revised to reflect regulation 483.60 regarding meals or nutritional supplements are provided to residents within 45 minutes of either a residents request or less depending on the facility's scheduled time for meals. Education on the revised policy and open dining process which includes the recording of specific times on meal tickets will occur again daily 02/14/2020 through 02/21/2020, as well as on 02/25/2020, 02/26/2020, and 02/27/2020. 4. Random audits observing areas affected by the deficiency and identified by the survey team will be conducted starting on 02/17/2020. These audits will be conducted on 10% of the residents a week for four weeks, 10% of the residents a month for two months, and 10% of the residents per quarter for three quarters. Audits will be completed by the Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of Correction: 02/27/2020	

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F 802	Continued From page 16 the dining room table. The resident ordered the featured supper meal (pureed food), the food tray arrived to the table at 5:45 p.m., (87 minutes later). During the Resident Council interview on 01/22/20 at 11:00 a.m., Resident A, B, C, and D stated they have to wait a minimum of 45 minutes after they order before the food will be delivered. They also stated they thought the special meal of the day would be served faster since it is already prepared ahead of time, however that is not the case. During an interview on the afternoon of 01/22/20, two dietary managers (#4 and #5) stated staff serve trays by a first-come, first-serve basis and they use a restaurant style menu. The goal is for the residents to receive their meal within 30 minutes. The facility failed to serve the residents meals in a timely manner.	F 802		