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 _____	01/24/2019

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 on 01/22/19 and concluded on 01/24/19.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to provide supervision and assistance for 1 of 1 sampled residents (Resident #100) observed during meals whose care plan identified assist and tray set up with verbal cues, explaining location of food and fluid when serving each meal, and assisting with feeding PRN (as needed). Failure to implement techniques and interventions consistently for a resident with a visual impairment has the potential to decrease independence and dignity in the resident's environment. Findings include: The facility failed to provide a policy regarding dining assistance per request. Review of Resident #100's medical record occurred on days of survey. Diagnoses included legal blindness and vision loss R/T (related to) macular degeneration, Alzheimer's disease,	F 558	It is the intent of this facility to remain in compliance with F-558 as evidence by the following: 1. Resident #100 has a visual impairment and needs assistance as well as cueing/explanations during meal time. All staff working with this resident were educated on 2/19/19 and 2/20/19 in regards to dining assistance/cueing/explanations needed per careplan. 2. All residents who have a visual impairment have the potential to be affected. 3. All residents who have a visual impairment will be assessed for verbal cues during meal times in regards to food and drink location. If needed, the care plan will be updated accordingly.	2/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/21/2019

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 _____	01/24/2019

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 558	Continued From page 1 dementia. The quarterly Minimum Data Set (MDS), dated 12/26/18 , identified supervision, set up assistance, and cueing required for eating. The current care plan identified "regular diet . . . nutrition status . . . assist with tray set up. Verbal cues. Plate guard . . . tell location of food and fluid when serving her each meal. Assist with feeding PRN . . . explain cares as you provide them . . . reassurance of her surroundings . . . offer gentle reorientation and reassurance if resident displays signs of forgetfulness, confusion . . . be sure to get her attention so that she knows you are speaking to her . . . due to her blindness, she may not recognize when someone is speaking to her . . . speak in clear, simple, short messages . . . devote your full attention to resident." During an interview on 01/22/19 at 10:01 a.m., Resident #100's family member (A) stated he/she has observed facility staff assisting his/her mother inconsistently during mealtimes. The family member stated they have talked to different staff members about the problem in the past or did not say anything, hoping it would improve. The family member stated they observed the following: * Glasses of fluid placed around Resident #100's food plate in different places * Resident fumbling to locate the glasses by feeling, sometimes spilling the glasses * Placing Resident #100's food tray on the table with no explanation/cueing of location or type of food * Resident using her fingers to feel for the location of the food on the tray and asking what/where is on the plate.	F 558	4. Random audits observing areas identified by the survey team will be conducted starting on 2/15/19. 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: February 28th, 2019	

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 _____	01/24/2019

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 558	Continued From page 2 During a interview on 01/22/19 at 12:01 p.m., Resident #100's family member (B) reported the following observations made during mealtimes: * Lack of cueing/explanations during the meal * Observations of silverware wrapped in napkins and placed where Resident #100 cannot find it * Food served in small custard cups instead of larger bowls * Lack of assist making mealtime difficult with her visual impairment. The family member stated through his/her observations over the past months, Resident #100's visual impairment requires more specialized attention and the facility could do things better to maintain more independence. Observation on 01/24/19 at 09:23 a.m. showed Resident #100 at the dining room table for breakfast. A staff member delivered the resident's breakfast tray and failed to provide explanation, cueing or assist with what/where food was on the plate. Resident #100 attempted to feed herself, moving her fingers/hands across the food plate, in an attempt to locate silverware, food and liquids, and dropping food on her lap. Staff failed to offer assistance to the resident. Observation on 01/24/19 at 12:39 p.m., showed Resident #100 at the dining room table eating lunch, feeling with her hands around the plate/table attempting to locate the glasses of fluids with no staff nearby to assist/cue resident. During an interview on 01/24/19 at 2:03 p.m., an administrative nurse (#6) acknowledged Resident #100 is blind and confirmed inconsistency of care to be a problem and things could be done better.	F 558		

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 _____	01/24/2019

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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		2/28/19

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 _____	01/24/2019

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 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a clean and homelike environment for 1 of 1 sampled resident (Resident #60) with a urine odor in their room. Failure to locate and clean the urine odor placed Resident #60 and all residents and visitors in an unpleasant environment. Findings include: Observation on all days of survey identified a urine odor in one of the hallways in the Morning Star Neighborhood. The morning of 01/22/19 found the urine odor came from Resident #60's room. During an interview on 01/24/19 at 11:15 a.m., an administrative nurse #6 indicated she was unaware of the odor and stated, "Maybe I will contact housekeeping to do a deep clean of the resident's room [Resident #60] to see if that helps." During an interview on 01/24/19 at 2:04 p.m., a nurse (#14) and a certified nursing assistant (CNA) (#13) agreed an odor present in Resident #60's room. The CNA (#13) stated Resident #60's "bag [collects urine from a tube inserted into the bladder] broke last Sunday [01/20/19]. The big night bag. It was really full. It had a lot of urine in it. . . . There was urine all over floor. Around and under the resident's bed." The nurse (#14) stated she would contact housekeeping to	F 584	It is the intent of this facility to remain in compliance with F-584 as evidence by the following: 1. Resident #60 room had the potential to be affected during the deficient practice found during survey. The room was deep cleaned on 1/24/19 after being brought to staff attention by surveyors. 2. All resident have the potential to be affected. 3. The facility will ensure residents rooms are free from unpleasant odors to help promote their dignity. Resident #60□s entire room wiped down and floor scrubbed multiple times, linen was changed completely on 1/29/2019. Carpet outside of room was shampooed on 1/30/2019 and a room deodorizer was placed in resident□s room on 1/29/2019. Resident□s room is deep cleaned weekly on Saturdays. 4. Random audits observing areas identified by the survey team will be conducted starting on 2/15/19. 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	

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 _____	01/24/2019

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 584	Continued From page 5 "maybe use a different cleaning solution."	F 584	Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: February 28th, 2019	
F 658 SS=E	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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to meet professional standards of practice for 4 of 29 sampled residents (Resident #36, #62, #57, and #131) and 1 supplemental resident (#47). Failure to notify the physician for vitals outside parameters (Resident #36), to offer food within the recommended time after rapid-acting insulin administration (Resident #47), and to complete neurological checks per policy (Resident #57, #62 and #131) may result in negative health effects for the residents. Findings include: VITALS OUTSIDE PARAMETERS Review of Resident #36's medical record occurred on all days of survey. The current physician's orders stated Xopenex-levalbuterol hcl (a medication used to prevent bronchospasms) solution for nebulization	F 658	It is the intent of this facility to remain in compliance with F-658 as evidence by the following: 1. For resident #36, the doctor was notified about the VS outside of normal parameters on 1-23-19. Parameters were established for when the physician wanted to be contacted and added to the resident's order on the eTAR. The nebulizer policy was reviewed and the statement "notify physician for all pulses under 40" was added to the policy. For resident #47, the policy and procedure was reviewed and no changes were necessary. Resident has short acting insulin and must be served a meal, appropriate drink or snack within 10-15 minutes of receiving insulin. Resident's #57, #62, and #131 all had missing data on neuro checks as staff failed to complete the form accurately. All staff were educated on 2-19-19 and 2-20-19.	2/28/19

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 _____	01/24/2019

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 658	Continued From page 6 inhalation four times a day. The electronic medication administration record (eMAR) showed parameters of 50-110 beats per minute (bpm) for acceptable pre and post pulse readings with nebulizer treatments. Review of Resident #36's eMAR from January 1 - 23, 2019 identified the following: *Pre Pulse range of 30 bpm to 39 bpm = 50 times documented *Pre Pulse range of 40 bpm to 49 bpm = 27 times documented *Post Pulse range of 30 bpm to 39 bpm = 38 times documented *Post Pulse range of 40 bpm to 49 bpm = 39 times documented The medical record showed both the pre and post pulse range below acceptable parameters 154 out of the 182 times. The record lacked evidence of notification of the medical provider for the low pulse rates. During an interview on 01/24/19 at 11:15 a.m., an administrative nurse (#6) stated the facility's policy is to retake an abnormal pulse manually and agreed staff should have notified the physician of the abnormal pulses. INSULIN ADMINISTRATION Review of facility policy titled "DIABETIC MANAGEMENT INSULIN INJECTION GUIDELINES" occurred on 01/24/19. This policy, undated, stated, ". . . When a resident has scheduled rapid insulin the injection may be held if there is reason to believe resident's meal consumption may be delayed. If insulin has been	F 658	2. All residents who require vital signs, neuro checks, and insulin have the potential to be affected. 3. All residents who require vitals will be assessed for VS out of parameters and physician notified of results if pulse less than 40. Neuro check policy was reviewed and updated to current best practice. Neuro check form has been reviewed and updated to reflect best practice. Policy was reviewed and staff will be re-educated that those who receive insulin are provided a snack or appropriate drink while waiting for their meal providing their meal is not going to be ready in appropriate time. All staff was educated on changes and updates on 2/19/19 & 2/20/2019. 4. Random audits observing all areas identified by the survey team will be conducted starting on 2/15/19. 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 Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: February 28th, 2019	

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 _____	01/24/2019

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 658	Continued From page 7	F 658		

given and meal consumption is delayed for more than 10-15 minutes, staff should consider offering resident carbohydrates . . . See guidelines for treatment of hypoglycemia. . . . Instructions: 1. Insulin reactions can occur at any time and come on quickly. They are most apt to occur: a. Before meals or if meals are delayed . . ."

Observation on 01/23/19 at 4:46 p.m. showed a nurse (#14) administered 8 units of NovoLog (fast-acting insulin) to Resident #47 while in his room. Staff transferred Resident #47 to the dining area at 5:09 p.m. and he received his meal tray at 5:15 p.m., (29 minutes after receiving the NovoLog insulin). Staff failed to provide food or liquids during this time period.

Failure to ensure staff offered food/liquids within the recommended time after rapid-acting insulin administration may result in hypoglycemia.

NEUROLOGICAL CHECKS

Review of the facility policy titled "NEURO-CHECKS," revised October 2017, occurred on 01/24/19. This policy stated, ". . . Neurological assessment is done to monitor the resident for the potential of increased intracranial pressure (ICP) . . . Neuro checks should be performed on any resident who has sustained a sudden impact . . . and on any unwitnessed fall . . . in order to establish baseline information, the resident's neurological status should be monitored every 15 minutes for the first hour, then every 30 minutes for the next hour after the injury . . . after baseline parameters have been established, at the conclusion of the first two-hour assessment period, neuro-checks

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 _____	01/24/2019

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 658	Continued From page 8	F 658		

should continue every one hour times two; every 4 hours times two and every eight hours times two . . . the neuro-checks should include vital signs, checking pupils, assessing consciousness, assessing upper and lower extremity strength, and determining response to pain . . . the nurse should monitor the resident's condition and record finding on the Neurological Assessment . . ."

- Review of Resident #57's medical record occurred on all days of survey. A progress note, dated 01/17/19, stated, ". . . Resident had an unwitnessed fall at the unit's sunroom at 1130. He was trying to reach for a side table and fell. He scraped the left side of his head and the left side of his back . . . He is alert and oriented to person only, his speech is at baseline, PERRLA [pupils equal round reactive to light and accommodation], upper extremities are strong, he denied pain . . . neuro checks were started."

Review of Resident #57's Neurological Assessment Form completed after the initial neurological check identified staff completed the vital signs portion of the neurological assessment but failed to check pupils, assess consciousness, assess upper and lower extremity strength, and determine response to pain for 9 of the 11 assessments.

During an interview on 01/24/19 at 4:15 p.m., a supervisory nurse (#3) stated she expected staff to complete the neurological assessment form including monitoring pupils, consciences and responses to pain.

- Review of Resident #131's medical record

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 _____	01/24/2019

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 658	Continued From page 9	F 658		

occurred on all days of survey. A progress note, dated 07/21/18 (recorded as late entry on 07/22/2018 at 3:36 p.m.) stated, ". . . Resident had an unwitnessed fall on 07/21/18 . . . Resident was found on the floor in her room immediately next to her bed . . . neuro checks initiated . . . resident denied pain and was assessed for injury . . . vitals signs obtained and reviewed . . . neuro checks per facility policy-remain WNL (within normal limits) with the exception of elevated blood pressures. Provider updated regarding resident's blood pressure history as related to neuro checks and orthostatic pressures performed in AM on 07/22/18 . . ."

Review of Resident #131's medical record showed no neurological assessment in the chart from the unwitnessed fall on 07/21/18.

During an interview on 01/24/19 at 11:01 a.m., an administrative nurse (#12) stated they were not able to locate the Neurological Assessment for Resident #131 and she expected staff to complete the assessment.

- Review of Resident #62's medical record occurred on all days of survey. A progress note, dated 01/20/19, stated ". . . Resident was found face down on the floor . . . large pool of blood noted under residents head . . . see vitals in TAR and Neuro sheet started . . . ".

Review of resident medical record showed the Neurological assessment on Resident #62 dated 01/20/19 was not completed by nursing staff. Resident #62 had an unwitnessed fall on 01/20/19 with Neurological Assessments started at 2:40 a.m. and completed all the vital signs,

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 _____	01/24/2019

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 658	Continued From page 10 pupil checks, consciousness, speech, respirations and signature but nursing staff failed to complete any documentation for the 11:25 a.m. and 7:25 p.m. neurological checks. During an interview on 01/23/19 at 5:27 p.m., an administrative nurse (#6) stated the neurological checks on Resident #62 were not completed by nursing staff per facility policy.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to adequately assess nutritional needs, and	F 692	It is the intent of this facility to remain in compliance with F-692 as evidence by the following:	2/28/19

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 _____	01/24/2019

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 692	Continued From page 11 implement appropriate interventions to restore/maintain sufficient nutritional status for 1 of 4 sampled residents (Resident #57) who experienced severe weight loss. Failure to meet the residents' nutritional needs through diet, supplements, or other interventions may have contributed to the resident experiencing severe weight loss. Findings include: Review of the facility policy titled, "Resident Weight Monitoring and Evaluation of WeightLoss/Weight Gain" occurred on 01/24/19. This policy, revised June 2017, stated, "Policy: To have the resident weighed on a regular basis and monitor residents with a significant or continual weight loss or weight gain and intervene as necessary . . . Licensed Registered Dietitian (LRD) will check all resident's weights monthly. Those that have significant weight loss of 5% in 30 days and/or 10% in 180 days will be reviewed and assessed. Upon the review of the monthly weights, the LRD will request from nursing any re-weighs necessary. Significant weight changes will be reviewed on a regular basis at interdisciplinary meetings. . . ." Review of Resident #57's medical record occurred on all days of survey. The current care plan stated, ". . . Nutritional Status - Alteration in nutrition: Appetite may be affected by dx [diagnosis] of Cortcobasal degeneration . . . Resident's weight will stabilize between 185-195# [pounds] X [times] 90 days. . . .Assist with tray set-up and may assist with eating as needed . . . monitor weight."	F 692	1. Resident #57 had weight loss without intervention in an appropriate amount of time. Individuals involved accidentally missed the December review of this resident on weights. The weight loss was noticed and addressed, but it was not in accordance with the policy. 2. All residents have the potential to be affected. 3. Reviewed weight loss policy was reviewed and no changes were necessary. Staff educated on 2/19/19 and 2/20/19 and implemented a monthly weight change monitor form of significant weight changes. 4. Random audits observing all areas identified by the survey team will be conducted starting on 2/15/19. Audits will be conducted on 10% of the resident every month for three months, then 10% of the residents per quarter for three quarters. Audits will be completed by Quality Assurance Nurse or designee and results will be reported to the Quality Assurance Committee quarterly. 5. Date of correction: February 28th, 2019	

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 _____	01/24/2019

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 692	Continued From page 12 Review of Resident #57's weight record identified the following: 07/03/18 189.4 (lbs.) pounds 08/07/18 189. 8 lbs. 09/04/18 188.1 lbs. 10/02/18 179.5 lbs. 11/06/18 170.8 lbs. 12/04/18 164.3 lbs. 01/01/19 157.2 lbs. (17 percent weight loss in 6 months represents severe weight loss) A physician's progress note, dated 11/08/18, stated, ". . . He admits to having a poor appetite, but denied any pain or discomfort. Over the past few months time, staff have noted a weight loss of approximately 10 pounds . . . Assessment/Plan . . . Abnormal weight loss . . ." The dietary progress notes showed the following: * 11/19/2018 at 10:40 a.m. ". . . Resident shows weight loss over 3 months despite continuing to have good meal intake. On 11/8/18 his physician wrote a dx of abnormal weight loss. Weights are as follows: 11/6/18 170.8#, 10/2/18 179.5#, 8/7/18 189.8#, 5/1/18 190.9#. Staff continue to provide assistance prn [as needed] and supervision during meals. Diet order is regular cut food into bite sized pieces and nectar liquids. Added a Might [sic] Shake daily to help maintain his weight. His BMI [body mass index] is within normal range 23.82." * 01/08/2019 4:32 p.m. ". . . Resident continues to be on a regular diet (food is cut into bite sized pieces) and nectar consistency liquids by spoon. Meal intake has ranged 50-100% which has been consistent for him. He is on a Mighty Shake daily and intake has been good. Despite his consistent intake and the supplement he continues to have	F 692		

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 _____	01/24/2019

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 692	Continued From page 13 weight loss. Weights are as follows: 1/1/8 157.2#, 12/4/18 164.3#, 10/2/18 179.5#, 7/3/18 189.4#. Increased the Mighty Shake to TID [three times daily] to help prevent further weight loss." During a phone interview on 01/24/19 at 9:34 a.m. a dietary supervisor (#15) stated, staff did not inform her of the physician's visit on 11/08/18, the 10 pound weight loss or the new diagnosis of abnormal weight loss. She further stated she checks resident's weights once a month and when she checked Resident #57's weight on 11/19/18 (11 days after abnormal weight loss diagnosis) she "started the mighty shake." When asked about weights being done monthly she replied at times she may "request more frequent weights." During an interview on the afternoon of 01/24/19 a dietary supervisor (#15) confirmed staff failed to complete a nutritional assessment to evaluate Resident #57's nutritional needs. The facility staff failed to assess Resident #57's weight loss on a routine basis, (missed the December 2019 review) implement new interventions, and complete a nutritional assessment to evaluate Resident #57's nutritional needs.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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	F 695		2/28/19

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 _____	01/24/2019

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 695	Continued From page 14 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: NEBULIZER TREATMENTS 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services consistent with professional standards of practice for 1 of 6 sampled residents (Resident #62) who received respiratory care with nebulizer treatments. Failure to monitor and recognize changes in respiratory status may have resulted in the delay of interventions. Findings include: Review of the facility policy titled "Nebulizer Therapy" occurred on 01/24/19. The policy, dated November 2017, stated, ". . . a nursing assessment including pre and post treatment on all residents . . . position resident in a semi-fowlers . . . (when the patient is positioned on their back with the head elevated between 15 to 45 degrees) . . . perform pre-treatment vitals and record in the eTAR (electronic treatment administration record) . . . return to stop therapy when nebulizer is no longer misting as the treatment is complete and the machine can be turned off . . . do post HHN [hand held nebulizer] treatment O2 [oxygen] sats [saturations], respiratory and heart rate and lung sounds and record on the eTAR. Also record on the eTAR entry the number of minutes that it took for the length of your pre-treatment assessment and your post-treatment assessment . . ."	F 695	It is the intent of this facility to remain in compliance with F-695 as evidence by the following: 1. Staff that were involved with Resident #62 were counseled and reeducated on correct nebulizer treatments as well as accurate charting. The physician caring for resident #134 was notified on 01/24/19 in regards to the discrepancy in oxygen and a clarifying order was obtained. 2. All residents who require nebulizer treatments and receive oxygen have the potential to be affected. 3. The current policy related to oxygen use was reviewed and remains unchanged. Education was provided to all nursing staff on 2/19/19 & 2/20/19 regarding caring for residents with oxygen needs. Areas that were emphasized included reviewing orders and to notify physician if resident is requiring more oxygen than ordered. Staff has been educated on 2/19/19 & 2/20/19 on the importance of assessing resident post nebulizer treatment in an appropriate manner to get the most accurate post assessment. The nebulizer policy was reviewed and revised and the statement was added, "under no circumstances should a nebulizer treatment be left on for	

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 _____	01/24/2019

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 695	Continued From page 15 - Resident #62's medical record reviewed on all days of survey, identified diagnosis chronic respiratory failure. The resident's current care plan identified, ". . . Falls . . . don't leave me alone in room in wheelchair. . . . Disease Management . . . hx [history] of chronic bronchitis, shortness of breath when lying flat, reactive airway disease . . . . continuous oxygen at 1-4 liters via nasal cannula. Titrate to keep SATS [oxygen saturation] greater than 90% . . . notify physician of any severe pain . . . be alert for increasing signs of anxiety . . . provide update to her nurse and physician as needed . . . notify physician if resident is not showing improvement . . ." Resident #62's physician's orders, dated 06/04/18, showed oxygen at 2 liters via nasal cannula continuous to keep sats greater than 90% and DuoNeb (a medication used for a respiratory nebulizer treatments) four times per day. Observation showed the following: * 01/22/19 at 4:23 p.m.: Resident #62 lying in her room in bed, DuoNeb treatment per O2 mask started by a nurse (#8). * 01/22/19 at 4:46 p.m.: A CNA (certified nursing assistant) (#10) entered another resident's room next door to Resident #62 to take the resident to the dining room. The CNA (#10) did not look or walk into Resident #62's room to check on her. * 01/22/19 at 5:16 p.m.: Resident #62 observed with nebulizer face mask sitting on her chin, the medication completed, no longer misting, and the nebulizer machine remained on. Resident #62 appeared restless, pulling her shirt around her	F 695	more than 30 minutes". 4. Random audits observing areas identified by the survey team will be conducted starting on 2/15/19. 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: February 28th, 2019	

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 _____	01/24/2019

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 695	Continued From page 16 neck, right hand in her brief, rolling side to side, and attempting to get out of bed. * 01/22/19 at 5:33 p.m.: Resident #62's nebulizer mask hanging around resident's neck with the medication done and the nebulizer machine remained on. * 01/22/19 at 5:52 p.m.: The nurse (#8) entered Resident #62's room and found the resident lying flat in bed with the nebulizer mask and nasal cannula hanging around her neck and the nebulizer machine on. The nurse (#8) performed post treatment vital signs that showed: Oxygen saturation 86% on 2 liters oxygen per nasal cannula, respirations 16 breaths per minute, heart rate 68 bpm (beats per minute), and lung sounds auscultated by nurse (#8), who reported "they were ok". Observation showed the resident was restless and breathing heavily. During an interview at 6:02 p.m., the staff nurse (#8), stated she administered the DuoNeb treatment to Resident #62 "about 4:30 p.m." and she had not charted the neb treatment yet. When asked how long she keeps the nebulizer treatment on, the nurse (#8) stated "it takes about 15 minutes to complete" and she "forgot about the nebulizer treatment." * 01/22/19 at 6:16 p.m.: A CNA (#10) entered Resident #62's room and stated to nurse (#8) she was in her room "every fifteen minutes" checking on her (Resident #62). Observation on 01/22/19, showed the nurse (#8) applied the DuoNeb treatment at 4:23 p.m., and it remained on until 5:52 p.m. (a total of one hour and twenty nine minutes with the surveyor observing the entire time). During the time frame, staff failed to check on Resident #62.	F 695		

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 _____	01/24/2019

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 695	Continued From page 17 On 01/22/19 at 6:29 p.m., review of Resident #62's treatment record showed staff failed to document the 4:00 p.m. DuoNeb nebulizer treatment. Later that evening, the treatment record showed a late entry for Resident #62's neb treatment with the following post treatment vitals: oxygen saturation =95%, pulse= 65, respirations=15, post lung sounds=clear. The late entry documentation by the nurse (#8) conflicts with the surveyor's observation on 01/22/19 at 5:52 p.m. No documentation was recorded in Resident #62's medical record by the nurse (#8) the physician was notified of the resident's status on 01/22/19. On 01/23/19 at 08:23 a.m., record review identified a nurse (#11) contacted Resident #62's physician and family and the resident was transported to the hospital on 01/23/19 at 8:23 a.m. with a diagnosis of respiratory failure. During an interview on 01/23/19 at 11:17 a.m., an administrative nurse (#6) stated she is aware of some of the happenings that occurred with Resident #62 and confirmed staff should follow policies and standards. OXYGEN THERAPY 2. Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #134) receiving oxygen. Failure to provide oxygen as ordered may complicate a resident's respiratory status.	F 695		

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 _____	01/24/2019

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 695	Continued From page 18 Findings include: Review of the facility policy titled, "Oxygen Use" occurred on 01/24/19. This policy, revised October 2017, stated, ". . . Use only the amount of oxygen prescribed by the physician . . ." Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." Review of Resident #134's medical record occurred on all days of survey. Diagnosis included respiratory insufficiency and pulmonary hypertension. A physician's order dated 12/26/19, stated, "Oxygen @ [at] 1 liter via nasal cannula continuous" The current care plan stated, "Alteration in comfort related to history of colds, cough, sore throat and URI [upper respiratory infection] shortness of breath with exertion and while lying flat, wheezing . . . Continuous oxygen: Oxygen at 1L [liter] via NC [nasal cannula] continuously . . ." Observations on 01/22/19 at 5:17 p.m. and 01/23/19 at 9:19 a.m. and 2:40 p.m. showed resident #134 with oxygen on at two liters per nasal cannula. Review of the resident's electronic treatment	F 695		

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 _____	01/24/2019

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 695	Continued From page 19 record from January 01-23 2019, identified oxygen at one liter per nasal cannula. The oxygen level and saturation were document twice a day and identified the oxygen rate at two liters 20 times and at three liters 22 times. During an interview on 01/24/19 at 2:07 p.m. a licensed nurse (#16) confirmed Resident #134's oxygen is ordered for one liter nasal cannula and staff administered the oxygen at two to three liters.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, professional reference review, resident interview, and staff interview, the facility failed to ensure the care and services consistent with professional standards of practice for 1 of 2 sampled residents (#16) on dialysis with a central venous catheter. Failure to assess the hemodialysis vascular access site (central venous catheter) has the potential to result in complications such as dislodgement, bleeding, and/or infection. Findings include: Review of the facility policy "Dialysis Care" dated 11/27/17, occurred on 01/24/19. The policy	F 698	It is the intent of this facility to remain in compliance with F-698 as evidence by the following: 1. All staff involved caring for resident #16 were educated on her CVC as well as the fact that it needs to be checked and charted on daily. 2. All residents have the potential to be affected that are on dialysis. Currently we have three residents on dialysis, two of those with CVC. 3. Policy was reviewed and updated, changes to the policy include that all	2/28/19

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 _____	01/24/2019

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 698	Continued From page 20 addresses the care of fistulas/shunts, but fails to address the care of central venous catheters used for dialysis. Review of the "Core Curriculum for the Dialysis Technician - A Compressive Review of Dialysis, Fifth Edition, pages 121, 148, and 149, stated, "Vascular access makes chronic hemodialysis (HD) possible . . . An access is an HD patient's lifeline. Each access must be cared for as if it is the last one a patient can have. . . . The three main types of access are: 1. Fistulas 2. Grafts 3. Central venous catheters. . . . Central Venous Catheters . . . some patients may need them for months or even years. . . . catheters are much more likely . . . to develop blood infections. . . ." During an interview on 01/22/19 at 4:03 p.m., Resident #16 stated she is on dialysis and showed the surveyor her right upper chest, which had a central venous catheter (CVC) covered with a clear dressing. Review of Resident #16's medical record occurred on all days of survey. Diagnosis included end stage renal disease with hemodialysis treatments three days a week. The Treatment Administration Record (TAR) identified Resident #16 has a fistula in her left arm and staff documented they assessed the fistula every evening. The facility staff failed to document assessment of the CVC site on the TAR. Review of the medical record identified staff assessed Resident #16's CVC site and documented the assessment in the nursing notes up until 12/08/18, with no further nurses notes regarding the CVC after that date.	F 698	residents who are receiving dialysis and have a CVC, will have their CVC visually assessed daily and physician notified if s/s of infection. Resident #16 care plan updated to include checking CVC daily. Assessment of sites will be added to resident□s eTAR. Education provided to all nursing staff on 2/19/2019 & 2/20/2019 regarding updated care plan. 4. Random audits observing areas identified by the survey team will be conducted starting on 2/15/19. Audits will be conducted on 10% of the residents with a CVC, a week for four weeks, 10% of the residents with a CVC, a month for two months and 10% of the residents with a CVC, 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: February 28th, 2019	

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 _____	01/24/2019

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 698	Continued From page 21 Review of the current care plan identified Resident #16's fistula but failed to address the resident's central venous catheter. During an interview on the afternoon of 01/23/19, a nurse (#4) stated Resident #16 has both a catheter and a fistula for dialysis. When asked about assessment of the catheter site, the nurse confirmed staff had not documented this assessment. An administrative staff nurse (#3), on the afternoon of 01/24/19, confirmed Resident #16's care plan did not address her central venous catheter.	F 698		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services	F 880		2/28/19

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 _____	01/24/2019

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 880	Continued From page 22 under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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 _____	01/24/2019

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 880	Continued From page 23 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 7 sampled residents (Resident #36) observed during wound dressing changes and 1 of 3 sampled residents (Resident #26) on isolation precautions. Failure to follow appropriate infection control practices related to wound dressing changes and isolation precautions may result in the spread of infection to residents, staff, and visitors. WOUND DRESSING CHANGE Review of facility policy titled "DRESSINGS - CLEAN TECHNIQUE" occurred on 01/24/19. This policy, revised November 2013, stated, ". . . PURPOSE: 1. To protect open wound from contamination. . . . 3. Decrease risk of infection . . . PROCEDURE: 1. Complete hand hygiene. . . . 4. Remove old dressing and dispose of it . . . 5. Remove gloves and complete hand hygiene. 6. Apply clean gloves. . . . 8. Cleanse wound using gauze and cleansing solution . . . 9. Apply ointment as ordered. . . . 10. Apply clean dressing. . . . 13. Remove gloves and complete hand hygiene. . . ."	F 880	It is the intent of this facility to remain in compliance with F-880 as evidence by the following: 1. Resident #26 had the need to be in isolation. The involved physician who failed to gown and glove was educated by the DON on proper PPE usage per telephone on 01/23/19. He verbalized understanding. Nurse #2, was reeducated on clean wound dressing changes as well as the need to perform hand hygiene between glove changes on 02/20/19. She was also educated on the need to utilize a clean ABD after coming into contact with a dirty wound. Policies were reviewed for both and no changes were necessary. 2. All residents have the potential to be affected by improper infection prevention and control practices. 3. All nursing staff were re-educated on hand hygiene between dressing changes and proper use of PPE with residents who are in isolation on 2/19/2019 & 2/20/2019. They were also educated on the fact that	

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 _____	01/24/2019

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 880	Continued From page 24 Review of facility policy titled "HAND HYGIENE" occurred on 01/24/19. This policy, revised January 2014, stated, "POLICY: It is the policy of the facility that hand washing/alcohol based hand rub be regarded as the single most important means of preventing the spread of microorganisms and transmission of infection. PROCEDURE: 1. All personnel shall follow hand hygiene policies and procedures to prevent the spread of infection and disease to resident, visitors, and other personnel. . . . 3. When to perform hand hygiene: . . . q. After handling soiled or used linens, dressings, . . . s. After removing gloves . . ." Observation on 01/24/19 at 7:58 a.m. showed a nurse (#2) performed hand hygiene, donned gloves, removed Resident #36's wound dressing to the right heel, placed the right heel on a clean abdominal dressing pad (ABD) and changed gloves without performing hand hygiene. The nurse then cleansed the wound, changed gloves, applied Silvadene (a cream used to prevent and treat wounds), covered the wound with the same ABD the dirty wound rested on, and secured the ABD with Kerlix and tape. Without performing hand hygiene, the nurse changed gloves, placed lambs wool (used for pressure relief) between Resident #36's toes, removed her gloves, put the wound dressing supplies away, and then performed hand hygiene. The nurse (#2) failed to perform hand hygiene between glove changes and to utilize a clean ABD after it came into contact with a dirty wound. CONTACT PRECAUTIONS Review of the facility policy, "Transmission-based	F 880	this is our facility and any individual's that are in our building working with our resident's must adhere to our policies and procedures. This includes doctors, dentists, therapists or any other professional individuals that care for our resident's in our facility. Instructions on how to properly don and doff PPE have been added to our isolation carts and are to be placed for any person to see prior to entering resident□s room who is on isolation. 4. Random audits observing areas identified by the survey team will be conducted starting on 2/15/19. 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: February 28th, 2019	

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 _____	01/24/2019

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 880	Continued From page 25	F 880		

Precautions," occurred on 01/24/19. This policy, dated December 2014, stated, "Transmission based precautions are use IN ADDITION TO STANDARD PRECAUTIONS. . . . PROCEDURE: Patients with suspected or confirmed diseases Transmission Based Precautions will be utilized until the condition has been ruled out or the criteria for removal from isolation have been met. . . . Contact Precautions. Contact, or touch, is the most common and most significant mode of transmission of infectious agents. Residents in Contact Precautions include those infected with . . . active MRSA [methicillin resistant staphylococcus aureus, a multi-drug resistant organism] . . . Contact transmission can occur by direct or indirect contact with the resident, through contact with the resident's environment, or by using contaminated gloves or equipment. . . . Healthcare workers caring for patients in Contact Precautions must: Wear clean, nonsterile examination gloves when having direct contact with infective material . . . Remove gown and gloves before leaving room. Do not allow clothing to contact potentially contaminated surfaces or items before leaving the room. . . ."

- Review of Resident #26's medical record occurred on all days of survey. Microbiology culture results from the left toe, dated 1/15/19, identified MRSA. Resident #26's current care plan stated, "Problem: Start Date: 01/16/2019. . . Impaired skin integrity related to left great toenail bed infection. . . . Approach: . . . Contact isolation . . ."

Nursing Progress Notes, dated 01/17/2019, stated ". . . culture returned MRSA placed in

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 _____	01/24/2019

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 880	Continued From page 26 contact isolation [name of physician] notified to remain on Bactrim DS [an antibiotic] . . ." Observation on 01/21/19 at 9:00 a.m. showed a medical provider (#17) touching Resident #26's left great toe, his other toes, and then touching the bed and bedframe. A supervisory nurse (#4) asked the provider if Resident #26 should remain on contact precautions and the provider stated yes. The medical provider (#17) failed to wear gloves and a gown while providing care for a resident in contact precautions. During an interview the afternoon of 01/24/19, an administrative nurse (#1) confirmed providers should wear a gown and gloves when providing wound care for residents in contact precautions.	F 880		