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 _____	07/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(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 For the standard Medicare/Medicaid recertification survey started on 07/26/10 and completed on 07/29/10 the sample included five (5) residents for complete review, 16 residents for focused review, and three (3) closed records for review. The sample included eleven (11) additional residents to verify specific concerns during the survey.	F 000		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, individual resident interview, resident group interview, review of menus, review of the Resident Handbook, and staff interview, the facility failed to provide choices of food and drink items significant to residents or as listed menu items, for 5 of 7 residents attending the group interview (Resident #29, #30, #33, #34, and #35), 3 of 21 (Resident #5, #16, and #21) sampled residents, and 2 (Resident #25 and #26) supplemental residents. Failure to provide food and drink items listed on the menu, without comparable alternatives, or without explanation did not respect each resident's right to exercise his or her autonomy regarding what they considered important in their lives.	F 242	F242 The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. This requirement is not met as evidenced by failure to provide food and drink items listed on the menu, without comparable alternatives, or without explanation. 1. The corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. Resident Handbook was revised to state.. "Restaurant Style Dining offers choices at each meal. The Baptist Home	9/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vincent Pesek | TITLE: Administrator | (X6) DATE: 9/14/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 Findings include: Review of the facility's Resident Handbook occurred on 07/29/10. This document, dated 03/10/09, stated "DIETARY . . . food and eating serve a number of other functions for our residents and society which are basically social in nature. . . . The dietary staff endeavor to meet resident's nutritional needs and personal preferences. . . ." Review of the facility's "Weekly Features" menu occurred on July 29, 2010. The menu stated, "Water, milk, juice, and bread are available at all meals and served per choice of resident." - A group interview occurred on July 27, 2010 at 1:00 p.m. Of the seven residents in attendance, five residents (Resident #29, #30, #33, #34, and #35) stated the facility ran out of bread on several occasions. The residents stated facility staff told them they were out of bread, and a substitution was not offered. Three residents (Resident #33, #34, and #35) stated the facility "is always out" of orange and apple juice. When the residents ask for juice, facility staff tell them it is not available right now. These three residents (Resident #33, #34, and #35) also stated they write down their preferences on "slips" (which are given to dietary staff and indicate what the residents would like to eat at each meal), but they do not get their preferences; something else is usually substituted. One resident (Resident #33) stated she used to get a fried egg once a week, which she really enjoyed; however, now she gets one once a month. The resident stated no explanation was given to her, only that "the menus are changing."	F 242	provides a wide variety of food and drink choices over the course of the menu cycle. Special requests will be discussed with residents and families and provided on an individual basis." LRD will continue to discuss special requests with residents/family and develop a plan on an individual basis. This is discussed upon admission, quarterly and as resident/family requests. LRD and/or nutritional services designee will continue to have resident menu meetings. The most recent meeting was August 30th, 2010 at 10:30am. All residents were invited to attend. 12 residents attended. Resident #5 stated when asked if he would like to attend the meeting "I don't have any concerns with the menu. I am happy with the food here. Why do I need to	

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F 242	Continued From page 2 - In an interview on July 28, 2010 at 8:45 a.m., Resident #33 stated no caramel rolls were available that morning for breakfast, although the menu stated caramel rolls would be served. Facility staff told Resident #33 "the staff that were supposed to make them [the rolls] were off." The resident stated she was offered a pancake substitution, but she does not like pancakes. Resident #33 stated, "I had my heart set on a caramel roll, but they didn't have any. I had a piece of toast. That's not breakfast." - Observation in the Third Floor Southview Dining Room, on 07/28/10 at 8:00 a.m., identified the following: *Resident #16 requested an egg from an unidentified staff member. The staff member told the resident the facility was "out of eggs." *Resident #21 requested a bran muffin from an unidentified staff member. The staff member told the resident a bran muffin was not available and offered the resident a pancake, which the resident accepted. *Resident #25 requested a caramel roll from an unidentified staff member. The staff member told the resident a caramel roll was not available and offered the resident a pancake, which the resident accepted. *At 8:25 a.m., Resident #26 requested eggs and meat for breakfast from an unidentified staff member. The staff member told the resident these items were not available and offered the resident a pancake, which the resident accepted. - Review of Resident #5's medical record occurred on July 26-29, 2010. The facility admitted the resident in January 2010. Current diagnoses included dependent personality	F 242	go?" He did attend the meeting after he was asked again if he would like to go. Resident menu meetings will be held on a quarterly basis. A "Resident Choice" meal was added to the menu. Special Menu suggestions will be added in on for this meal. The Resident Choice meal will rotate throughout the 3 week menu cycle based on requests received from residents. Residents will be informed of these changes at Resident Council Meeting on Monday, August 30, 2010. Family members will be informed by a letter explaining the changes made to the Resident Handbook. b. Dietary Cards are the vehicle for communication for resident choices. Staff education focuses on reading the dietary cards correctly to assure that the residents' choice is being honored. Staff education	

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F 242	Continued From page 3 disorder, anxiety, depression, and history of malnutrition. The resident's current Minimum Data Set (MDS), dated 07/26/10, identified short term memory problems, modified independence in daily decision making, and supervision and set-up help for meals. Resident #5's Nutritional Resident Assessment Protocol (RAP) Summary, dated 07/27/10, stated ". . . has a history of weight loss, history of not eating well and he is underweight. . . ." Quarterly Nutrition Care Conference Notes, dated 07/27/10, stated ". . . He is on a double protein diet. . . ." Resident #5's current care plan, dated 04/27/10, stated "Problem, Alteration in nutrition: [updated] 07/27/10, Hx [History] of weight loss, poor meal intake, underweight . . . Approaches . . . Feeds self, assist with tray set-up . . . Double protein diet . . . Problem, Mood symptoms related to dependent personality disorder . . . Approaches . . . Provide reassurances and provide reminders in a positive way (ie [in example] telling him what you can do for him rather than what cannot be done.) Encourage him to stay in DR [dining room] until meal is finished for safety and improved nutrition. . . ." Observation, on 07/27/10 at 12:15 p.m., identified Resident #5 independently propelling his wheelchair from the dining room, having finished his meal. The resident consumed 100% of his pork chop and mashed potatoes, 50% of his squash, none of his pudding and 100% of his milk and supplement. Further observation showed his dietary meal ticket with handwritten "cold beef sandwich." Unidentified staff members in the dining room	F 242	includes treating all residents, in a manner that respects their dignity and privacy. Dietary Meeting was held August 31st, 2010, Nurses Meeting was held August 31st, 2010, and CNA meeting was held on September 2nd, 2010. Special circumstances that individual residents have will be discussed with those staff directly caring for them, including dining room staff. This will be communicated through unit meetings, dietary meetings and/or as circumstances arise. c. The facility will now be receiving 2 deliveries per week from our food company to ensure we have sufficient amounts of product on hand. d. The facility will have a communication board in all resident dining rooms to alert residents and staff of any changes to the menu for each meal.	

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F 242	Continued From page 4 identified Resident #5 requested the "cold beef sandwich" and did not know why he received the pork chop instead of the sandwich. Review of the facility's "Bistro" menu for the week of July 26-August 1, 2010 showed "roast beef sandwich" as a selection. Review of the facility's menu for 07/27/10 showed the "pork chops with gravy" as the "featured noon meal." The facility identified Resident #5 requires a double protein diet and should be approached in a positive way of what can be done for him. The facility provides residents the opportunity to order meal items from the "Bistro" menu. Resident #5 requested a beef (a source of protein) sandwich from the menu. The facility failed to honor the resident's choice of meal item. Failure to honor Resident #5's choice of beef sandwich did not respect his right to make decisions important to him and failed to provide him with positive approaches for dealing with his dependent personality disorder. - Review of Resident #16's medical record occurred on July 28-29, 2010. Diagnoses included gastroesophageal reflux disease, constipation, B-12 deficiency, and depression. The resident's quarterly MDS, dated 07/22/10, identified short term memory impairment, moderate impairment in making daily decisions, makes self understood, and eats independently with set-up help only. The quarterly MDS, dated 06/22/10, identified weight loss. A dietary progress note, dated 07/23/10, indicated Resident #16's appetite increased since Metamucil discontinued on 06/23/10, weight	F 242	2. The facility will identify other residents having the potential to be affected by the same deficient practice; a. All residents have the potential to be affected by this deficiency. Therefore, the facility will have a communication board in all resident dining rooms to alert residents and staff of any changes to the menu for each meal 3. The facility will put into place the following measures or systemic changes made to ensure that the deficient practice will not recur; a. Dietary staff will be educated on reading cards correctly at special dietary meeting on Tuesday, August 31, 2010. b. Regular dietary staff meetings will be held to discuss dietary or dining room issues. c. Residents and/or family's satisfaction is monitored through monthly Resident Council Meetings, Resident Suggestion Boxes	

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F 242	Continued From page 5 stable since June, albumin level (protein made by the liver) 3.0 in May (below normal), added a protein supplement, and receives a fried egg for breakfast per her request. An egg is a source of protein. Failure to honor Resident #16's request for an egg did not respect the resident's right to make decisions important to her; did not address the resident's history of below normal albumin and may contribute to the low albumin level. - Review of Resident #21's medical record occurred on July 28-29, 2010. The facility admitted the resident in January 2007. The resident's current diagnoses included constipation. Physician's orders included a regular diet. Failure to honor the Resident #21's request for the bran (a source of fiber) muffin did not respect the resident's right to make decisions important to her and may have contributed to her constipation. - Review of the facility's breakfast menu for 07/28/10 identified caramel rolls on the menu; and, failed to identify pancakes on the menu. Failure to honor Resident #25's request for the caramel roll did not respect the resident's right to make decisions important to her. - Review of the facility's breakfast menus for the week, July 26, 2010 - August 1, 2010, identified bacon on two days, sausage patties on one day, and egg items on four days. Failure to honor Resident #26's request for eggs and a meat item (sources of protein) or offer a	F 242	which are available 24/7 in all the dining rooms, Quarterly Menu Committee Meetings, and monthly Family Support Group. d. Dietary personnel will be using a Dietary QA form for the following residents: #5, 16, 21, 25, 26, 29, 30, 33, and 35. Resident # 34 is no longer at the facility. This QA form will be completed at every meal for 3 months and then randomly thereafter. e. Dietary supervisors will be using a Form 52-62 Supervisors QA on Staff Reading Cards Correctly. This QA form will be done daily at random meals and dining rooms for 3 months and then randomly thereafter. 4. The facility plans to monitor its performance to make sure that solutions are sustained. a. Dietary personnel will be using a Dietary QA form for the following residents: #5, 16, 21, 25, 26, 29, 30,	

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F 242	Continued From page 6 protein item did not respect the resident's right to make decisions important to him and may have limited his protein intake. During interview, on 07/29/10 at 2:00 p.m., two dietary management staff members (#15 and #28) stated their expectation is that Resident #5 would have received the cold beef sandwich as requested; the facility has had difficulty obtaining grocery deliveries from a supplier and recently changed supplier for fresh fruits and vegetables; the facility did run out of eggs on 07/28/10; the facility did run out of bread on 07/06/10 due to delay of delivery; the facility has not run out of juices; the facility "didn't have supplies" to make caramel rolls for breakfast on 07/28/10 (despite being a menu item); the facility cannot provide each resident with every choice; and the dietary department offers residents many choices. These staff members did not report any short term purchases of eggs or bread as corrective actions. The facility residents requested food items consistent with their diets and nutritional needs, and planned to be available on the facility's menus, and as their preferences. The facility failed to honor those requests for unknown reasons and/or due to a lack of availability. The facility failed to provide short term corrective action by purchasing bread and eggs when regular deliveries were delayed. Failure to honor the residents' requests did not respect the residents' rights to make decisions important to them and failed to follow the care approaches for these residents.	F 242	33, and 35. Resident # 34 is no longer at the facility. This QA form will be completed at every meal for 3 months and then randomly thereafter. b. Dietary supervisors will be using a Form 52-62 Supervisors QA on Staff Reading Cards Correctly. This QA form will be done daily at random meals and dining rooms for 3 months and then randomly thereafter. c. A QA report will be presented at monthly QA meetings by the LRD or her designee. 5. The corrective actions will be completed on or before September 2, 2010.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 7 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary interior regarding accumulated dust/debris on the circulating fans in 2 of 3 dining rooms, 2 of 4 nursing stations, and 1 resident's personal fan (Resident #17). Failure to keep the fans free of dust and debris placed residents at risk for airborne illness. Findings include: Observation on July 27-29, 2010, showed the following: * An accumulation of dust and debris on the circulating fan in the 3rd floor Southview dining room. Observation showed the fan blew air in the direction of the food steam table and residents seated at a dining room table directly below the circulating fan. * An accumulation of dust and debris on the circulating fan in the 2nd floor Southview dining room. Observation showed the fan blew air in the direction of the food steam table. * An accumulation of dust and debris on the fans at the 2nd and 3rd floor north nurses stations. * An accumulation of dust on Resident #17's personal fan positioned on his bedside table. During the environmental tour of the facility on the afternoon of 07/28/10, an environmental administrative staff member (#24) stated it's the responsibility of the housekeeping staff to clean the facility fans. She stated the staff clean the	F 253	F-Tag 253 The facility must provide housekeeping and maintenance service necessary to maintain sanitary, orderly, and comfortable interior. The facility failed to ensure a sanitary interior regarding accumulated dust/debris on the circulating fans. 1. The corrective action will be accomplished by all fans in the facility, will be checked for cleanliness on a weekly basis and cleaned on a regular monthly basis. 2. The facility will identify other residents having the potential to be affected by the same deficient practice; a. All residents have the potential to be affected by this deficiency. Therefore, the facility will have the housekeeping department check the rooms weekly for fans and make sure that new fans are put on the list. *Continued on 8-2 (next page)*	

F-tag 253 Continued from Page 8

3.The facility will put into place the following measures or

systemic changes made to ensure that the deficient practice will not recur;

a. All rooms will be checked for fans on a weekly basis and put on a maintenance scheduled. The fans will be checked on a weekly basis and cleaned on a monthly basis.

4.The facility plans to monitor its performance to make sure that the solutions are sustained;

a. Director

b. Eenvironmental Service will review audit sheets and report to the Quality Assurance team montly at the regular scheduled meeting.

5. All facility fans were cleaned on or before August 15, 2020.

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F 253	Continued From page 8 fans when needed and they're not on a routine cleaning schedule.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being regarding bowel function, for 1 of 1 (Resident #4) sampled resident requiring manual extraction of stool. Failure to provide dietary interventions for constipation placed the resident at risk of physical and psychological harm related to manual extraction and use of unnecessary medications and their side effects. Findings include: Review of the facility policy and procedure, Bowel Management, occurred on 07/29/10. This document, undated, stated "A. POLICY: Bowel Management will be used as an option for residents with dysfunctional bowel elimination patterns and neurogenic bowel fecal incontinence. The programs will be utilized to decrease the overall use of PRN [as needed]	F 309	F-Tag 309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical well being. The requirement was not met as the facility failed to provide the necessary care and services to regarding bowel function for Resident #4. 1. No changes have been made to Resident #4 Plan of Care, in reviewing the residents chart; Resident #4 has had a medium to large every day, except five (5) days, this past month. The longest Resident #4 went without a bowel movement was two (2) days in succession on one occasion, nursing staff followed the Bowel Management Program as to which laxative would be used. Resident #4 has used Dulcolax tabs three (3) times in the past month 7/25/2010; 7/30/2010; 8/02/2010. Nursing will	9/2/10

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F 309	Continued From page 9 Laxatives [sic] throughout the facility. B. PROCEDURE: . . . 3. . . . Dietary interventions will be incorporated for all residents not meeting RDA's [recommended daily allowances] of food which promote bowel function or have a long history of constipation. These may include, but are not limited to, one or more of the following - prune juice, prunes, fruits and vegetables, fibercare fruit spread, bran muffins or an increase in fluids. If these dietary interventions are not successful, Benefiber will be added as a dietary supplement and administered by the Nursing staff. . . . ADDITIONAL INFORMATION, 1. It is necessary to incorporate a team approach to bowel management which include both medical and dietary interventions. The likeliness of having a successful program is through a multi pronged approach. . . ." Review of Resident #4's medical record occurred on July 26-29, 2010. The facility admitted the resident in March 2010. The resident's current diagnoses included dementia, constipation, and history of urinary tract infections. The resident's current Minimum Data Set (MDS), dated 06/17/10, identified short and long term memory problems, moderately impaired daily decision making, extensive assistance of two or more persons for toilet use, a bowel movement at least every three days during the assessment period, a scheduled toileting program, consumed insufficient fluids, and left 25% or more of food uneaten at most meals. Resident #4's Quarterly Nursing Care Conference Notes, dated 06/17/10, stated ". . . Senna S [stool softener] 1 tab [tablet] every HS [hour of sleep] was ordered 04/05/10 and increased to BID [two	F 309	communicate to LDR any episodes of manual extraction of stool for resident #4, or the impletation of changes in laxative medication approaches. Nursing will alert changes to LRD and LRD will assess and consider dietary interventions. 2. The nursing department will send copy of physician orders or standing orders regarding assist in bowel stimulation/ evacuation and/or any constipation intervention. This will alert the dietary department of new laxative orders. All residents in the past 30 days that have required manual extraction have been identified. The LRD has been notified in all instances and, an assessment has taken place and dietary interventions have been put in place. 3. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 309	Continued From page 10 times each day] on 05/21/10 for constipation; took PRN MOM [milk of magnesia] 1 x [time], PRN Dulcolax Tabs [laxative] 17 x, PRN Dulcolax Suppository 3 x for constipation. . . ." The Care Conference Notes failed to identify any dietary interventions for constipation. Resident #4's Nutritional Assessments, dated 05/18/10 and 06/17/10, identified the resident received "MOM prn, Dulcolax tabs & [and] suppos [suppository] prn, fleet [enema] prn, senna." The assessments failed to identify the frequency the resident received these bowel interventions. The assessment, dated 05/18/10, also stated, "Laxatives - Dietary Interventions, 0 [none]." The assessments and the medical record identified only oatmeal each morning as a dietary fiber intervention. Resident #4's current care plan, dated 06/17/10, stated "Problem, Alteration in elimination: Bowel and bladder incontinence . . . Approaches, Habit training . . . Problem, Alteration in elimination: Constipation related to decreased physical activity . . . Approaches, See Med/Tx. [medication/treatment] Flow Sheet for physician's orders . . . Give PRN MOM or Dulcolax Tabs. if no BM [bowel movement] in 2 days, PRN Dulcolax Suppository if no BM in 3 days and chart effectiveness." The care plan failed to include dietary approaches for constipation. Resident #4's Nurse's Notes identified the resident required manual extraction of stool on 03/24/10 (five days after admission), 05/14/10, and 05/20/10. Nurse's Notes also identified "hard BM's" the week of 06/25/10. The Quarterly Nursing Care Conference Notes and the Nutritional Assessments failed to identify the	F 309	recur; Nursing department will send a copy of physician standing orders regarding assist in bowel stimulation/ evacuation and or any constipation intervention. This will alert the dietary department of new laxative orders. Nursing staff was educated on August 31, 2010 on the importance of identifying residents that have had a change in their bowel routine. Staff nurses will notify unit managers and LRD to ensure that residents receive the necessary care and services to attain and maintain the highest practicable well being regarding bowel function. 4. The facility will initiate a QA monitoring audit tool form # 55-192 Bowel Management audit; this audit will be completed for all residents before the residents regular scheduled care conference for 3 months. The Director of Nurses will report to the	

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	355058	A. BUILDING _____ B. WING _____	07/29/2010

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F 309	Continued From page 11 episodes of manual extraction and the "hard BM's." A health care provider's (HCP) progress note, dated 05/21/10, identified the need for manual extraction the previous week. The HCP provided orders for increased Senna S to BID and instructions to be contacted if the resident required manual extraction again. The medical record did not show the facility staff contacted the HCP again regarding Resident #4's constipation or "hard BMs." Resident #4's PRN Drug Sheet showed the facility staff provided two Dulcolax tablets on 05/13/10 and manual extraction of large amount of stool occurred on that date. The facility staff provided the resident two Dulcolax tablets without a bowel movement on 05/17/10, and a Dulcolax suppository with a large bowel movement on 05/18/10. Resident #4's next BM occurred on 05/26/10 when the resident received two Dulcolax tablets. Facility staff failed to provide any interventions to promote a BM from 05/18/10 to 05/26/10. During interview, on 07/29/10 at 9:45 a.m., a nursing supervisory staff member (#19) reported she was uncertain of any dietary approaches attempted or implemented for Resident #4's constipation. This staff member reported each resident's status is reviewed and the number of bowel intervention medications or laxatives provided in a period of time is noted at the resident's care conference. During interview, on 07/29/10 at 2:00 p.m., a dietary management staff member (#15) reported the facility staff attempted dietary interventions for	F 309	Quality Assurance Team at every scheduled monthly Quality Assurance meeting. 5. Corrective action will be completed on or before September 2, 2010.	

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F 309	Continued From page 12 Resident #4's constipation without success. This staff member also reported she was not aware of the need for manual extraction of stool on three occasions for Resident #4 or the number of laxatives the facility staff provided to the resident. Review of Resident #4's medical record failed to identify the additional interventions and the dietary staff member (#15) failed to provide additional information regarding the dietary interventions. The facility identified Resident #4 required laxatives and stool softeners on admission and required manual extraction of stool five days after admission. The resident continued to require stool softeners, laxatives, and manual extraction of stool on two occasions in May 2010. The facility nursing staff notified the HCP and received orders to increase the resident's medications. The medical record shows Resident #4 continued to have "hard BMs." The manual extraction of stool is not included in the Quarterly Care Conference Notes, is not included in the Nutritional Assessments, and is not included in Resident #4's current care plan. Resident #4's medical record lacked information regarding dietary interventions and approaches for the resident's constipation and history of requiring manual extraction of stool. The medical record lacked evidence of communication between nursing and dietary departments regarding Resident #4's need for manual extraction on three occasions, increased bowel medications, and continued "hard BMs." Failure of facility staff to communicate regarding Resident #4's initial episode of manual extraction of stool may have resulted in the two subsequent episodes of manual extraction. Failure to communicate regarding these two episodes; and,	F 309		

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F 309	Continued From page 13 failure to include the manual extraction and approaches for treatment on the resident's care plan limited the staff's ability to communicate and coordinate Resident #4's care. These failures have resulted in Resident #4 receiving increased laxatives, stool softeners, and enemas, and continuing with constipation.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy and procedure, and staff interview, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents, and the resident environment remained as free of accident hazards as possible, for 5 of 16 sampled residents (Residents #1, #3, #8, #10, and #20) who required supervision in the bathroom, assistance with a gait belt or stand-up mechanical lift, or regarding removal of a fall hazard. Failure to provide supervision during toileting, use transfer devices appropriately, and remove a bedside stand deemed a fall hazard from a resident's room, placed these residents at risk of sustaining an injury. Findings include:	F 323	F-tag 323 The facility must ensure that the resident environment remains free of accident hazards as is possible. The requirement was not met as the facility failed to ensure each resident received adequate supervision, and assistant devices to prevent accidents. 1. The corrective action put in place for Resident #1 are as follows: a. Resident # 1 transfer with the mechanical lift E-Z Stand was evaluated by the Restorative Therapy Nurse and Staff Development Nurse and resident Plan of Care was changed to "Transfer with full body lift and assist of two". b. Resident #3 ambulation Unit Manager evaluated residents gait and stability	9/2/10

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F 323	Continued From page 14 Review of the facility policy and procedure, "Resident Fall," occurred on 07/29/10. This document, undated, stated "POLICY: Baptist Home promotes a safe environment for its resident's [sic], and has incorporated a Fall Prevention Program to reduce resident's [sic] risk of falling by improvement in four areas: 1) resident's living space and personal safety . . . 4) equipment safety. INTERVENTIONS WHICH CAN BE USED TO PREVENT FALLS . . . 8. Remove wheels from overbed tables. . . . 27. Close monitoring by staff . . ." Review of the facility policy and procedure, "Accident And Injury Review And Prevention," occurred on 07/29/10. This document, undated, stated "PURPOSE: To review and evaluate residents who may be at risk for potential for accident or injury and determine subsequent interventions or measures designed to minimize the risk of accident or injury. PROCEDURE: . . . 5. It shall be the responsibility of licensed nursing personnel to implement preventive measures after each and every resident accident or injury and to document the implementation of these preventive measures. . . ." - Review of Resident #3's medical record occurred on July 26-29, 2010. Current diagnoses included dementia with behavioral disturbances and macular degeneration. The resident's current Minimum Data Set (MDS), dated 07/13/10, identified short term memory problems, moderately impaired daily decision making, extensive assistance of two or more persons for transfers, independent ambulation in room, and falls within the previous 30 and 180 days.	F 323	when ambulating Changes to the Care Plan were made on 8/18/2010 Nurses progress notes state, "discontinue the fall intervention of "not leaving resident alone in bathroom by himself". Resident's gait has improved where he is ambulating and transferring per self and takes self to bathroom. "The bedside table was removed from the resident's room and an audit will be done to ensure that bedside table is not in resident's room. c. Resident #8 transfer with use of gait belt. Gait Belt Policy was reviewed with nursing staff and at the Monthly Nurses meeting and Certified Nursing Assistant meeting. The proper procedure demonstrated for doing a transfer with a gait belt. Monitoring will be done by the CNA Supervisor and the Staff Development Nurse with all CNA's that	

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F 323	Continued From page 15 Resident #3's Activities of Daily Living (ADL) Resident Assessment Protocol (RAP) Summary, dated 04/23/10, stated ". . . he is not able to use the call light consistently to make his ADL needs know [sic] . . ." The resident's Falls RAP Summary, dated 04/23/10, stated ". . . even though he is at high risk for falls the team would like to allow him the freedom to transfer and ambulate independently . . ." Quarterly Nursing Care Conference Notes, dated 07/13/10, stated ". . . He transfers and ambulates per self. . . . A fall risk assessment was completed and he is at high risk for falls. . . ." Resident #3's medical record identified the resident fell in the bathroom on 05/04/10, without injuries. The Restraints/Falls Notes, dated 05/07/10, stated ". . . Will not leave alone in bathroom." Resident #3's current care plan, dated 07/13/10, stated "Problem, Alteration in elimination . . . Approaches . . . Do not leave alone in bathroom. . . . Problem, Impaired physical mobility . . . Approaches . . . Do not leave alone in bathroom . . . [modified] 07/15/10, 15 min [minute] [checks] for 2 hours then hourly for 22 hours." Observations of Resident #3 included the following: *07/26/10, 4:30 p.m. - Certified nurse assistants (CNA) (#16) and (#17) assisted the resident to the bathroom for toileting after an episode of bowel incontinence. The CNAs removed the resident's lower garments and soiled brief, seated the resident on the toilet, provided the resident the call light, and both CNAs left the resident's room. At 4:54 p.m., CNA (#16) returned to	F 323	work with resident #8, to ensure that gait belt policy is followed. d. Resident #10 transfer with use of gait belt. Gait Belt Policy was reviewed with nursing staff and at the Monthly Nurses meeting and Certified Nursing Assistant meeting. The proper procedure demonstrated for doing a transfer with a gait belt. Monitoring will be done by the CNA Supervisor and the Staff Development Nurse with all CNA's that work with resident #8, to ensure that gait belt policy is followed. e. Resident #20 transfer with mechanical lift. Resident #20's transfer will be evaluated by Restorative Nurse, to ensure the safety of using the EZ stand mechanical lift, for this resident . 2. The facility will identify other resident's having the potential to be affected by the same	

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F 323	Continued From page 16 Resident #3's room to perform perineal cares, complete dressing, and assisted the resident to his arm chair. The CNAs left the resident alone in the bathroom for a period of approximately ten minutes. *07/27/10, 2:20 p.m. - CNA (#16) and (#18) assisted the resident to the bathroom, lowered the resident's pants and brief, seated the resident on the toilet, and both CNAs left the room. Approximately five minutes later, Resident #3 activated the call light and CNA (#16) returned to the bathroom, provided perineal cares, assisted the resident to dress, and ambulated the resident to his arm chair. The CNAs left the resident alone in the bathroom for a period of approximately five minutes. Resident #3's Nurse's Notes, dated 07/15/10 at 9:20 p.m., stated "Resident was walking on [sic] his room with his bedside table. A CNA [certified nursing assistant] walked by and told resident to stop . . . before CNA could do anything resident triped [sic] over table leg and fell. [No injuries identified.] . . . His bedside table was removed from his room . . ." Resident #3's current care plan failed to include modification for removal of the bedside table after the fall on 07/15/10. Observation on July 26-29, 2010 identified a wheeled bedside table next to Resident #3's arm chair throughout the survey. During interview, on 07/29/10 at 9:45 a.m., a nursing supervisory staff member (#19) reported Resident #3 improved in alertness and staff discussed being able to leave him alone in the bathroom, but did not remove this approach from	F 323	deficient practice, by evaluating all residents who are care planned for transfers with a mechanical sit-to-stand lift. Restorative Therapy staff will evaluate the use of the sit-to-stand lift for those residents. Since all residents have the potential to be affected by the deficient practice of not using the gait belt correctly during a transfer, the staff development nurse, CNA supervisor, Restorative Nurse Therapy coordinator, and designees will evaluate CNA's on all shifts to ensure that gait belts are used appropriately. The facility has reviewed all care plans and identified residents who are not to be left alone in the bathroom and those residents with fall prevention measures implemented before the Falls Committee meets on September 14, 2010. 3. The following measures will be put in place or systemic changes made to ensure that	

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F 323	Continued From page 17 the resident's care plan. This staff member also reported Resident #3's fall of 07/15/10 would be discussed at the next Falls Committee meeting next week and staff members failed to communicate the removal of the beside table on 07/15/10 to other staff members. Resident #3 has a history of falls in the bathroom and limited ability to use the call light to call for assistance. The resident experienced a fall with the wheeled bedside table on 07/15/10 and facility staff implemented immediate corrective action. The facility staff failed to provide Resident #3 with supervision in the bathroom as identified on the current care plan and failed to communicate the removal of the bedside table or reassess the resident's ability to safely have the bedside table in his room. These failures placed Resident #3 at risk of falls and injuries. Review of facility procedure titled "Procedure for EZ Stand" occurred on 07/29/10. The procedure, undated, stated, "Procedure: . . . D. Transferring the resident 1. Apply harness a. Position the top of the harness around the upper body of the resident (approximately 4-5 inches below the underarm [parenthesis symbol missing]. b. For the safety of the resident, securely fasten the safety strap around the resident's chest. c. On harnesses with the plastic buckles, secure the buckle and pull the loose strap to tighten. . . ." Review of the facility policy titled "Gait Belt Policy" occurred on 07/29/10. This policy, dated April 2008, stated, "Policy: Staff must provide safety and protection during transfer. In most cases a gait/transfer belt is used for assisting a resident to ambulate. . . . * 1. Apply the belt snugly around the waist, over	F 323	~~the deficient practice will not~~ recur. a. Nursing staff will be inserviced at the Nurses Meeting on August 31, 2010 and CNA meeting on September 2, 2010, and all regular scheduled monthly unit meetings throughout the month of September, on the proper way to transfer a resident using a sit-to-stand lift and the proper usage of a gait belt. b. CNA supervisor, staff development nurse, RNT nurse, night nurse supervisor, and Director of Quality Assurance will monitor all CNA's during transfers of residents, utilizing form# 62-46 "~~Proper Gait Belt~~ Usage Monitoring Tool". c. Restorative Therapy will evaluate all resident's that are care planned for use of a mechanical lift, sit-to-stand on a monthly basis to ensure that residents are transferred safely and according to facility policy and procedure. The	

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F 323	Continued From page 18 the clothing; it is best to position the belt under the abdominal girth if possible. . . . * 3. . . . Do not lift resident under their arms or hold on to their arm to lift them. If the belt loosens, snug it again after the resident is standing. . . . * 4. . . . Keeping your hands on the gait/transfer belt. One hand should be holding the belt in an underhand fashion at all times. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and history of falls. Resident #1's quarterly MDS, dated 05/11/10, identified transfer with extensive assist of two staff, mechanical lift, walk in room/corridor did not occur, short/long term memory problem, and moderate impairment in daily decision making. Resident #1's care plan, dated 12/29/04, stated, "PROBLEM: Impaired physical mobility: Potential for falls related to poor balance and unsteady gait, severe DJD (degenerative joint disease) of knees, . . . APPROACHES: . . . Transfer with standing lift with assist of two [updated from 'assist of one' on 06/23/10]. Transfer with full body mechanical lift and assist of two PRN [as needed]." On 07/27/10 at 3:15 p.m., observation showed Resident #1 asleep in her recliner. Two CNAs (#10 and #11) woke the resident up and applied the leg strap, harness, and chest safety strap of the stand-up mechanical lift to the resident. The CNAs assisted Resident #1 to hold onto the handles. The resident failed to participate in the transfer. The CNAs (#10 and #11) failed to tighten the chest safety strap upon standing the resident, and the strap slid upward and hung loosely over her breasts, with her arms/elbows	F 323	restorative aide will report to the charge nurse that an evaluation was done and the results of such evaluation shall be charted in resident progress notes. 4. The facility will utilize the following audits to ensure that correction is achieved: a. CNA supervisor, staff development nurse, RNT nurse, night nurse supervisor, and Director of Quality Assurance will monitor all CNA's during transfers of residents, utilizing form# 62-46 "Proper Gait Belt Usage Monitoring Tool". The information will be presented at every monthly scheduled Quality Assurance meeting, with changes or modifications that were necessary. The audits will continue monthly for three months, and then randomly through out the rest of the year. b. Restorative Therapy staff will evaluate all resident's that are care planned for	

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F 323	Continued From page 19 extended above her shoulders. The CNAs lowered the resident into her wheelchair and brought her into the tub room. The CNAs transferred Resident #1 from her wheelchair to the tub chair using the stand-up lift. The CNAs (#10 and #11) again failed to tighten the chest strap with the strap hanging loosely and the resident's arms/elbows extended above her shoulders. The resident failed to straighten her knees, and the CNA's did not cue her to stand up straight. On 07/27/10 at 3:45 p.m., two CNAs (#10 and #11) assisted Resident #1 out of the tub per the tub chair on a hoist. The CNAs connected the leg strap, harness, and chest safety strap to the resident and stood her up with the stand-up lift. Resident #1 failed to straighten her knees, and the CNAs failed to remind her to do so. Resident #1's arms and elbows elevated above her shoulders as she held onto the handles. The CNAs applied a new brief and pants to Resident #1 before transferring her into her wheelchair. On 07/28/10 at 5:15 p.m., two CNAs (#11 and #12) connected the leg strap, harness, and chest safety strap to Resident #1. The CNAs assisted the resident to hold onto the handles of the stand-up lift and stood her up. The resident's knees bent under her weight, and her arms/elbows extended above her head, as the CNAs transported her into the bathroom and onto the toilet. At 5:23 p.m., the CNAs (#11 and #12) raised Resident #1 up from the toilet. The resident's arms again extended above her shoulders as she hung from the sling with her body bent at nearly a 90 degree angle at the hips and knees. The CNAs failed to cue the resident to stand up straight. The chest belt surrounded her	F 323	use of a mechanical sit-to-stand lift, utilizing form #62-72, "Proper Standing Lift usage Monitoring Tool" on a monthly basis to ensure that residents are transferred safely and according to facility policy and procedure. The restorative aide will report to the charge nurse that an evaluation was done and the results of such evaluation shall be charted in resident progress notes. The audit report will be presented at the monthly Quality Assurance meeting by the Restorative Therapy Nurse or her designee. c. Education to Certified Nurse Assistants regarding leaving residents alone in the bathroom and fall prevention measures will be presented at the September 2, 2010 mandatory CNA meeting. Director of Nurses will review the fall prevention measures that can be utilized to prevent resident falls.	

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F 323	Continued From page 20 upper chest, above her breasts. The CNAs completed pericares, applied a brief and pants, and transferred the resident to her wheelchair. - Review of Resident #20's medical record occurred on 07/28/10. Medical diagnoses included cerebral vascular accident (CVA) and Alzheimer's disease. The resident's most recent MDS, dated 06/16/10, indicated the resident required extensive assist from two or more persons for transfers, dressing, toileting, and personal hygiene. The care plan, dated 05/27/10, stated, "Self Care Deficit . . . Assist of 2 with transfers, transfer with a standing lift . . ." Observation on 07/28/10 at 5:30 p.m., showed two CNAs (#1 and #2) used an E-Z stand lift to transfer Resident #20 to the toilet. The CNAs raised the resident to a semi-standing position with her knees bent at a 45 degree angle. The harness sling, placed around the resident's back and under her arms, slipped upward and into her axillae. As a result, the resident's shoulders shrugged upward and her arms bowed outward. Neither CNA tightened or adjusted the safety strap during the transfer. Observation on 07/29/10 at 8:05 a.m., showed three CNAs (#3, #4, and #5) transferred Resident #20 from the toilet to her wheelchair using an E-Z stand lift. A CNA (#3) secured the harness sling around the resident's chest and under her arms. As the resident was raised into a standing position, the strap slipped under her axillae. As a result, the resident's shoulders shrugged upward and her arms bowed outward. The CNAs failed to tighten or adjust the chest safety strap during transfer.	F 323	d. Professional nursing staff will monitor cares provided to residents who may not be left alone in bathroom. The audits will be done daily for thirty (30) days and randomly weekly for three (3) months. e. The Director of Nurses will review the audits and file a report at the regular scheduled monthly Quality Assurance meeting. 5. The corrective action will be completed on or before September 2, 2010.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 21 - Review of Resident #8's medical record occurred on all days of survey. Medical diagnoses included psychoneurosis, macular degeneration, and Alzheimer's dementia. Resident #8's most recent MDS, dated 06/16/10, indicated the resident required extensive assist of one person for transfer, toileting, and personal hygiene. The care plan stated, . . . "not safe for self transfer, extensive assist of one. . . ." Observation on 07/26/10 at 4:40 p.m., showed a CNA (#8) loosely applied a gait belt around Resident #8's waist, grabbed the resident under her right arm, and pulled her to a standing position with some difficulty. The CNA (#8) assisted Resident #8 into the bathroom. When Resident #8 finished in the bathroom, the CNA (#8) assisted her off the toilet by pulling on her arm to assist her to a standing position. The CNA (#8) failed to use the gait belt to assist with the transfer. Observation on 07/27/10 at 7:50 a.m., showed two CNAs (#6 and #7) assisted Resident #8 from the chair to her wheelchair. They applied a gait belt around her waist, and without adjusting it, proceeded to pull the resident up by her arms. One CNA held onto the gait belt near the resident's back. The resident grunted as they stood her up. Observation on 07/27/20 at 3:50 p.m., showed two CNAs (#8 and #9) assisting Resident #8 to the bathroom. The CNAs (#8 and #9) loosely applied the gait belt around her waist. Each CNA used one hand to grab the gait belt near the resident's back and used their other hand to pull her under her arms. As the CNAs (#8 and #9) raised the resident to a standing position, the gait	F 323		

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F 323	Continued From page 22 belt slide upward across her upper chest creating a potential unsafe transfer. - Review of Resident #10's medical record occurred on July 26-29, 2010. Medical diagnoses included blind in left eye, peripheral vascular disease, Alzheimer's, and osteoarthritis. The resident's most recent MDS, dated 07/08/10, indicated the resident required extensive assist of two or more persons with transfer, locomotion on and off the unit, dressing, toileting, and personal hygiene. The care plan, dated 06/01/10, addressed extensive assist of one to two persons with transfer. Observation on 07/27/10 at 5:45 p.m., showed two CNAs (#21 and #22) toileting Resident #10. A CNA (#21) loosely applied the gait belt to Resident #10's waist. Each CNA used one hand under the resident's arm to assist him to a standing position. The CNAs failed to use the gait belt to assist in standing the resident. During an interview on 07/29/10 at 9:20 a.m. and 10:05 a.m., administrative staff nurses (#14 and #20) agreed staff inappropriately used the gait belt during transferring of Resident #8 and #10. An administrative staff nurse (#20) agreed staff should have repositioned the chest safety strap on the E-Z stand lift before standing the residents up. During an interview on 07/29/10 at 9:45 a.m., an administrative nurse (#13) agreed a resident's arms shouldn't be elevated above his/her shoulders during mechanical lift transfers. Failure to properly use a stand lift or gait belt has the potential to cause pain and/or injury to	F 323		

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F 323	Continued From page 23 residents during transfer.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility serving size guide, and staff interview, the facility failed to meet the nutritional needs of residents by using incorrect utensil sizes during 3 of 4 meals observed (07/27/10 evening meal and 07/28/10 noon and evening meals). Failure to use the correct utensil size during meal service has the potential to negatively impact the nutritional status of residents who eat meals in the facility's dining rooms. Findings include: Review of the facility's serving size guide, provided by facility staff on 07/29/10 at 10:00 a.m., showed the regular, mechanical soft, and pureed diet portion sizes to be 1/2 cup (3-4 oz) of meat, 1/2 cup of starch, and 1/2 cup of vegetables. - Observation during the evening meal on 07/27/10 in the second floor south dining room identified inconsistencies between the scoops used to serve food and the facility's serving size guide:	F 363	F363 Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences: be prepared in advance; and be followed. This requirement is not met by failure to use correct utensils size during meal service. 1. The corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Revised the Dietary Orientation Training Checklist (form 52-79) to include training on portions, scoop and ladle sizes. b. All dietary staff will be required to review the	9/2/10

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F 363	Continued From page 24 * Macaroni/hamburger hotdish served with a 4 oz scoop (should have used an 8 oz scoop) * Cucumber salad served with a 3 oz scoop (should have used a 4 oz scoop) * Pureed squash served with a 2 oz scoop (should have used a 4 oz scoop) * Mashed potatoes served with a 2 oz scoop (should have used a 4 oz scoop) * Pureed hotdish served with a 2 oz scoop (should have used an 8 oz scoop) * Dietary staff used the same size scoops for every resident. During the observation, the surveyor asked an unidentified staff member to verify scoop sizes. When asked what the scoop sizes were, the staff member could not locate the scoop size on the utensil's handle. After the surveyor indicated where to find the scoop size, the staff member stated, "It says 2 and 2/3 cup." Upon closer inspection, observation showed the scoop size to be 4 oz (1/2 cup). - Observation during the noon meal on 07/28/10 in the second floor south dining room identified inconsistencies between the scoops used to serve food and the facility's serving size guide: * Pureed carrots served with a 1/3 cup scoop (should have used a 4 oz scoop) * Pureed chicken served with a 1/3 cup scoop (should have used a 4 oz scoop) * Mashed potatoes served with a 1/3 cup scoop (should have used a 4 oz scoop) - Observation during the noon meal on 07/28/10 in the third floor south dining room identified inconsistencies between the scoops used to serve food and the facility's serving size guide: * Pureed carrots served with a 2 oz scoop (should have used a 4 oz scoop)	F 363	Dietary Orientation Training Checklist (form 52-79) with a supervisor and sign that they have reviewed it and understand it. c. Dietary staff will be educated on proper scoop and portion sizes at a special dietary meeting on Tuesday, August 31st 2010. 2. The Facility will identify other residents having the potential to be affected by the same deficient practice: a. All residents have the potential to be affected by this deficiency. Therefore, the facility will require all new dietary staff to complete the Dietary Orientation Training Checklist (form 52-79) with their supervisor and/or trainer by the last day of their training. The Dietary Orientation Training Checklist (form 52-79) will again be	

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F 363	Continued From page 25 * Mechanical soft chicken served with a 2 oz scoop (should have used a 4 oz scoop) - Observation during the evening meal on 07/28/10 in the second floor south dining room identified inconsistencies between the scoops used to serve food and the facility's serving size guide: * Rice to be served with a 3 oz scoop (should have used a 4 oz scoop) * Beef/vegetable stir fry to be served with a 4 oz scoop (should have used an 8 oz scoop) * Pureed stir fry to be served with a 2 oz scoop (should have used an 8 oz scoop) * Pureed beets to be served with a 4 oz. scoop (which was the correct scoop size, a dietary supervisor [#35] later replaced it with a 3 oz scoop) During the observation, the surveyor asked the dietary staff member (#34) to identify the scoop sizes she would be using to serve the meal. The staff member could not locate the scoop size on the utensil's handle and stated, "I'm not sure. Somebody switched my utensils. I'll just have to improvise." The surveyor identified the location of the scoop size to the staff member. The staff member (#34) further stated (regarding large and small portion meals), "Large portions equal double scoops. With small portions, I just don't fill the scoop as full." A dietary supervisor (#35) then approached and indicated to the staff member (#34) the wrong size scoops were being utilized. The supervisor (#35) provided the staff member (#34) with a 4 oz scoop for the pureed stir fry and a 3 oz scoop for the pureed beets. The supervisor (#35) failed to provide the staff member (#34) with the correct size scoops according to the facility's serving size guide.	F 363	reviewed with each new employee at their 3 month performance evaluation. 3. The Facility will put into place the following measures or systemic changes made to ensure that the deficient practice will not recur: a. Dietary staff will be educated on proper scoop and portion sizes at a special dietary meeting on Tuesday, August 31, 2010. b. Regular dietary staff meetings will be held to discuss dietary or dining room issues. c. Dietary Aides will be using Form 52-76, QA Scoop Sizes and Serving sizes. This QA form will be completed daily at each meal for one month starting September 1, 2020, and then monthly for 2 months, then quarterly for 9 months. Dietary Supervisors will require more frequent QA	

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F 363	Continued From page 26 - Observation during the evening meal on 07/28/10 in the second floor north dining room identified inconsistencies between the scoops used to serve food and the facility's serving size guide: * Beef/vegetable stir fry served with a 4 oz scoop (should have been an 8 oz scoop) * Pureed meat served with a 2 oz scoop (should have been a 4 oz scoop) * Pureed beets served with a 3 oz scoop (should have been a 4 oz scoop) During the observation, the surveyor asked the dietary staff member (#33) to identify the scoop sizes used during the meal service. The staff member could not locate the scoop sizes and stated, "I don't know." The surveyor showed the staff member where to find scoop sizes on the utensil's handle. - Observation of the noon meal on 07/28/10 in the third floor Southview dining room showed the dietary aide (#27) scooped the last of the sliced cooked carrots out of the serving pan and divided the carrots between Resident #18 and #32, the last two residents served. Observation showed each resident received about 1/3 of a scoop, six coin-sized sliced carrots each. A conversation between an unidentified dietary aide and the aide (#27) revealed the second floor dining room also ran out of carrots and the kitchen staff delivered more to the second floor dining room. The kitchen staff failed to deliver more carrots to the third floor dining room, therefore, Resident #18 and #32 did not receive a full serving. During interviews on 07/29/10 at 10:00 a.m. and 1:50 p.m., a dietary supervisor (#15) stated facility staff should have two separate scoops in foods, one for regular portions and one for small	F 363	monitoring if less than 100% compliance is noted. d. Dietary Supervisors will be using Form 52-78, Supervisors QA for Scoop Sixes and Portion Sizes. This QA form will be completed daily, one meal a day (rotating breakfast, dinner and supper) for one month starting September 1st, 2010, and then monthly for 2 months, then quarterly for 9 months. Dietary Supervisors will require more frequent QA monitoring if less than 100% compliance is noted. e. Dietary personnel will be using Form 52-77, Kitchen Calls. All calls to the kitchen will be recorded to assure the correct item is delivered to the correct floor. This form will be completed for all calls for 2 weeks starting	

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F 363	Continued From page 27 portions. The supervisor (#15) verified the staff used incorrect utensils to serve food. Hotdish is expected to be served with a one cup scoop, as it is the residents' starch and meat source; and stir fry is expected to be served with a one cup scoop, as it is the residents' meat and vegetable source. The supervisor (#15) stated dietary staff were expected to follow the facility's serving size guide. The supervisor (#15) also stated dietary staff received training on scoop sizes during the orientation process.	F 363	September 1st, 2010, then one day monthly for 2 months, and then one day quarterly for 9 month. *Continued on Page 28-a (next page)*	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 4 sampled residents (Resident #15) and 2 supplemental residents (Resident #27 and #28) with physician orders for mechanically altered diets received those diets. Failure to provide food in a form designed to meet individual needs may place residents at risk of reduced food intake and nutritional risk. Findings include: Review of the facility policy and procedure, "Altered Consistency Of Foods And Liquids", occurred on 07/29/10. This document, revised 07/10, stated "POLICY: Any resident who requires alterations in the consistency of food and/or	F 365	F365 Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This requirement is not met as evidenced by failure to provide food in a form designed to meet individual needs that may place residents at risk of reduced food intake and nutritional risk. 1. The corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. Cooks were educated at a special cook's meeting on Tuesday, August 24, 2010 regarding preparing correct textures for all residents on	9/2/10

F-tag 363Continued from pg 28

4. The Facility plans to monitor its performance to make sure that solutions are sustained
   a. Dietary personnel will be using Form 52-76, A Scoop Sizes and Serving Sizes at Each Meal. This QA form will be completed at every meal for 3 months and then randomly thereafter.
   b. Dietary Supervisors will be using Form 52-78, Supervisors QA on Scoop Sizes and Portion Sizes. This QA form will be done daily at random meals and dining rooms for 3 months and then randomly thereafter.
   c. Dietary personnel will be using Form 52-77, Kitchen Calls. All call downs to the kitchen will be recorded to assure the correct item is delivered to the correct floor. This QA form will be completed for

Continued on page 28-b

F-tag 363Continued from pg 28a

All call downs to the kitchen for 3 months and then randomly thereafter.

d. A QA report will be presented at monthly QA meetings by the LRD or her designee.

5. The corrective actions will be completed on or before September 2, 2010.

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F 365	Continued From page 28 liquids will receive an individualized diet, as per physician's order and/or speech therapy recommendations. PROCEDURE: . . . 4. The physician and/or SLP [speech-language pathologist] will write the diet order with specified food and liquid consistencies. The change in diet order will be communicated to the Nutritional Services department and Care Plan Team according to facility protocol. 5. The Nutritional Services department will be responsible for preparing and serving food and liquids as ordered. . . . MECHANICAL SOFT, The purpose of altering foods is to provide foods that can be successfully and safely swallowed. This diet consists of foods that are soft and easy to chew and swallow. This diet consists of food of nearly regular textures but excludes regular meats (except fish, meat loaf, meatballs, and hamburgers) and very hard, sticky, or crunchy foods. Foods should be moist. Recommended Foods . . . Meat and Other Protein Products - Well moistened, thin-sliced, tender, or ground meat, poultry, or fish with gravy or sauce. . . . Casseroles with small chunks of meat, ground or tender meats. . . ." - Review of Resident #15's medical record occurred on July 28-29, 2010. The medical record identified the facility admitted the resident in June 2006. Current diagnoses included dementia, constipation, and gastroesophageal reflux disease. The resident's current Minimum Data Set (MDS), dated 06/30/10, identified short term memory problems, moderately impaired daily decision making, required set-up help with eating, leaves 25% or more of food uneaten at meals, and received a mechanically altered diet. Resident #15's Nutritional Resident Assessment	F 365	regular, mechanical soft and pureed textures. b. The facility will have a communication board in the kitchen to alert staff of any texture changes for individual residents. 2. The facility will identify other residents having the potential to be affected by the same deficient practice; a. The facility will have a communication board in the kitchen to alert staff of any texture changes for individual residents. 3. The facility will put into place the following measures or systemic changes made to ensure that the deficient practice will not recur; a. Cooks were educated at a special cook's meeting on Tuesday, August 24, 2010 regarding preparing correct textures for all residents on regular, mechanical soft and pureed textures. b. Regular dietary staff meetings will be held to discuss dietary issues.	

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F 365	Continued From page 29 Protocol (RAP) Summary, dated 07/01/10, identified poor intake and assistance required with meals. The resident's current physician orders identified a regular mechanical soft diet with thin liquids. Resident #15's Meal Intake Report identified "Regular, M [mechanical soft]" diet. Observation of the evening meal service, on 07/28/10 at 5:25 p.m., identified the facility staff served Resident #15 beef stir fry over rice. The pieces of beef were firm, larger than bite size, and not mechanically altered. During interview at this time, Certified Nursing Assistants (CNAs) (#17) and (#18) serving the meal, confirmed the meal was not mechanically soft. Observation of other residents (Resident #27 and #28), on mechanical soft diets according to the Meal Intake Report, showed Resident #27 received the same meal as Resident #15 and Resident #28 received the meat pieces without the stir fry vegetables. During interview, on 07/28/10 at 5:27 p.m., two CNAs (#17 and #18) confirmed Resident #27 and #28 did not receive mechanical soft diets and, regarding Resident #28, referred to the meat pieces and stated "She won't eat this." On request of the surveyor, the facility staff contacted the dietary department and obtained mechanically altered diets for Resident #15, #27, and #28. During interview on 07/28/10 at 5:40 p.m., regarding the failure to provide mechanically altered diets, a dietary management staff member (#15) stated she was not aware of any problems with the mechanically altered diets and considered stir fry a mechanically soft diet.	F 365	Dietary personnel will be using a dietary QA form for the following residents: #15, 27 and 28. This QA form will be completed at every meal for 3 months and then randomly thereafter. c. Cooks will be using Form 52-72 Cook's QA food textures. This QA form will be completed at every meal for 3 months and then randomly thereafter.	

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F 365	Continued From page 30 The facility identified Resident #15 had poor nutritional intake. The beef stir fry meal provided to Resident #15, #27, and #28 failed to meet the needs of these residents as confirmed by the facility staff. Failure to provide mechanically soft diets to Resident #15, #27, and #28 placed these residents at risk of limited food intake and nutritional risk.	F 365		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of a professional reference, facility policy review, record review, and staff interview, the facility failed to prepare, distribute, and serve food under sanitary conditions during 3 of 4 days of survey (July 27-29, 2010). Failure to follow proper sanitation and food handling practices has the potential to result in a foodborne illness and can affect all residents who consume food in the dining areas. Findings include: Review of the facility policy titled "Cleaning and Sanitation of Tables" occurred on 07/29/10. This undated policy stated, "POLICY: All tabletops	F 371	F371 The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This requirement is not met as evidenced by failure to follow proper sanitation and food handling practices which has the potential to result in a foodborne illness and can affect all residents who consume food in the dining areas. 1. The corrective action will be accomplished for those residents found to have been affected by the deficient practice;	9/2/10

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BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(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 371	Continued From page 31 shall be cleaned and sanitized after each meal. PROCEDURE: 1. Wipe all tabletops using warm, soapy water. 2. Spray tables with Quatinary [sic] Sanitizer. 3. Allow tables to air dry." Review of the facility policy titled "Food and Fluid Temperature Policy" occurred on 07/29/2010. This policy, dated 07/09/10, stated, ". . . PROCEDURES: . . . All foods held in the steam table will read no less than 135 [degrees] F [Fahrenheit] . . . and will be served at that temperature or above. . . . Temperatures shall be obtained at the point of serving. . . . The Dietary Supervisor is responsible for assuring that the temperature record is utilized at each meal. . . ." - Observation in the facility's secured unit kitchenette identified the following: * 07/27/10, 10:50 a.m. - Using bare hands, Certified Nursing Assistant (CNA) (#29) prepared a butter and jelly bread snack for Resident #4. * 07/28/10, 7:50 a.m. - The CNA (#30) served the breakfast meal to a unit resident and assisted with the meal set-up by cutting his pancakes. The CNA determined the pancake was not hot enough, and placed the plate in the microwave and heated it. The CNA opened the micorwave, placed her bare hand on the pancake to check the temperature, and then served the pancake to the resident. The CNA (#30) did not sanitize or wash her hands before touching the pancake. - Observation on 07/29/10 at 1:15 p.m., showed two unidentified dietary aides cleaned the dining tables in the third floor Southview dining room. One aide stated they used regular soap and water to clean the tables. When asked if they used a sanitizer, they stated no, just soap and water.	F 371	e. Revised the Dietary Orientation Checklist (form 52-79) to include training on proper techniques for washing and sanitizing tables and food temperatures including proper techniques for washing and sanitizing tables and taking food temperatures. b. All dietary staff will b required to review the Dietary Orientation Training checklist (form 52-79) with a supervisor and sign that they have reviewed it and understand it. c. Dietary staff will be educated on proper techniques for washing and sanitizing tables at a special dietary meeting on Tuesday, August 31, 2020. d. Dietary staff will be educated on taking food temperatures at a special dietary meeting on Tuesday, August 31, 2010. e. Nursing staff has been reeducated in infection	

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 _____	07/29/2010

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BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(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 371	Continued From page 32 During an interview on the afternoon of 07/29/10, a dietary supervisor (#15) stated the dietary staff members are expected to sanitize the tabletops. - Observation of tray line occurred on 07/28/10 at 11:45 a.m. on the second floor south dining room. A dietary supervisor (#35) stated staff are expected to check food temperatures when it arrives on each unit and prior to serving. The supervisor (#35) and an unidentified staff member failed to check food temperatures at the point of service. At approximately 12:05 p.m., immediately after the last resident received his/her tray, the surveyor requested the supervisor (#35) to take food temperatures. The temperature readings included: * Baked chicken - 130 degrees F * Steamed carrots - 130 degrees F * Mashed potatoes - 129 degrees F * The above temperature readings fell below the facility's policy of holding foods at 135 degrees F. - Observation of tray line occurred on 07/28/10 at 11:45 a.m. on the second floor north dining room. At approximately 12:10 p.m., immediately after the last resident received his/her tray, the surveyor requested an unidentified staff member to take food temperatures. The temperature readings included: * Baked chicken - 108 degrees F * Vegetable soup - 130 degrees F * Pureed vegetables - 120 degrees F * Mechanical soft chicken - 120 degrees F * The above temperature readings fell below the facility's policy of holding foods at 135 degrees F. - Observation of tray line occurred on 07/28/10 at 12:00 noon on the third floor Southview dining room. At 12:20 p.m., immediately after the last	F 371	control issues regarding setting resident meals. Hand washing policy and procedure, glove usage when handling food items reviewed, and explained to nursing staff that hair must be pulled back away form face and not allowed to hand forward when setting up a resident's meal or when assisting with eating. According to North Dakota Requirements for Food and Beverage Establishments 33-33-04-31.1 hair restraints section 2: This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses and wait staff if they present a minimal risk of contaminating exposed food; clean equi9pment, utensils, and linens; and unwrapped single-service and single-use articles. 2. The facility will identify other	

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	355058	A. BUILDING _____ B. WING _____	07/29/2010

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F 371	Continued From page 33 resident received his/her tray, the surveyor requested the dietary supervisor (#15) take temperatures of the foods. The temperature readings included: Pureed carrots - 129 degrees Fahrenheit (F) Soup -132 degrees F Pureed chicken - 120.5 degrees F * The above temperature readings fell below the facility's policy of holding foods at 135 degrees F. Review of the facility's "Steam Table Food Temperature Records" revealed the following regarding the noon and evening meals: * Second floor south steam table: From 05/01/10 - 07/28/10, facility staff recorded food temperatures at 57 out of 178 possible meals. * Second floor north steam table: From 05/01/10 - 07/28/10, facility staff recorded food temperatures at 59 out of 178 possible meals. * Third floor steam table: From 05/01/10 - 07/28/10, facility staff recorded food temperatures at 21 out of 178 possible meals. * Of the above recorded temperatures, facility staff documented 13 occurrences of food held below 135 degrees F. During an interview on 07/28/10 at 5:40 p.m., a dietary staff member (#25) stated he/she thought hot foods should be 130 degrees F or higher and temperatures are taken of steam table meal items at every meal. During at interview on 07/28/10 at 5:50 p.m., a staff member (#26) stated he/she thought hot foods should be 180 to 200 degrees F and temperatures of steam table meal items are taken before and after each meal.	F 371	residents having the potential to be affected by the same deficient practice; a. All residents have the potential to be affected by this deficiency. Therefore, the facility will require all new dietary staff to complete the Dietary Orientation Training Checklist (form 52-79) with their supervisor and/or trainer by the last day of their training. The Dietary Orientation Training Checklist (form 52-79) will again be reviewed with each new employee at their 3 month performance evaluation. 3. The Facility will put into place the following measures or systemic changes made to ensure that the deficient practice will not recur: a. Dietary staff will be educated on proper techniques for washing and sanitizing tables at a special dietary meeting on Tuesday, August 31, 2010.	

Continued on page 35

F-tag 371 continued from pg 34

b. Dietary staff will be educated on taking food temperatures at a special dietary meeting on Tuesday, August 31, 2010.
c. Regular dietary staff meetings will be held every 4-6 weeks to discuss dietary or dining room issues and provide any further training or education needed.
d. Dietary personnel will be using Form 52-80 Washing and Sanitizing Tables. This QA form will be completed at every meal for 3 months and then randomly thereafter.
e. Dietary aides and cooks will be using form 52-81 Breakfast Temperature Log and form 52-82 dinner/Supper Temperature Log to record temperatures of food held in steam tables. These forms will be completed daily and monitored by the dietary supervisors to assure they are being

completed. Dietary staff were educated on food temperatures including proper techniques for taking temperatures, acceptable temperatures and correction procedures if temperatures are not acceptable. A special dietary meeting was held on Tuesday, August 31, 2010.

f. Dietary supervisors will be using form 52-83 Supervisors Monitor of Tables and Temperatures Medals and dining rooms will be randomly monitored daily by the Dietary Supervisors, using this form.

g. All dining rooms will be audited by supervisory nursing staff, utilizing form # 55-187 to ensure that proper hand washing, and food service is completed under sanitary conditions, on a daily basis for 30 days and random weekly for 3 months.

h. Audits will continue random on a monthly basis to be presented at the monthly Quality Assurance meeting by the Director of Nurses.

4. The Facility plans to monitor its performance to make sure that solutions are sustained.
   a. Dietary personnel will be using Form 52-80 QA Washing and Sanitizing Tables. This QA form will be completed at every meal for 3 months and then randomly thereafter.
   b. Dietary personnel will be using Form 52-81 Breakfast Temperature