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 _____	08/20/2009

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 08/17/09 and completed on 08/20/09 the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy , and staff interview, the facility failed to identify 1 of 1 sampled resident (Resident #2) who wears a one piece zip up outfit as having a restraint, and failed to ensure 1 of 1 sampled resident (Resident #19) with a history of a pelvic belt restraint remained safe and free from a significant hazard risk. Findings include: Review of the facility policy titled "Restraint Policy" occurred on 08/20/09. This policy, undated, stated ". . . Restraint use may constitute an accident hazard and professional standards of practice have eliminated the need for physical restraints except under limited medical circumstances. Therefore medical symptoms that would warrant the use of restraints should be reflected in the comprehensive assessment and care planning. It is further expected that for those residents whose care plans indicate the need for restraints that the facility engage in a systematic	F 221	F-Tag 221 It is the policy of the Baptist Home to respect resident's rights to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. For resident # 2, the body suit intervention has been assessed as a restraint. The appropriate physician order has been obtained, the family has been updated and educated and the appropriate consent/acknowledgment form has been signed. The MDS, scheduled for Tuesday, September 8, 2009 will reflect the body as a restraint. The care plan for resident #2 has been reviewed and updated as appropriate. Staff will be educated as to the one piece outfit being classified as a restraint. For resident # 19, the restraint was discontinued on 06-24-2009. Because all residents could be affected by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Pemble — TITLE: administrator — (X6) DATE: 9/11/09

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 221	Continued From page 1 and gradual process toward reducing restraints. Physical restraints are defined as any manual or physical device, material or equipment attached or adjacent to the resident's body that he cannot remove easily and which restricts freedom of movement or normal access to one's body . . . Restraints are . . . trunk restraints (e.g. lap belt, pin dot release, quick release), limb restraint which includes any device or equipment or material that the resident cannot easily remove . . . The resident and/or his responsible party, must acknowledge and be educated prior to the use of physical restraints . . . A physician's order for the use of the restraint is required. The facility shall provide the resident and/or responsible party with appropriate information about the risks and benefits with the use of restraints . . . The use of any restraint should occur only after comprehensive assessment, including an evaluation of less restrictive methods to manage the resident's problem, and where the determination is made that the use of the restraint will enable and promote greater functional independence for the resident. 1. Physical restraints of a specified type are applied ONLY WITH THE ACKNOWLEDGMENT OF THE RESIDENT AND/OR THEIR RESPONSIBLE PARTY AND THE DIRECT ORDER OF THE ATTENDING PHYSICIAN . . . 2. Intervention that results in using a physical restraint must be preceded with a thorough assessment of the resident's needs. At a minimum, the assessment must include: a. Identification of the purpose of using the restraint for that resident; b. Documentation of alternatives tried c. P.T. [physical therapy]/O.T. [occupational therapy] evaluation d. Consideration of the risks and probable effects	F 221	the cited deficiency, the facility reviewed and revised it's policy and procedure for definition of a restraint, the use of restraints and restraint reduction update as deemed necessary. Documentation of ongoing assessments and changes made to the care plan will be combined with a systemic and gradual process toward reducing restraints. The facility will include a time frame and a goal for the institution of restraint reduction process for each resident who has a restraint. A review of the nursing and therapy notes will be done by the restraint committee at each monthly restraint meeting, reviewing time frame, goal and progress for each resident who has a restraint. A QA will be initiated for the review and compliance of the plan of correction for Resident #2 and # 19 and other residents potentially affected by this deficiency. The corrective action will be completed on or before September 24, 2009. This will be done on a weekly basis by the unit managers & reviewed monthly by the QA team. 9-15-09 Per telephone conversation with Deb Larson & Sally Fischer @ 9:00 am K Beehler RN	

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F 221	Continued From page 2 of the use of the restraint against the risks and probable effects of other interventions. e. Physical Restraint Assessment after all alternatives have been exhausted 3. Only after it has been determined that the risk of using a physical restraint poses less danger than other interventions may the facility pursue securing a physicians order for a physical restraint and signed acknowledgment from the resident and/or responsible party. 4. The need for a physical restraint shall be explained to the resident. If the resident is unable to understand the explanation, the explanation should be made to both the resident and their responsible party. Explanation must be documented in the resident's medical record. Acknowledgment to use the physical restraint by the appropriate person (resident or responsible party) must also be documented in the medical record. (The signed notice will serve as documentation.) 5. In an event that a physical restraint is used, the resident's plan of care must indicate that such restraint is used only for the times and duration necessary to enable the resident to attain and maintain the highest practicable physical, mental and psychosocial function. The Restraint Evaluation Committee will review all residents who use physical restraints on a monthly basis. . . ." - Review of Resident #19's medical record occurred August 19-20, 2009. Medical diagnoses included, in part, anxiety, depression, osteoporosis, glaucoma, legally blind, and incontinence. Medications included, in part, Ativan (an antianxiety), Zoloft (an antidepressant), Trazodone (an antidepressant used for sleep), and Risperdal (an antipsychotic).	F 221		

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F 221	Continued From page 3 Resident #19's annual Minimum Data Set (MDS), dated 06/18/09, and the quarterly MDS, dated 12/18/08, both identified short term memory difficulties and moderately impaired in daily decision making. The MDS's identified no problems with long term memory, able to make self understood, and understands others. Comparison of Resident #19's MDS from 12/18/08 to 06/18/09 showed a decline in bed mobility, transfers, ability to walk in her room and the corridor, locomotion off the unit, and toilet use. The MDS, dated 12/18/08, identified this resident as continent of bowel and the 06/18/09 MDS identified this resident frequently incontinent of bowel. The MDS, dated 12/18/08, identified falls in the past 180 days and the MDS, dated 06/08/09, identified no falls. Both MDS's identified a trunk restraint used daily. Review of Resident #19's therapy notes showed this resident utilized a PVC walker (a walker used to prevent falls) until 10/09/08. The notes identified the PVC walker increased this resident's behaviors (resident reports dislike and "this isn't natural"), and did not decrease the amount of falls. On 10/09/08, facility staff initiated a pindot pelvic belt. On 10/21/08, facility staff discontinued the pindot pelvic because of Resident #19's ability to remove the belt "with multiple objects," and initiated rear fasten quick release clip type belt on the resident's wheelchair. On 12/05/08, facility staff discontinued the quick release buckle belt because direct care staff encountered difficulties with its placement on the rear of the wheelchair and initiated a Posey belt crisscrossed on the back of the resident's wheelchair. Facility staff eliminated the pelvic restraint on 06/24/09 related to Resident #19's	F 221		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	Continued From page 4 weight gain and the pelvic belt fitted snuggly. Review of the nurse's notes and therapy notes related to Resident #19's pelvic belt identified the following: * 10/20/08 (Occupational Therapy) (OT) note - "Call from Unit Manager at 1655 [4:55 p.m.] due to res. [resident] undoing pindot pelvic belt in w/c [wheelchair] several x's [times] . . ." * 10/22/08 (OT note) - "Late entry for 10/21/08 . . . a rear fasten quick release clip-type belt on resident's w/c . . ." * 11/04/08 at 8:00 p.m. (nurse's note) - "Remains angry about back fastening w/c belt. Insists it should be off @ [at] noc. [night]. Unable to reason [with] her . . ." * 11/06/08 (OT note) - "30 day review of rear fastened belt in w/c . . . Benefits continue to outweigh the risks due to Dx [diagnoses] of: legal blindness, fall risk . . ." * 11/19/08 at 4:00 p.m. (nurse's note) - "Res. continues to c/o [complaints of] w/c belt. Unable to please her." * 12/03/08 at 8:55 p.m. (nurse's note) - "Resident slouched down in w/c & pulled belt over head & began to stand up to get out of w/c. Resident said she knows how to get out of belt." * 12/05/08 at 8:20 p.m. (nurse's note) - "Res. somehow removed one side of w/c belt et [and] got into bed. Belt was crossed in back as ordered. Unknown how she did this. Foul mood. Yelling @ staff. Continually wants belt off. Will monitor." * 12/06/08 at 2:00 p.m. (nurse's note) - "Talked [with] [staff name] (PT) about w/c belt. She will check it Mon. [Monday] a.m." * 12/08/08 - (Restorative Therapy (RT) note) "Observed rear fastened belt on w/c due to recent transfer from w/c to bed. Staff to cross belt in rear & [and] secure over rear anti tippers & adjust	F 221		

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F 221	Continued From page 5 tension to prevent belt from slipping off of back of w/c . . ." * 12/16/08 - (OT note) "60 day review of rear fastened belt used in w/c to [decrease] risk of injury [secondary to] poor judgement et attempts to tra [transfer] self . . . Benefits of use continue to outweigh the risks . . . She is tolerating it quite well. No problems reported by staff . . ." * 12/27/08 at 5:00 a.m. (nurse's note) - ". . . Calling CNA's [certified nursing assistants] nasty names trying to prevent them from putting on belt . . ." * 01/08/09 at 9:10 p.m. (nurse's note) - ". . . Staff trying to position res. in chair et apply back fasten belt. Res. not cooperating, Hitting, squeezing staffs hands . . ." * 01/08/09 - (OT note) "90 day review of rear fasten pelvic belt used in her w/c to [decrease] risk of falls/injuries [secondary to] [decreased] safety awareness, [decreased] judgement . . . Recommend cont. [continued] use of rear fasten pelvic belt as benefits outweigh the risks." * 02/09/09 at 2:20 p.m. (nurse's note) - "Staff reported that Res got her safety belt loose & transferred self from w/c to toilet . . . Therapy notified." * 02/10/09 - (RT note) "Observed belt in w/c [with] resident. Resident unable to release belt per self when secured to back of w/c." * 02/11/09 at 12:50 p.m. (nurse's note) - "Res. found a scissors & cut her belt in half. Res. put on observation . . . very adamant about not putting the belt back on 'I'm done [with] it, you can't make me have that.' Therapy dept. [department] informed . . ." * 03/02/09 at 10:00 a.m. - (nurse's note) "Requesting all kinds of things to be done. Wanting a scissors, & a pliers to take care of the belt . . ."	F 221		

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F 221	Continued From page 6 * 03/14/09 at 8:45 p.m. - (nurse's note) "Restless. Up in w/c [with] belt on. Agitated . . ." * 04/02/09 at 7:30 a.m. - (nurse's note) ". . . nurse went to help resident and resident wanted seat belt cut, when nurse said does not have a scissors resident stated, you do to . . ." * 06/22/09 (OT note) - " Discussed trial restraint elimination . . . Pelvic belt cont. [continues] to be used, however becoming quite snug [secondary to] wt [weight] gain . . ." * 06/24/09 (RT note) - "Trial today restraint elimination. Resident unable to stand @ [at] toilet [with] rails when assisted into BR [bathroom] . . . " * 06/25/09 at 9:00 p.m. (nurse's note) - "Has not tried to get up on own this shift. Belt in w/c remains off . . ." During an interview on 08/19/09 at 5:45 p.m., an administrative nursing staff member (#1) stated she "never felt the pelvic belt placed Resident #19 in harms way." During an interview on 08/20/09 at 8:45 a.m., a restorative staff member (#5) agreed restraint reduction/elimination should have been attempted earlier than June due to Resident #19's ongoing attempts to remove the pelvic belt and her dislike of this restraint. Record review identified on four different occasions, Resident #19 successfully exited her wheelchair with the Posey belt crisscrossed on the back of her wheelchair. Each one of these incidents posed an accident hazard. Record review also identified a decline in Resident #19's physical function, bowel continence and an increase in agitation with the use of the trunk restraint. Review identified a lack of communication between OT and nursing staff regarding this resident's reaction and safety utilizing the restraint and the restraint committee,	F 221		

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F 221	Continued From page 7 which meets monthly, only looked at the restraint as a method to prevent Resident #19 from standing and did not look at as causing increased agitation. The utilization of Resident #19's pelvic belt occurred irregardless of this residents repeated requests and attempts to remove the belt. Resident #19's attempts to remove the belt poised a significant hazard risk. - Observation showed Resident #2 wearing a one piece outfit (his pants and shirt attached and zip up from the back) on all days of survey. Review of Resident #2's medical record occurred on August 17-20, 2009. The record identified Resident #2 admitted on 01/08/08. Diagnoses included, in part, frontotemporal dementia, agitation, anxiety, depression, and dementia with severe behavioral disturbances. The current quarterly Minimum Data Set (MDS), dated 08/06/09, identified Resident #2 with short and long term memory problems, moderately impaired daily decision making; behavioral symptoms not easily altered and occurring daily which include: wandering, socially inappropriate/disruptive behavioral symptoms, and resistive to cares. The MDS further identified Resident #2 required extensive assist of one staff member for dressing, toilet use, and personal hygiene; frequently incontinent of bowel and bladder, and on a scheduled toileting program with pads/briefs used. The facility failed to identify restraint use for Resident #2 regarding the one piece zip-up outfit he wears during the day and is unable to remove per self.	F 221		

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F 221	Continued From page 8 The current plan of care for Resident #2 in regard to mood and behavior stated, PROBLEM dated 01/08/08- "Mood and behavioral sx [symptoms] related to dx [diagnosis] of dementia: . . . pulls pants down and resists staff's attempts to pull them up . . . sits on toilet with pants down in other resident's BR [bathroom] frequently. . . ." APPROACH dated/implemented 12/29/08- "May wear 1 piece outfit that zips up the back to prevent him from exposing himself in public. . . ." Review of Resident #2's nurse's notes identified the facility notified the resident's daughter on 12/18/08 regarding the one piece outfit. The nurse's note stated "Phone call made to [Name] et [and] informed her of resident's behaviors of frequently going to the BR et not pulling up his pants et exposing himself when he walks up et down the hallway. UM [unit manager] told [Name] that we are going to order a one piece outfit that zips up the back et we want to try this et see if it will work in [decreasing] his exposing himself et observe if this will [increase] his agitation. [Name] says she agrees [with] trying the one piece outfit." Resident #2's physician received notification of the one piece outfit on 01/14/09. The note to the physician stated " . . . He was frequently exposing himself, resulting in complaints from other residents and visitors. A one-piece, back closure outfit was tried and was effective, so more of these outfits have been ordered. . . ." During an interview on 08/19/09 at 12:05 p.m., an administrative nursing staff member (#2) stated they implemented the one piece outfit to address Resident #2's disrobing behavior as it resulted in a dignity issue for him when he exposed himself,	F 221		

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F 221	Continued From page 9 and also affected other residents/visitors. She (#2) confirmed the facility did not identify the one piece zip-up outfit as a restraint. The facility failed to recognize the use of a one piece zip up outfit as a restraint for Resident #2, as it limits the resident's normal access to his own body and used to control a behavior. Failure to identify the one piece outfit as a restraint resulted in the lack of a physician order before using the device, and resulted in the lack of adequate monitoring, ongoing assessment, care planning, and evaluation required for restraint use.	F 221		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	The Baptist Home will endeavor to provide a safe environment for its residents by not tolerating resident neglect, abuse, mistreatment, or misappropriation of property by anyone. The Baptist Home has submitted copies of the three investigations to the North Dakota State Survey and Certification Agency, that had been conducted and had not initially been reported to the North Dakota State Survey and Certification Agency. No abuse was substantiated in either of the three incidences. Education has been provided to the Investigation Team regarding the policy and procedure updates so as part of the initiation of an investigation notification of the allegation will be submitted to the	

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F 225	Continued From page 10 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, review of the State Operations Manual (SOM), and staff interview, the facility failed to notify the state agency immediately and within 5 days of 3 of 6 alleged violations involving physical and/or sexual abuse. Findings include: Review of the facility policy titled "Abuse and Neglect Policy" occurred on 08/19/09. This policy, dated 2008, stated, ". . . Physical Abuse: includes hitting, slapping, pinching, kicking, etc. . . Sexual Abuse: includes, but is not limited to, sexual harassment, sexual coercion, sexual contact, or sexual assault. . . Handling Reports of Resident Abuse or Neglect. . . II. Reporting - C. Reporting - North Dakota State Ombudsman and Survey and Certification Agency (NDSSCA) will be notified of alleged abuse or neglect involving residents. . . Time frame - report allegations by phone immediately, Monday-Friday during business hours. . . VII. Closing - producing and reviewing the written report, notifying the Baptist Home	F 225	North Dakota State Survey and Certification Agency. The Baptist Home will notify the North Dakota State Survey and Certification Agency immediately of any allegations of abuse. Because all residents could be affected by the cited deficiency, the facility reviewed and revised the Baptist Home Abuse and neglect Policy to reflect the change of capability to report investigations of abuse. The following measure will be put into place to ensure that the deficient practice will not recur. The Baptist Home will review each investigation of abuse at monthly Quality Assurance meetings to verify that policy and procedure was followed. A QA monitor form was created to facilitate staff in appropriately reporting and completing the investigation. and will be reviewed as they are presented by Administration The corrective action will be completed on or before September 24, 2009 per telephon conversation on 9-15-09 @ 9:00 am with Sally Fischer & Deb Larson	

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(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 225	Continued From page 11 Administrator, the Ombudsman, the NDSSCA. . . Time frame - within five working days of the incident. Responsible person(s) - the team leader will gather each investigators report for typing and compile a cover letter for the NDSSCA. . . the team leader will notify the NDSSCA and coordinate the delivery of the written report to the NDSSCA. . . ." According to the SOM regulations and interpretive guidelines, page 67, F225- 483.13(c)(2)(4), "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). . . "The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken." - Review of investigations of alleged abuse/neglect occurred on 08/19/09. Review of three of six investigation forms, dated 10/12/08, 10/22/08, and 08/05/09, identified the facility failed to immediately report the allegations to the NDSSCA and, following the investigation, failed to report the findings to the NDSSCA. During an interview on 08/19/09 at 3:50 p.m., an administrative staff member (#3) confirmed the facility failed to report the above three investigations to the NDSSCA.	F 225		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	08/20/2009

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 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference and staff interview, the facility failed to assess for factors which contributed to the behaviors of 2 of 7 sampled residents (Resident #4 and Resident #15), and develop/implement appropriate interventions to modify/control behaviors and provide alternatives to drug therapy. The failure to individualize and identify target behaviors, assess the causative factors for the behaviors, implement appropriate individualized interventions, and accurate on-going monitoring of the behaviors, resulted in Resident #4 and Resident #15 receiving anti-anxiety medications to address behaviors prior to the implementation of nonpharmacologic interventions, limiting the residents' highest practicable physical, mental, and psychosocial well-being. Findings include: The Surveyor Guidebook on Dementia, dated 1995, on pages 21-22, stated "4.7 Developing Specific Plans for Behavioral Interventions: Interventions to identify and treat specific behavioral responses should be a part of the overall care plan . . . A behavioral assessment is the basis for caregiver or staff interventions and should identify and describe (as objectively as	F 250	The Baptist Home must provide medically-related social services to maintain the highest practicable physical, mental, and psycho social well-being of each resident. For resident # 15 a cover sheet was placed on the Behavior Tracking Sheet to give staff ideas on approaches to try when resident # 15 is agitated. Resident # 15's POC was updated to include trying to determine physical cause for agitation such as hunger and pain, attempt distraction when resident is agitated to include but not limited to conversation, snack, 1:1 time in quiet area, allowing resident time alone to calm, and magazines. Charge nurse may use prn medication prior to non-pharmacological approaches when resident's behavior is placing the safety of other residents at risk. For resident # 4 a cover sheet was placed on the Behavior Tracking Sheet to give staff ideas on approaches to try when resident # 4 is agitated. Resident # 4's POC was updated to include trying to determine physical cause for agitation such as hunger and pain, attempt distraction when resident is agitated to include but not limited to holding a doll, snacks, conversation, back rubs, magazines, holding her hand, and offering a hand massage. Because all residents could be affected by the cited deficiency, the Baptist Home	

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F 250	Continued From page 13 possible): . . . Caregiver actions that might trigger the symptoms. The importance of an objective assessment, not clouded by the observers' own emotional responses, is of major importance in determining 'caregiver-triggered' behaviors. The evaluation may need to be done over a period of days in order to record an accurate 'baseline' of the caregivers 'actions and the demented individual's responses, and to identify necessary modifications. . . . Plans should be specific, realistic and focused. Interventions should involve as many caregivers as necessary and be monitored and evaluated on a continuous basis to determine if the plan is effective." The Surveyor Guidebook on Dementia, page 27, stated ". . . When the individual is calm and relaxed, reinforce some aspects of 'here and now' . . . reminders of day, time, and place, . . . Never argue about whether a stated perception or fact is real or if an activity has, in fact, occurred or been done." The Centers for Medicare and Medicaid (CMS) has defined "Catastrophic reactions" as extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care. One definition in current literature is: ". . . catastrophic reactions [are] defined as reactions or mood changes of the resident in response to what may seem to be minimal stimuli (e.g., bathing, dressing, having to go to the bathroom, a question asked of the person) that can be characterized by weeping, blushing, anger, agitation, or stubbornness. - Review of Resident #4's medical record occurred on August 17-20, 2009. Diagnoses included, in part, Alzheimer's disease, anxiety,	F 250	Social Service "Interdisciplinary Resident care Management" Policy was reviewed and revised to include: Unit Managers will maintain a Behavior Tracking folder on each unit containing a Behavior Tracking sheet for each resident who has a prn psychoactive medication. The following measures will be put into place to ensure that the deficient practice will not recur. The Social Service "Interdisciplinary Resident Care Management Policy" was revised to include Social Service staff will bring Tracking Sheets to the interdisciplinary meeting for review and for use assessment and care-planning. Nurses and Certified Medication Aide's will be educated about the importance of non-pharmacological approaches prior to the use of prn psychoactive medications. The QA monitor addressing the non-pharmacological interventions and the prn psychoactive medications used, resident pre-activity before onset of agitated behavior, and what was effective, will be done on a daily basis for the two residents identified in F-Tag 250, for one month, weekly for one month and randomly for one month. The QA monitor will continue to be monitored randomly for 6 months. The corrective action will be completed on or before September 24, 2009.	

by the Social Worker and unit managers per telephone conversation on 9-15-09 at 9:00 am
C Sally Fischer
& Deb Lausch

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F 250	Continued From page 14 and depression. The current quarterly Minimum Data Set (MDS), dated 07/28/09, identified Resident #4 with short and long term memory problems, moderately impaired daily decision making; mood patterns exhibited up to five days a week, including: insomnia, change in usual sleep pattern, sad, pained, worried facial expressions, and repetitive physical movements; behavioral symptoms including resisting cares, not easily altered, and occurring 1-3 days in the last 7 days. This MDS further identified Resident #4 required extensive assist of two or more staff members for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. A significant change MDS, completed on 03/26/09, identified mood patterns exhibited up to five days a week, including: sad, pained, worried facial expressions, and repetitive physical movements; a deterioration in mood; and daily resistance to cares, not easily altered. The current plan of care for Resident #4 in regard to mood and behavior problems, dated 09/06/07, stated "Hx [history] of mood and behavioral symptoms related to dementia: threats to leave the facility, threats of suicide, angry facial expression . . . refuses cares, threatens roommate and staff, wandering, sad facial expression, insomnia. . . .," with approaches of: "Allow her to refuse HS [hour of sleep] cares. Allow her to sleep in street clothes if she refuses pajamas. May use 2 for bath and physical shaping if needed. Have [resident] wear pajama top and bottom instead of gown at HS if available to decrease behaviors. Give PRN Ativan for agitation and chart effectiveness. See Med/Tx [medication/treatment] Flow Sheet for physician's orders. [Name of Dr.] to follow . . . Resident may be placed in a secured unit to allow wandering	F 250		

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F 250	Continued From page 15 without risk to safety (07/23/09). . . ." The current plan of care for Resident #4 in regard to disorientation, confusion, and forgetfulness related to dementia, dated 09/06/07, stated for approaches " . . . See Med/Tx. Flow Sheet for physician's orders. Call resident by name. Explain cares as you provide them, visit socially while you provide cares. Touch resident while visiting. Offer gentle R.O. [reality orientation] if resident displays signs of forgetfulness or confusion. Use Validation if R.O. is ineffective. Staff or family to assist with Bingo. Praise resident for her participation, involvement, constructive use of leisure time and spending quality time with her family. Family will take off unit to play Bingo occasionally. Activity staff to involve resident in 1:1 any group activities each a.m. and p.m. to include but not limited to music, picture books, magazines, hand massages, folding towels, and ball toss. . . ." Review of Resident #4's physician orders for PRN (as needed) medications identified Ativan (an anti-anxiety medication) 0.5 mg (milligram) by mouth or intramuscular (IM) every 4 hours PRN, initially ordered on 07/11/08. Review of Resident #4's Nurse's Notes identified the following: * 03/19/09, 4:25 p.m.- "Res. [resident] restless-keeping (sic) trying to get out of bed/w/c[wheelchair]/room chair Ativan IM given." * 03/23/09, 4:10 p.m.- "Resident up [and] down, agitated [with] sitting in w/c. Stating she wants to go home. Doing one to one [with] resident. Resident given Ativan at 3:40 p.m. in hopes to help calm resident. . . ." * 03/26/09, 12:05 a.m.- "Resident was up in w/c	F 250		

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F 250	Continued From page 16 [at] station. Had Ativan 0.5 mg [at] 10:30 p.m. for agitation. Was toileted [and] put to bed." * 03/27/09, 9:20 p.m.- "Resident very restless [and] agitated. Up [and] down set-off [sic] alarms. One to one done for redirection, res still trying to stand. Ativan IM given. Was effective within half hour of given [sic] Ativan. Res now sleeping in bed. . . ." * 03/28/09, 3:00 p.m.- "Res was restless [after] lunch [and] kept trying to transfer self. She was given PRN Ativan [and] this was effective. She also had a medium BM [after] lunch." * 04/02/09, 8:00 p.m.- "Very confused [after] visitor here. Restless. Med [Ativan] x 1." * 04/04/09, 10:00 p.m.- "Resident up [and] down, very restless. Staff tried redirecting, res became agitated. Was given Ativan x 2 during shift, both times were fairly effective." * 04/19/09, 7:00 p.m.- "Restless/attempting to get out of w/c [and] "go home" Med [Ativan] given." * 04/27/09, 9:00 p.m.- " . . . At 7:10 p.m. med was given for [increased] anxiety/agitation-wanting to go home [and] see mother [and] dad- attempting several times to get out of w/c." * 04/28/09, 10:30 p.m.- "Sleeping at present- medicated [at] 4:35 p.m. with Ativan- resident calmer. . . ." * 05/01/09, 10:00 p.m.- "Resident restless [and] anxious. Was given Ativan x 2 after redirecting did not work." * 05/04/09, 10:00 p.m.- "Resident restless [and] very anxious, redirection not effective. Ativan given [and] effective." * 05/06/09, 7:25 p.m.- "Res kept getting out of chair- alarm sounds. Res says she needs to leave and go home. Med [Ativan] given- 1-1 staff/res done- res did not start to relax until 10 p.m." * 05/09/09, 3:30 p.m.- "Res kept standing [up] from w/c. Wanting to leave."	F 250		

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F 250	Continued From page 17 * 05/09/09, 8:00 p.m.- "Med [Ativan] x 1 at 3:30 p.m. one to one staff res observation. In bed quiet." * 05/09/09, 8:15 p.m.- "Res trying to get out of bed- adament [sic] [at] leaving. Difficult to redirect. Med [Ativan] given." * 05/10/09, 7:00 p.m.- "Res restless- repeatedly getting up from w/c-alarm sounding- wanting to leave. Med [Ativan] x 1 given. [staff initials] Did 1-1 [with] resident for 1 hour then staff took over at desk. Res calmer at 9:00 p.m. [and] HS cares done [and] tucked into bed." * 05/15/09, 9:50 a.m.- " . . . Ativan 0.5 mg PO given for restlessness." * 05/16/09, 2:30 p.m.- "Res restless this am . . . need one on one. PRN Ativan given [at] 9:40 a.m. was 12:00 p.m. before res calmed down. Daughter here at present time took her to activities." * 05/16/09, 4:25 p.m.- "Restless . . . med [Ativan] given." * 05/17/09, 12:00 p.m.- "Res agitated . . . Would not stay in bed or sit in recliner need one on one. She did calm down after lunch and is asleep in bed. PRN Ativan given at 9:40 a.m." * 05/23/09, 3:45 p.m.- "Res upset [with] family visiting because they won't take her home [with] them- crying- threw cookie at dau [daughter] [name]- hard to redirect- med [Ativan] given. . . ." *08/16/09, 12:45 a.m.- "Resident wide awake. Telling everyone she's 'going crazy, the people in the cupboard are going to get me.' Resident given some Ativan. Seems to be settling down." The nurse's notes lacked information regarding other interventions attempted to address the resident's behaviors/restlessness/agitation prior to administering PRN Ativan. The plan of care lacked specific interventions tailored to Resident	F 250		

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F 250	Continued From page 18	F 250		

#4's behaviors and needs. The facility failed to thoroughly assess the resident, care plan accordingly, and implement alternative interventions to address each individualized behavior before administering the PRN Ativan.

- Review of Resident #15's medical record occurred on August 19-20, 2009. Diagnoses included, in part, depression, anxiety, Alzheimer's disease, agitation, and dementia with behaviors. The current quarterly Minimum Data Set (MDS), dated 07/15/09, identified Resident #15 with short and long term memory problems, moderately impaired daily decision making; mood patterns exhibited up to five days a week, including: repetitive verbalizations, persistent anger with self or others, sad, pained, worried facial expressions, and repetitive physical movements; behavioral symptoms not easily altered and occurring daily, including: wandering, verbally abusive, and resistive to cares. This MDS further identified Resident #15 required extensive assist of one staff member for bed mobility, transfers, dressing, toilet use, and personal hygiene. An annual MDS, dated 01/15/09, identified mood patterns exhibited up to five days a week, including: repetitive verbalizations, insomnia/change in usual sleep pattern, and sad, pained, worried facial expressions; and behavioral symptoms not easily altered and occurring daily, including: wandering, verbally abusive, and resistance to cares.

The current plan of care for Resident #15 in regard to mood and behavior problems, dated 04/16/07, stated "Mood and behavioral symptoms related to dementia: anxiety, verbal and physical aggression toward staff and residents, sad facial expression, irritability, and easily annoyed, easily

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F 250	Continued From page 19 agitated, hallucinations, delusions, accuses and threatens staff and residents, paranoid, unrealistic fears, wandering, insomnia, refuses meds [medications], has made threats of suicide especially when having pain or is angry, repetitive verbalizations. . . .," and included approaches of- "See Med/Tx Flow Sheet for physician's orders. [Name of Dr.] to follow . . . Resident may be placed in a secured unit to allow wandering without risk to safety. Encourage resident to participate in activities. If she resists cares try back at a later time if she continues to resist cares, cares will not be given. Try to determine a physical cause if agitated i.e.. pain or constipation. When resident is making threats of suicide, assess her for pain and medicate as needed. If resident is making threats of suicide and pain has been determined not to be a factor, try to distract her with a change in conversation subject. Give PRN Lorezpam [sic] [Ativan] for agitation and chart effectiveness. . . ." The current plan of care for Resident #15 in regard to disorientation, confusion, and forgetfulness related to dementia, dated 04/16/07, stated for approaches "Call resident by name. Explain cares as you provide them, visit socially while you provide cares. Ask yes and no questions. Touch resident while visiting; can use hand massage or hand stimulation. Offer gentle R.O. if resident displays signs of forgetfulness or confusion. Use Validation if R.O. is ineffective. She does come to most activities when asked. Resident's interests include but are not limited to sorting socks, folding towels, using sewing cards, looking through magazines, sing-a-longs, playing catch, bean bag toss, trivia, balloon toss, reminiscing and watching TV movies. Activity staff to offer 1:1 room visits AM and PM consisting of	F 250		

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F 250	Continued From page 20 R.O., friendly conversation, reading to her, pet therapy, matching cards and looking at pictures. Praise resident for her participation, involvement, constructive use of leisure time and spending quality time with her family. . . ." Review of Resident #15's physician orders for PRN medications identified Ativan 0.5 mg 1/2 tab BID (twice daily)-TID (three times daily) PRN orally or IM, initially ordered on 08/15/07. Review of Resident #4's Nurse's Notes identified the following: * 03/15/09, 10:30 p.m.- "Resident has been very agitated this evening Ativan given once which help [sic] her to be calmer." * 04/14/09, 1:30 p.m.- "Res was down in the beauty salon having a perm [and] she became restless [and] agitated. Given Ativan 0.5 mg IM at this time." * 04/14/09, 2:30 p.m.- "Res calmed down [after] getting IM Ativan [and] was able to receive rest of perm." * 06/16/09, 3:10 a.m.- " . . . Restless. Given Ativan." * 08/13/09, 8:00 p.m.- "Resident yelling loudly, because staff were in helping roommate. Staff tried to redirect x 2 but were unsuccessful. Ativan given for behaviors." The nurse's notes lacked information regarding other interventions attempted to address the resident's behavior/restlessness/agitation prior to administering PRN Ativan. The plan of care lacked specific interventions tailored to Resident #15's behavior and needs. The facility failed to thoroughly assess the resident, care plan accordingly, and implement alternative interventions to address each individualized	F 250		

F-Tag 323 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.

For resident # 9 the restraint was removed in June as per the restraint committee. The call cord was shortened to a length that does not pose a safety hazard on August 20, 2009. The resident was given a call bell and a bell sign alert was posted to alert staff that she is not to have a regular length or longer call light cord. Her care plan was updated as of August 20, 2009, to prevent accidental injury.

Because all residents could be affected by the cited deficiency, the facility will assess the residents who have exhibited behaviors that pose a threat of accidental injury from the use of a restraint and receive appropriate follow up. A resident who is identified with a behavior that poses a threat of accidental injury will be assessed for appropriate alternatives.
Baptist Home policy and procedure will be revised to direct staff to utilize the same communications and intervention methods for incidents of accidental life threatening injury as those used for residents who attempt life threatening self injury. Staff will educated on policy changes and newly devised form "Resident Safety Management Form" to assure that accidental injuries are prevented.

Nursing staff will monitor for call light placement each and every time a resident is placed in bed and periodically through the night when rounds are done. Restraint use if required will be monitored on a daily basis time one month by nursing staff reviewed on a monthly basis by the Quality Assurance team to ensure that the residents environment remains free of accidents.

QA study to monitor compliance with policy and procedures. All Resident Safety Management Forms will be reviewed at each regularly scheduled Quality Assurance meeting.

The corrective action will be completed on or before September 24, 2009.

Received Via fax 9-15-09 @ 9:40am

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F 250	Continued From page 21 behavior before administering the PRN Ativan. During an interview on 08/20/09 at 9:00 a.m., an administrative nursing staff member (#2) stated she expected staff to utilize PRN anti-anxiety medications last when addressing a resident's behaviors, and try multiple other interventions first. The lack of identifying target behaviors, assessment/identification of the causes for the targeted behaviors, implementation of appropriate interventions, complete monitoring of the frequency of the behaviors, and established pertinent goals to minimize behavior, and the use of behavior modifying anti-anxiety medications as a first line intervention, prohibits Resident #4 and Resident #15 from maintaining their highest level of overall well-being.	F 250		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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, record review, facility policy review, and staff interview, the facility failed to ensure 1 of 1 sampled resident with a history of a pelvic belt restraint (Resident #19) received ongoing assessment and review of the restraint due her repeated vocalization and attempts to remove the restraint and 1 of 16 sampled resident	F 323		

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F 323	Continued From page 22 (Resident #19) able to utilize a call light received immediate intervention to prevent possible injury/strangulation from a call light cord. Findings include: Review of the facility policy titled "Restraint Policy" occurred on 08/19/09. This policy, undated, stated, ". . . Restraint use may constitute an accident hazard and professional standards of practice have eliminated the need for physical restraints except under limited medical circumstances . . . It is further expected that for those residents whose care plans indicate the need for restraints that the facility engage in a systematic and gradual process toward reducing restraints . . . The use of any restraint should occur only after comprehensive assessment . . . and where the determination is made that the use of the restraint will enable and promote greater functional independence for the resident . . ." Review of Resident #19's medical record occurred August 19-20, 2009. Medical diagnoses included, in part, anxiety, depression, osteoporosis, glaucoma, legally blind, and incontinence. Resident #19's annual Minimum Data Set (MDS), dated 06/18/09, identified short term memory difficulties and moderate impairment in daily decision making. The MDS identified no problems with long term memory, and she makes herself understood and understands others. The MDS identified no falls in the past 180 days. - Review of the nurse's notes and therapy notes related to Resident #19's pelvic belt identified the following:	F 323		

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	355058	A. BUILDING _____ B. WING _____	08/20/2009

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F 323	Continued From page 23 * 10/20/08 (Occupational Therapy) (OT) note - "Call from Unit Manager at 1655 [4:55 p.m.] due to res. [resident] undoing pindot pelvic bet in w/c [wheelchair] several x's [times] . . ." * 10/22/08 (OT note) - "Late entry for 10/21/08 . . . a rear fasten quick release clip-type belt on resident's w/c . . ." * 11/04/08 at 8:00 p.m. (nurse's note) - "Remains angry about back fastening w/c belt. Insists it should be off @ noc. [night]. Unable to reason [with] her . . ." * 11/06/08 (OT note) - "30 day review of rear fastened belt in w/c . . . Benefits continue to outweigh the risks due to Dx [diagnoses] of: legal blindness, fall risk . . ." * 11/19/08 at 4:00 p.m. (nurse's note) - "Res. continues to c/o [complaints of] w/c belt. Unable to please her." * 12/03/08 at 8:55 p.m. (nurse's note) - "Resident slouched down in w/c & pulled belt over head & began to stand up to get out of w/c. Resident said she knows how to get out of belt." * 12/05/08 at 8:20 p.m. (nurse's note) - "Res. somehow removed one side of w/c belt et [and] got into bed. Belt was crossed in back as ordered. Unknown how she did this. Foul mood. Yelling @ staff. Continually wants belt off. Will monitor." * 12/06/08 at 2:00 p.m. (nurse's note) - "Talked [with] [staff name] (PT) about w/c belt. She will check it Mon. [Monday] a.m." * 12/08/08 - (Restorative Therapy (RT) note) "Observed rear fastened belt on w/c due to recent transfer from w/c to bed. Staff to cross belt in rear & [and] secure over rear anti tippers & adjust tension to prevent belt from slipping off of back of w/c . . ." * 12/16/08 - (OT note) "60 day review of rear fastened belt used in w/c to [decrease] risk of injury [secondary to] poor judgement et attempts	F 323		

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F 323	Continued From page 24 to tra [transfer] self . . . Benefits of use continue to outweigh the risks . . . She is tolerating it quite well. No problems reported by staff . . ." * 12/27/08 at 5:00 a.m. (nurse's note) - ". . . Calling CNA's [certified nursing assistants nasty names trying to prevent them from putting on belt . . ." * 01/08/09 at 9:10 p.m. (nurse's note) - ". . . Staff trying to position res. in chair et apply back fasten belt. Res. not cooperating, Hitting, squeezing staffs hands . . ." * 01/08/09 - (OT note) "90 day review of rear fasten pelvic belt used in her w/c to [decrease] risk of falls/injuries [secondary to] [decreased] safety awareness, [decreased] judgement . . . Recommend cont. use of rear fasten pelvic belt as benefits outweigh the risks." * 02/09/09 at 2:20 p.m. (nurse's note) - "Staff reported that Res got her safety belt loose & transferred self from w/c to toilet . . . Therapy notified." * 02/10/09 - (RT note) "Observed belt in w/c [with] resident. Resident unable to release belt per self when secured to back of w/c." * 02/11/09 at 12:50 p.m. (nurse's note) - "Res. found a scissors & cut her belt in half. Res. put on observation . . . very adamant about not putting the belt back on 'I'm done [with] it, you can't make me have that.' Therapy dept. [department] informed . . ." * 03/02/09 at 10:00 a.m. - (nurse's note) "Requesting all kinds of things to be done. Wanting a scissors, & a pliers to take care of the belt . . ." * 03/14/09 at 8:45 p.m. - (nurse's note) "Restless. Up in w/c [with] belt on. Agitated . . ." * 04/02/09 at 7:30 a.m. - (nurse's note) ". . . nurse went to help resident and resident wanted seat belt cut, when nurse said does not have a	F 323		

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F 323	Continued From page 25 scissors resident stated, you do to . . ." * 06/22/09 (OT note) - Discussed trial restraint elimination . . . Pelvic belt cont. [continues] to be used, however becoming quite snug [secondary to] wt [weight] gain . . ." * 06/24/09 (RT note) - "Trial today restraint elimination. Resident unable to stand @ [at] toilet [with] rails when assisted into BR [bathroom] . . . " * 06/25/09 at 9:00 p.m. (nurse's note) - "Has not tried to get up on own this shift. Belt in w/c remains off . . ." During an interview on 08/20/09 at 8:45 a.m., a restorative staff member (#5) agreed, restraint reduction/elimination should have been attempted earlier than June due to Resident #19's ongoing attempts to remove the pelvic belt and her dislike of this restraint. Continued use of the restraint while Resident #19 continueously attempted to remove it placed this resident at risk for an accident hazard. - Review of Resident #19's nurse's notes revealed the following: * 08/17/09 at 5:00 a.m. - "Staff found call light cord wrapped around Res neck 1x [times once] when they went into do cares on Res. Nurse asked Res. if she was trying to hurt herself. Res. states 'no' why would I do that. States I keep my keys on a cord around my neck so I don't loose them . . . light cord removed & work order make out to shorten cord on call light. Res. has a bell." Observation on 08/19/09 at 5:05 p.m., showed Resident #19 laying awake on her bed, positioned on a bedpan, and her call light cord coiled on her pillow next to her head and long enough for Resident to wrap around her neck.	F 323		

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F 323	Continued From page 26 During an interview on 08/19/09 at 5:45 p.m., an administrative nursing member (#1) stated the nurse on duty the night of the incident placed a work order for environmental services to shorten Resident #19's call light cord and she was unaware it had not occurred. During an interview on 08/20/09 at 8:15 a.m., an administrative staff member (#4) showed the work order to shorten the call cord dated 08/17/09 and verified a staff member completed the request on 08/17/09, and shortened the cord enough so Resident #19 could still hold the cord from her wheelchair four feet away from her bed. He stated the work order failed to explain why the cord needed to be shortened.	F 323		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Each resident's drug regimen must be free from unnecessary drugs. Communication was distributed to all nurses and CMA's regarding the deficient practices identified in the use of prn pain medications and prn antipsychotic medication. Resident # 4; staff was given information regarding using non-pharmacological interventions before given pain medication and antipsychotic medication. Since the Survey date of August 20, 2009, Resident # 4 has required no Ativan and Tylenol 650 mg has been given 3 times for restlessness, after non-pharmacological interventions had been used.	

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F 329	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional references, and staff interview, the facility failed to ensure residents' drug regimens were free from unnecessary drugs by not monitoring the results of as needed (PRN) medications for 4 of 21 sampled residents (Resident #4, #13, #15, and #16) who received PRN medications. An unnecessary drug includes any drug used without adequate monitoring, indication of need, and prolonged use of the medication. Failure to assess and monitor medications limits staff's ability to identify alternatives to pharmacological approaches, identify potential adverse effects of medications, and determine the effectiveness of PRN medications. Findings include: Review of the facility policy titled "Nursing Pain Management" occurred on 08/19/09. This policy, dated 2007, stated ". . . 6. Medication Regimens to address pain: A. In order of preference, if possible, select analgesic intervention in accordance with the following choices: 1. Non-prescriptive analgesic 2. Non-narcotic analgesic 3. Narcotic analgesic - oral or trans-dermal 4. Injection · Base the choice of analgesic on the resident's descriptive report of pain & other pertinent	F 329	Resident #13: staff was given information regarding using non-pharmacological interventions before giving pain medication and antipsychotic medication. Physician ordered Tylenol 650 mg TID and discontinued the Vicodin. Resident continues to be restless and hollers out but only has used Tylenol 650 times three, Tylenol 1000mg times 1, and Ativan times one. Staff continue to offer non-pharmacological interventions before prn meds are administered. Resident # 16: staff was given information regarding using non-pharmacological interventions before giving pain medication ad antipsychotic medication. Resident continues to ask for Oxycodone 2.5mg. Staff will recommend the Tylenol 1000 mg and a couple of times she has excepted Resident # 16 states that the Tylenol 1000 mg is not effective and will request Oxycodone within 2-3 hours after the Tylenol 1000 has been given. Staff will ask her to rate her pain, she rates the pain as mild pain according to pain scale, with Oxycodone being effective. Resident # 15: staff was given information regarding using non-pharmacological interventions before giving pain medication and antipsychotic medication. Resident # 15 according to nurses notes has had periods of restlessness and crying out, non pharmacological interventions have been tried and been effective. Resident # 15 has used Ativan x 1 since the August 20,	

2009 survey.

Because all residents could be affected by the cited deficiency, the facility will identify other residents having the potential to be affected by the deficient practice through regular review of the medical record and administration of such prn medication and monitor the medical record for appropriate medication administration and documentation.
Staff will receive education and monitoring to assure that the proper documentation is recorded in the residents medical record for the use of the prn antipsychotic and prn pain medication and assessments. Policy and procedure was developed and nurses and CMA's will be mandated to review new policy which address non pharmacological approaches, encouraging activities, using massage, hot/warm or cold compressed to address a resident's pain or discomfort. The policy also address visiting with the physicians to order scheduled pain medication rather than ordering pain medication on a prn basis.
Resident Pain-Rating scale was reviewed with nursing staff and revisions made to assist residents and staff to understand the rating scale.
Nursing staff will be inserviced at regularly scheduled monthly nurses meeting regarding changes made in PRN medication policy.

Nursing staff will complete a QA monitor on PRN pain medication and PRN antipsychotic medication, monitoring,

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F 329	Continued From page 29 - Review of Resident #13's medical record occurred on August 17-19, 2009. Medical diagnoses included, degenerative joint disease, neuropathy, chronic pain, and a left femoral fracture. The physician's orders included, Tylenol (a non-prescriptive analgesic) 650 milligrams (mg) orally or rectally every four hours as needed (PRN) for pain, and Vicodin (a narcotic analgesic) 5/500 mg every four hours PRN, initiated after Resident #13's fracture and hospitalization on 03/03/09. Review of Resident #13's significant change Minimum Data Set (MDS), dated 05/21/09, identified mild back, joint, and other pain less than daily. The current care plan stated, "Problem: Alteration in comfort . . . Approaches: . . . Give PRN analgesics at resident's request and chart effectiveness. Monitor location and severity of pain . . ." A "PRN Drug Sheet," used by facility staff to document any PRN medications administered to a resident, identified the following areas: "date; time; drug, dosage, route; rate the pain; reason for giving medications and initials; rate the pain & (and) effect of medication; and time & initials of observer." Review of Resident #13's PRN drug sheets identified facility staff administered the following PRN analgesics: * April 2009 - 37 Vicodin and one Tylenol * May 2009 - 18 Vicodin and four Tylenol * June 2009 - 27 Vicodin and one Tylenol * July 2009 - 34 Vicodin and one Tylenol * August 1-18, 2009 - 13 Vicodin and no Tylenol Review of Resident #13's PRN drug sheets	F 329	reason for medication, interventions tried before administering prn medication and prn antipsychotic medication to residents will be done on a daily basis time one month. Randomly weekly for three months, and random monthly for three months. The corrective action will be completed on or before September 24, 2009	

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F 329	Continued From page 30 identified facility staff administered Vicodin (a narcotic analgesic) rather than Tylenol (a non prescriptive analgesic) for reported mild pain as follows: * April 2009 - 14 of 37 times * May 2009 - 13 of 18 times * June 2009 - 10 of 27 times * July 2009 - 13 of 34 times * August 1-18, 2009 - 2 of 13 times Review of Resident #13's PRN drug sheets showed facility staff failed to "rate the pain" prior to administration as follows: * April 2009 - 8 of 37 times * May 2009 - 5 of 18 times * June 2009 - 6 of 27 times * July 2009 - 10 of 34 times * August 1-18, 2009 - 3 of 13 times Review of Resident #13's PRN drug sheets showed facility staff failed to a "rate the pain & effect of medication" after administration as follows: * June 2009 - 4 of 27 times * July 2009 - 8 of 34 times Review of Resident #13's PRN drug sheets showed facility staff failed to document "time & initials of observer" as follows: * April 2009 - 13 of 37 times * June 2009 - 3 of 27 times * July 2009 - 6 of 34 times Review of Resident #13's PRN sheets showed facility staff administered Vicodin for other reasons than pain as follows: * June 2009 - two times "prior to getting dressed" and once for "possible pain, no sleep" * July 2009 - two times for "agitation, confusion"	F 329		

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F 329	Continued From page 31 and "calling out help me, restless" * August 2009 - three times for "crying out" and "crying, yelling help me, can't sleep" Facility staff failed to assess Resident #13's pain and the effectness of pain medication on a consistent basis. Failure to assess the resident's response to pain medication administered on a consistent basis may have resulted in administration of a more potent analgesic then necessary. During an interview on 08/20/09 at 9:40 a.m., an administrative nursing staff member (#2) agreed facility staff should assess pain prior to administering Tylenol or Vicodin and medicate accordingly. - Resident #16's medical record, reviewed August 19-20, 2009, identified diagnoses including osteoarthritis, neck pain, shoulder pain, and postherpetic neuropathy. An annual MDS, dated 01/13/09, identified Resident #16 experienced no pain. Quarterly MDSs, dated 04/13/09 and 07/14/09, identified Resident #16 experienced mild pain less than daily, with pain sites of joint pain (other than hip) and other. The Quarterly MDS, dated 07/14/09, also identified Resident #16 experienced short term memory problems and modified independence for daily decision making, requiring assistance in new situations only. Resident #16's current care plan stated, "Problem: Alteration in comfort: Generalized pain related to osteoarthritis . . . Approaches: . . . Give PRN analgesics at resident's request and chart effectiveness. Monitor location and severity of pain . . ." Physician orders for Resident #16, in part,	F 329		

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F 329	Continued From page 32 included, Tylenol ES [extra strength] 500 mg 2 tablets every four hours prn and oxycodone (an opioid analgesic)2.5 to 5 mg every]6 hours - prn indefinitely. Review of Resident #16's PRN drug sheets showed facility staff failed to "rate the Pain" prior to administration as follows: * March 2009 - 13 of 30 times * April 2009 - 16 of 28 times * May 2009 - 12 of 29 times * June 2009 - 21 of 27 times * July 2009 - 14 of 22 times * August 2009 - 4 of 9 times During an interview on 08/19/09 at 2:10 p.m., an administrative nursing staff member (#1) stated staff should assess and complete the "Rate the Pain" section of the "PRN Drug Sheet" prior to the administration of a PRN pain medication. Review of Resident #16's PRN drug sheets showed facility staff failed to "rate the pain & effect of medications as follows: * April 2009 - 3 of 11 times * May 2009 - 6 of 29 times * June 2009 - 7 of 21 times * August 2009 - 2 of 9 times Review of Resident #16's PRN drug sheets showed facility staff failed to "rate the pain" after administration as follows: * March 2009 - 20 of 30 times * April 2009 - 19 of 28 times * May 2009 - 22 of 32 times * June 2009 - 18 of 27 times * July 2009 - 15 of 22 times * August 2009 - 2 of 9 times	F 329		

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F 329	Continued From page 33 Review of Resident #16's PRN drug sheets from April 2009 to August 18, 2009 showed staff gave Tylenol and oxycodone for the same type of pain and pain rating. The medical record lacked indications to show the necessity for stronger pain medication, oxycodone (a narcotic), rather than Tylenol (a non-prescriptive analgesic). - Review of Resident #4's medical record occurred on August 17-20, 2009. Diagnoses included, in part, Alzheimer's disease, anxiety, and depression. The current quarterly Minimum Data Set (MDS), dated 07/28/09, identified Resident #4 with short and long term memory problems, moderately impaired daily decision making; mood patterns exhibited up to five days a week, including: insomnia, change in usual sleep pattern, sad, pained, worried facial expressions, and repetitive physical movements; behavioral symptoms including resisting cares not easily altered and occurring 1-3 days in the last 7 days. This MDS further identified Resident #4 required extensive assist of two or more staff members for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Review of Resident #4's physician orders for PRN medications identified Ativan (an anti-anxiety medication) 0.5 mg by mouth or intramuscular (IM) every 4 hours PRN, initially ordered on 07/11/08. Review of Resident #4's Nurse's Notes identified nursing staff administered Ativan five times in March 2009; five times in April 2009, 12 times in May 2009, and once in August 2009 for restlessness, agitation and/or anxiousness without first attempting non-pharmacological approaches.	F 329		

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F 329	Continued From page 34 - Review of Resident #15's medical record occurred on August 19-20, 2009. Diagnoses included, in part, depression, anxiety, Alzheimer's disease, agitation, and dementia with behaviors. The current quarterly Minimum Data Set (MDS), dated 07/15/09, identified Resident #15 with short and long term memory problems, moderately impaired daily decision making; mood patterns exhibited up to five days a week, including: repetitive verbalizations, persistent anger with self or others, sad, pained, worried facial expressions, and repetitive physical movements; behavioral symptoms not easily altered and occurring daily, including: wandering, verbally abusive, and resistive to cares. This MDS further identified Resident #15 required extensive assist of one staff member for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of Resident #15's physician orders for PRN medications identified Ativan 0.5 mg 1/2 tab BID (twice daily)-TID (three times daily) PRN orally or IM, initially ordered on 08/15/07. Review of Resident #15's Nurse's Notes identified nursing staff administered Ativan once in March 2009, two times in April 2009, once in June 2009, and once in August 2009 for agitation, restlessness, and yelling without first attempting non-pharmacological approaches. Refer to F250. During an interview on 08/20/09 at 9:00 a.m., an administrative nursing staff member (#2) stated she expected staff to utilize PRN anti-anxiety medications last when addressing a resident's behaviors, and try multiple other interventions first.	F 329		

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 _____	08/20/2009

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 329	Continued From page 35 Facility staff failed to consistently address Resident #4 and Resident #15's basic needs (i.e. hunger, need to toilet, thirst, constipation, pain, safety/security, etc..) and attempt multiple nonpharmacologic (interventions other than medications) interventions before resorting to PRN Ativan.	F 329		