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 _____	R 08/25/2011

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 on-site revisit, conducted 08/24/11 and completed on 08/25/11 to determine compliance with the deficiencies identified during the 07/14/11 survey, the sample included 14 residents and one additional resident for focused reviews of the areas of noncompliance.	{F 000}	F-Tag 241 CNA (1) and CNA (2) were educated on the importance of talking to the residents in a dignified and respectful manner. Since the facility was unable to identify CNA (15) the Clinical Coordinators presented education regarding "What is dignity" to nursing staff. Dignity rounds and General observation Rounds are being conducted on a daily basis by clinical coordinators and administrative staff to ensure that staff treat the residents with respect and dignity. Clinical Coordinators will present a report regarding the Dignity Rounds at the regular scheduled Quality Assurance meeting. The corrective action will be completed on or before September 12, 2011. Clinical Coordinator will be responsible for facility compliance.	
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the dignity of 1 of 1 sampled resident (Resident #8) and 1 of 1 supplemental resident (Resident #15) observed being spoken to or about in an undignified manner. Failure of the facility staff to speak to or about Resident #8 and Resident #15 in a dignified manner does not preserve their personal dignity and places them at risk of embarrassment or emotional harm. Findings include: - Observation on 08/24/11 at 10:25 a.m., showed two CNAs (#1 and #2) transferred Resident #8 into bed and provided personal cares. Following the cares, the resident stated, "I'm cold." The CNA (#2) stated, "Do you want your blankie?," and covered her with two blankets. Resident #8 stated, "I'm still cold. I need another one." The	{F 241}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Kozle — TITLE: administrator — (X6) DATE: 9/7/11

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the dignity of 1 of 1 sampled resident (Resident #8) and 1 of 1 supplemental resident (Resident #15) observed being spoken to or about in an undignified manner. Failure of the facility staff to speak to or about Resident #8 and Resident #15 in a dignified manner does not preserve their personal dignity and places them at risk of embarrassment or emotional harm. Findings include: - Observation on 08/24/11 at 10:25 a.m., showed two CNAs (#1 and #2) transferred Resident #8 into bed and provided personal cares. Following the cares, the resident stated, "I'm cold." The CNA (#2) stated, "Do you want your blankie?," and covered her with two blankets. Resident #8 stated, "I'm still cold. I need another one." The	{F 241}		

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

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{F 241}	Continued From page 1 CNA (#2) searched her room, and then stated, "We'll go get you another blankie, okay?" Resident #8 shook her head, but did not reply verbally. -A random observation on 08/24/11 at 9:25 a.m. showed an unidentified nursing staff member coming out of a Resident #15's room. The staff member stopped at the doorway to the dining room and stated to another unidentified staff member (who was standing next to a dining room table where three residents sat), "[Resident name] needs some new bras. Hers are way too big." Observation showed the three residents sat close enough to hear the staff member's statement.	{F 241}		
{F 323} SS=D	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: 1. Based on observation, record review, review of facility policies and procedures, and staff interview, the facility failed to ensure staff appropriately used assistive devices to prevent accidents for 3 of 8 sampled residents (Resident #3, #4, #7) requiring assistance with transfers. Failure to use assistive devices correctly places Residents #3, #4, and #7 at risk of pain or injury.	{F 323}	F-Tag 323 Free of Accident Hazard/Supervision. CNA (#6, #7, #8 and #11) were educated on the proper way to apply a gait belt and the importance of making sure that the brakes of the wheel chair be locked during a transfer. The revised Gate Belt Policy was reviewed with CNA (#6 and #7). CNA #10 was re-educated in the proper use of a sit-to-stand lift per manufactures recommendations. The transfer of Resident #4 and care plan was reviewed and Clinical Coordinators evaluated updated. CNA (#6, #7 and #11) will be audited on a regular basis on proper gait belt usage. Clinical Coordinators presented education to nursing staff on proper gait belt usage, importance of locking brakes	

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{F 323}	Continued From page 2 Findings include: Review of the facility policy "Pro Assist Lift" occurred on August 24-25, 2011. The undated policy stated, "DESCRIPTION: The Pro-Assist is designed for semi-ambulatory patients (patients that have adequate upper body strength) PROCEDURE: 1. Transfer of a resident with use of the Pro-Assist will be accomplished with the assist of two staff. 2. Choose the proper size sling that is most comfortable for the resident. The sling fits across the back just above the waistline with the Velcro safety restraint strap fitted very snugly (without pinching) across the chest (on top of the bosom). 3. On a pear-shaped person (whose chest is smaller than midsection), slide the sling higher under the arms and adjust the safety strap very snugly. . . . Sling will have the tendency to ride up and pinch if not adjusted very snugly. . . . 6. Attach both sling couplings and adjust evenly. Encourage the resident to grasp the handgrips (any of the three positions) and use as much arm and leg strength as possible during the transfer. . . ." Review of facility policies and procedures occurred on August 24-25, 2011. A facility policy, titled, "GAIT BELT POLICY," dated 04/08, stated, "POLICY: Staff must provide safety and protection during transfers. In most cases a gait/transfer belt is used for assisting a resident . . . PROCEDURE: . . . 1. Apply the belt snugly around the waist, over the clothing; it is best to position the belt under the abdominal girth . . . 2. Fasten the safety buckle in the front . . . 3. Bring the resident to a standing position, using one or two hands. Do not lift resident under their arms or	{F 323}	on wheelchair during a transfer and proper use of a Sit-To Stand lift. Clinical Coordinators will evaluate residents who are care planned for Sit-to-Stand transfers on a monthly basis, at which times care plans will b updated if necessary, Team Leader and CNA staff notified of changes. Clinical Coordinators will present a QA audit report at each regular scheduled meeting. Appointed CNA staff, Clinical Coordinators and Administrative nursing will do random gait belt use audits on CNA's. Audit sheets will be reviewed at the regular scheduled QA meeting. Corrective action will be completed on or before September 7, 2011. Chemicals and items that could potentially cause harm were removed from the cupboards in the New Horizon's Unit. Staff education to employees on the importance of keeping resident areas safe and free from hazards was presented by Clinical Coordinator's at scheduled nursing staff meetings. Cupboards are checked on a regular basis by Director Environmental Services or designee, and signed off that cupboards are locked. Corrective action will be completed on or before September 7, 2011.	

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{F 323}	Continued From page 3 hold onto their arm to lift them. If the belt loosens, snug it again after the resident is standing. . . ." The facility's Gait Belt Policy conflicts with the Pro-Assist Lift policy which stated transfers with the lift should be accomplished with the assist of two staff members. Failure to ensure consistency of policies and procedures could result in inappropriate use of assistive devices. - Record review for Resident #7 occurred on August 24-25, 2011. Medical diagnoses included Alzheimer's disease, dementia, pain, and anxiety. The current care plan identified 1-2 person assistance with transfers and toileting. Observation on 08/24/11 at 10:15 a.m. identified two certified nursing assistants (CNAs #6 and #7) transferred Resident #7 to her recliner. The CNA (#6) applied a gait belt around the resident's waist. Observation showed the gait belt loose around the resident's waist and the wheelchair brakes not locked. The CNAs assisted Resident #7 to stand, and as the resident stood the wheelchair rolled backwards. The CNA (#6) grabbed Resident #7 underneath her arm with one hand and held the gait belt with the other hand. The CNAs did not tighten or re-adjust the gait belt after the resident stood. Observation on 08/24/11 at 1:40 p.m. identified two CNAs (#6 and #8) transferred Resident #7 from her wheelchair onto the toilet. The CNAs applied a gait belt loosely around the resident's waist. The CNAs did not lock the brakes on the wheelchair prior to the transfer. The resident held onto the grab bar and the CNAs held onto the gait belt. The gait belt rode upward toward the	{F 323}		

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{F 323}	Continued From page 4 resident's mid back and the wheelchair rolled backwards out from under the resident as she stood. The CNAs did not adjust or tighten the gait belt. - Record review for Resident #4 occurred on August 24-25, 2011. Medical diagnoses included Alzheimer's disease, dementia, and pain. The current care plan identified Resident #4 required a standing lift and 1-2 person assist for transfers. Observation on 08/24/11 at 11:10 a.m. identified two CNAs (#9 and #10) transferred Resident #4 to the bathroom using a stand lift. The CNAs applied the belt around the resident's waist. The CNAs transferred Resident #4 to a standing position. Observation showed the resident unable to bare full weight as the CNAs encouraged her to stand up straight. Further observation showed the safety strap rode upward toward the resident's upper back and the leg strap not fastened. The CNAs tightened the safety strap around the resident's waist but did not adjust the position. Observation showed Resident #4's elbows bowed outward parallel to her shoulders, the belt at her upper back, and sling underneath her under arms (axilla). Observation on 08/24/11 at 12:50 p.m. identified a CNA (#10) transferred Resident #4 to the bathroom using a stand lift. The CNA utilized the stand lift in the same manner as above. Observation showed Resident #4's elbows bowed outward parallel to her shoulders, the belt at her upper back, and sling underneath her under arms (axilla). - Record review for Resident #3 occurred on	{F 323}		

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{F 323}	Continued From page 5 August 24-25, 2011. Medical diagnoses included dementia, Parkinson's disease, hypotension, pain, history of falls, and difficulty walking. The current care plan identified Resident #3 on a toileting plan and required assistance of 1-2 staff with toileting and ambulation. Observation on 08/24/11 from 11:15-11:25 a.m. in the New Horizon's unit identified two CNAs (#6 and #11) assisted Resident #3 to the bathroom. Observation showed the CNAs applied a gait belt loosely around the resident's waist. Observation showed Resident #3 unsteady when transferred to the toilet. The CNAs did not tighten or adjust the gait belt. After toileting, the CNAs took the resident for a walk around the unit. Observation showed Resident #3 unsteady on his feet during ambulation. The CNAs held onto the loose gait belt, still observed around the resident' waist, but did not tighten it prior to ambulation. 2. Based on observation and staff interview, the facility failed to ensure the environment was as free of accident hazards as possible on 1 of 1 resident special care unit - New Horizons regarding storage of hazardous chemicals/items. Failure to secure chemical/hazardous item storage has the potential to result in injuries to the residents, especially residents who have dementia and wander. - An initial tour of the New Horizon's unit occurred on 08/24/11 at 9:00 a.m. Observation showed a nook area off the hallway containing a desk with a chair and a wooden shelf. The shelf contained a 19 ounce can of "Clorox Disinfecting Spray" labeled "Keep out of reach of children." This surveyor reached up and grabbed the can of	{F 323}		

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{F 323}	Continued From page 6 spray from the shelf. A CNA (#6) stated the unit does have a resident who wanders, but he "has not tried to grab the spray can yet." Observation later that morning showed the spray can removed from the shelf and stored in a secure location. Failure of the facility to correctly use assistive devices and failure to store chemicals in a safe manner has the potential to injury/pain to residents in the facility.	{F 323}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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}	F-Tag 329 Drug Regimen is Free from Unnecessary Drugs. Orders received to decrease Ambien and a sleep/wake log put in place to monitor resident's sleep pattern. Resident #5, psychiatrist was faxed regarding possible reduction of Seroquel, physician did reduce the dosage of Seroquel. Since all residents have the potential to receive unnecessary drugs the Pharmacists will review residents on a monthly basis, and notice will be sent to the physician requesting a review of medication and justification as to why GRD should not be attempted. A copy of Dr. Levingson's, Phychiatrist, teleconference presentation on Unnecessary Medication will be shared with facility physician's and staff nurses. The facility Pharm D will present a mandatory presentation to all nurses during this month's upcoming meeting;	

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{F 329}	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure a gradual dose reduction (GDR) was attempted for 1 of 6 sampled residents (Resident #5) receiving a scheduled antipsychotic and 1 of 1 sampled residents (Resident #1) receiving a scheduled hypnotic. Failure to attempt a GDR (unless contraindicated) may result in residents receiving unnecessary medications and experiencing adverse drug reactions related to these medications. Findings include: - Resident #5's medical record, reviewed on all days of survey, identified diagnosis including dementia, episodic mood disorder, anxiety disorder, and aphasia. Resident #5's medication regimen included Paxil (an antidepressant) 10 milligrams (mg) daily and Seroquel (an antipsychotic) 12.5 mg in the morning and 50 mg at bedtime daily. The record identified the physician increased Resident #5's Seroquel dose in March 2010 and September 2010. Review of physician's orders identified an order, dated 09/21/10, to increase Resident #5's Seroquel to 12.5 mg every a.m. and 50 mg every day at bedtime. The record lacked the physician's clinical rationale for the dose increase. The facility's Plan of Correction (PoC) for this deficiency, with a completion date of 08/20/11, stated the following related to this deficiency: ". . . physician will be notified, resident progress notes	{F 329}	for nursing staff regarding unnecessary medications. Clinical Coordinators will be responsible for follow up on the recommendations made by pharmacy regarding gradual dose reduction. The Clinical Coordinators will report to the Quality Assurance committee at regular scheduled QA meetings. Corrective action will be completed on or before September 7, 2011. Clinical Coordinators will be responsible for facility compliance.	

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{F 329}	Continued From page 8 reviewed, and request for trial reduction of antipsychotic medications. . . ." The facility failed to provide evidence of physician notification and a request for a dose reduction as per the PoC. Failure to implement the PoC resulted in Resident #5 continuing to receive the same dose of Seroquel without clinical indication or attempts at a dose reduction. - Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook," 31st edition, page 788, stated, "Ambien . . . Alert: . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety and dementia. Medications included Ambien (a hypnotic) 10 milligrams (mg) at bedtime, initiated on 04/16/10 with the indication "Symptom, insomnia NOS [not otherwise specified]." Resident #1's physician progress notes since the initiation of the Ambien failed to identify clinical rationale for continued use or contraindications for attempting a quarterly GDR. During an interview on 08/25/11 at 11:05 a.m., a supervisory nursing staff member (#3) confirmed the physician's notes failed to address Resident #1's continued use of Ambien and identify contraindications for attempting a GDR. Failure to attempt a GDR of Resident #1's Ambien may have resulted in the resident receiving an unnecessary medication and experiencing adverse drug reactions related to its use.	{F 329}		

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{F 371} SS=B	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 dietary meeting minutes, and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 facility kitchen during 2 of 2 days of survey (August 24-25, 2011). Failure to ensure food items are securely sealed, stored off the floor, and protected from condensation may result in contamination of the food items and places all residents, staff, and visitors who consume foods prepared in the facility's kitchen at risk for foodborne illness. Findings include: A tour of the facility's kitchen occurred on 08/24/11 at 8:25 a.m. Observation showed an open bag of biscuits on a shelf in the walk-in freezer. A dietary staff member (#4) removed the bag, sealed it, and placed it back in the freezer. Observation also showed frozen condensation under the freezer's cooling unit on top of an opened box of chicken tenderloins and a box of turkey meat. Observation in the walk-in cooler	{F 371}	F-Tag 371 Food Procure Store/Prepare/Serve – Sanitary The facility must- Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and Store, prepare, distribute and serve food under sanitary conditions. This requirement is not met as evidenced by: Failure to ensure food items are securely sealed, **stored off the floor, protected from condensation from food items.** The corrective action will be accomplished for those residents found to have been affected by the deficient practice; • **Each Dietary Staff person was individually counseled between 8/25/11 and 9/1/11.** • **A work order was written on 9/1/11 to have the freezer cooling unit inspected. 9/6/11 maintenance evaluated and applied more insulation around pipes. Food was removed from that area. Area will be monitored for ice during daily inspections.** The facility will identify other residents having the potential to be affected by the same deficient practice; • All residents have the potential to be affected by this deficiency. Therefore, all areas in the kitchen will be monitored for properly sealed and stored foods.	

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

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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 _____	R 08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 371}	Continued From page 10 showed a large, mesh bag of onions stored directly on the floor. On 08/25/11 at 8:35 a.m., observation in the facility's kitchen revealed the following: *A large, mesh bag of onions stored directly on the floor of the walk-in cooler (as noted on 08/24/11). A dietary staff member (#5) stated the onions should not be on the floor and moved them to a shelf. *A metal rolling rack in the walk-in cooler with 8 trays of uncovered orange gelatin salad in dessert bowls. A dietary staff member (#5) stated the trays should be covered. *An open bag of nine hot dog buns and an open bag of approximately one dozen hamburger patties stored in the walk-in freezer. A dietary staff member (#5) removed the bags, sealed them, and placed them back in the freezer. *Frozen condensation under the cooling unit in the walk-in freezer on top of an opened box of chicken tenderloins and a box of turkey meat (as noted on 08/24/11). The dietary staff meeting minutes, dated 08/11/11, revealed staff received education related to proper food storage. During an interview on the morning of 08/25/11, a dietary staff member (#5) stated the dietary staff received education at the meeting related to the proper storage of food, and that the condensation in the freezer was due to humidity. She also stated the cook dished up the orange gelatin earlier that morning but had not covered the gelatin before she began serving breakfast.	{F 371}	• **The Supervisors will check main cooler, freezer and other work areas for correct storage, labeling and dating daily using QA for 52-90. This QA form will b completed each day for 1 month, one day in a month for 3 months and 1 day in a month every 3 months thereafter.** • Dietary Personnel will check small reach in cooler/snack area and cereal area at the start of their shift using QA form 52-91 and 52-92. This QA form will • Be completed each day for 1 month, one day in a month for 3 months and 1 day in a month every 3 months thereafter.\ • A QA report will be presented at monthly QA meetings by the LRD or her designee. The corrective actions will be completed on or before September 7, 2011. Dietary Managers will be responsible for facility compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 11 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, facility information, and staff interview, the facility's consultant pharmacist failed to identify medication regimen irregularities for 1 of 1 sampled residents (Resident #1) receiving a scheduled hypnotic. Failure to recognize and report medication irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included anxiety and dementia. Medications included Ambien (a hypnotic) 10 milligrams (mg) at bedtime, initiated on 04/16/10. Review of the facility document titled "Indicators for Drug Review" occurred on 08/25/11. The document listed 34 indicators for review by the pharmacist, with indicator #11 stating the following: "Continuous use of hypnotic [sleep	F 428	F-Tag 428 Drug Regimen Review Resident #1, orders were received to decrease Ambien and a sleep/wake log put in place to monitor resident's sleep pattern. Since all residents have the potential to receive unnecessary drugs the Pharmacists will review residents on a monthly basis, and notice will be sent to the Physician requesting a review of medication and justification as to why GRD should not be attempted. A copy of Dr. Levingson's Psychiatrist, teleconference presentation on Unnecessary Medication will be shared with facility physician and staff nurses. The facility Pharm D will present a mandatory presentation to all nurses during this month's upcoming meeting for nursing staff regarding unnecessary medications. Clinical Coordinators will be responsible for follow up on the recommendations made by pharmacy regarding gradual dose reduction. The Clinical Coordinators will report to the Quality Assurance committee at regular schedul4d QA meetings. Corrective action will be completed on or before September 7, 2011.	

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F 428	Continued From page 12 induction] drug for more than 30 days . . ." Although the facility's consultant pharmacist reviewed Resident #1's medications monthly, the pharmacist failed to identify the drug regimen irregularity (the continued use of Ambien 10 mg since 04/16/10) and recommend a quarterly dose reduction attempt. During an interview on 08/25/11 at 11:05 a.m., a supervisory nursing staff member (#3) confirmed the pharmacist failed to make any recommendation related to Resident #1's use of Ambien.	F 428		