STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355036	A. BUILDING _____ B. WING _____	01/12/2022

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MARIAN MANOR HEALTHCARE CENTER	604 ASH AVE E GLEN ULLIN, ND 58631

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/10/22 and concluded 01/12/22.	F 000		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		1/27/22

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

Electronically Signed | 01/27/2022

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F 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to ensure the completion of the Centers for Medicare/Medicaid Services (CMS) Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form (CMS-10055) for 2 of 2 sampled residents (Resident #17 and #40) discharged from Medicare Part A services who remained in the facility. Failure to ensure the residents received all available options for care and to appeal the termination of coverage has the potential to hinder the residents' right to an expedited review of a service termination. Findings include: Review of the Medicare Part A letters/notices for	F 582	F 582 The office manager talked with Resident # 17 about the Medicare Beneficiary Notice on 2/1/2022. Each option was explained in detail showing the resident which box was picked previously but the form was not signed. The resident stated she understood fully what was explained . Her Medicare was discontinued on 11/12/2021 and she decided to keep Option 2. Paper was signed with 2/1/22 date. The office manager also called resident # 40 POA on 2/1/2022. She was informed of the Medicare Beneficiary Notice that was sent but not returned. The options were explained in detail and she verbally picked option 2. The	

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F 582	Continued From page 2 Residents #17 and #40 occurred the morning of 01/11/22. The review identified the facility sent the SNFABN forms to Resident #17 on 11/08/21 and to Resident #40 on 09/30/21. The residents/representative failed to return the SNFABN forms to the facility, and the facility failed to obtain communication/documentation of the resident's wishes for continued services and/or the option to appeal the termination of Medicare Part A coverage. During an interview on 01/11/22 at 11:20 a.m., an administrative staff member (#7) confirmed staff failed to obtain the SNFABN forms from Resident #17 and Resident #40.	F 582	Medicare was discontinued on 10/2/2021. I place a notation on the form that I spoke with the above POA on 2/1/2022 and option 2 was chosen. The facility immediately revised the system to issue and validate the completion of the Centers for Medicare/Medicaid Services Skilled Nursing Facility Advance Beneficiary Notice Non-coverage (SNFABN) form (CMS-10055) to ensure that residents received all available options for care and to appeal the termination of coverage. A cover letter is now attached to SNFABN CMS-10055 and sent to the resident or family to provide instructions for completion of the form and the deadline for returning the completed form to the facility. Prior to the deadline, a computer calendar reminder is used to notify the Office Manager or her designee to follow up with the resident or family member regarding the Advanced Beneficiary Notice of Non-Coverage. Reminders and follow-up will continue until the facility receives the completed SNFABN CMS-1005. The business office will review all current and discharged Medicare residents within the last three months to ensure that SNFABN CMS-10005 have been sent and returned to the facility. The Office Manager or designee will use a newly developed checklist to ensure that all system steps of the notification have been followed. The Office Manager will address any newly identified	

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F 582	Continued From page 3	F 582	non-compliance issues and develop action plans so all residents had the opportunity to choose their option for care through the SNFABN process. The Office Manager or designee will monitor all SNFABN being sent to residents tracking the dates when the form was sent, received and any related communication. The monthly monitoring will be performed and documented by business office, monitored by the Administrator, and reported quarterly to the quality assurance committee. Monitoring will not be discontinued until the facility completes four consecutive rounds of quarterly monitoring that demonstrate sustained compliance approved by the quality assurance committee. Corrective action will be completed by February 5, 2022.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		1/27/22

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F 755	Continued From page 4 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a system to account for controlled medications in order to enable an accurate reconciliation of medications for 1 of 2 observations (01/11/22 at 11:00 a.m.) of medication pass. Failure to ensure staff account and perform periodic reconciliation of Tramadol (a controlled medication used for pain) may cause medication loss or diversion of medications. Findings include: Review of the facility policy titled "Marion Manor Pharmaceutical Services Policy" occurred on 01/12/22. This undated policy, stated, ". . . Record of receipt and disposition of all controlled drugs will be maintained in sufficient detail to enable accurate reconciliation. . .."	F 755	F755: 1. It is the policy of Marian Manor Healthcare Center (MMHCC) to assure that all Controlled Medications each have their own sign out sheet and those medications are reconciled each shift by two nurses. 2. The Director of Nursing (DON) sent an Electronic Charting System (ECS) message to all nurses on 1/12/22 when it was brought to DON's attention from the surveyor that Tramadol is not being reconciled on the medication carts. This message informed all nurses that we in fact do need to be counting Tramadol the same as all other Schedule II-V medications. 3. On 1/12/22 facility DON contacted our consulting pharmacist to inform her that	

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F 755	Continued From page 5 Observation of medication pass on 01/11/22 at 11:00 showed a licensed nurse (#11) administered Tramadol and failed to reconcile the medication. During an observation of the medication cart on 01/12/22 at 1:15 p.m. a licensed nurse (#10) stated the facility does not reconcile Tramadol. During an interview on 01/12/22 at 2:08 p.m. an administrative nurse (#1) confirmed Tramadol is a controlled medication and the facility failed to reconcile the medication. This administrative nurse followed up with the consultation pharmacist who confirmed Tramadol needed to be reconciled.	F 755	we have not been counting Tramadol on the medication carts and will be implementing that practice immediately. DON also informed local pharmacy tech that when Tramadol is delivered to the facility, they will need to be signing in on a count sheet along with a nurse, as they do with all other narcotics. RN placed narcotic reconciliation sheets in the sign out binders on each wing for the residents with existing Tramadol orders. Medications were counted and signed into the sheets by two nurses at that time. Office personnel notified to change the color of the entries of Tramadol on the MAR to be red, a visual cue we use for our nurses for controlled medications. 4. DON will monitor for any new Tramadol orders and if so, that those medications are being reconciled. Will monitor weekly for 12 weeks then monthly for 3 months. This will be logged on an auditing form. 5. Correction date: 1/13/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		1/27/22

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F 880	Continued From page 6	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 7 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/06/20 Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed proper infection control practices for 3 of 8 sampled residents (Resident #35, #38 and #40) observed during incontinence cares. Failure to follow proper infection control practices for hand hygiene has the potential to transmit infectious agents to residents, staff and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 01/12/22. This policy, revised, June 2021, stated, ". . . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. . . . 2. Hand hygiene is indicated and will	F 880	Updated plan of correction 2/3/22 Infection control audits of all staff have been on-going since our last survey and also during the COVID-19 pandemic. These audits have been over various areas of infection control – such as PPE usage, proper disinfectation, hand hygiene, transmission-based precautions, etc. To address our current situation with the F880 deficiency a new audit tool has been developed. Moving forward, these audits will be specially focused on hand hygiene during perineal cares. DON/ICP reached out to Great Plains Quality Innovation Network on 1/26/22 for guidance on approaches to assist in auditing for and improving our compliance with hand hygiene. On 2/2/2022, DON/ICP held a Nurse and CNA in-service meeting where discussion topic	

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F 880	Continued From page 8 be performed under the conditions listed in, but not limited to . . . When, during resident care, moving from a contaminated body site to a clean body site . . . After assistance with personal body functions (e.g., elimination, . . .) . . . 4. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . " - Observation on 01/10/21 at 3:33 p.m. showed two certified nurse aides (CNAs) (#3 and #4) transfer Resident #38 from the wheelchair to the toilet using a mechanical sit to stand lift. The CNA (#3) donned gloves and removed Resident #38's soiled brief. After lowering the resident onto the toilet, the CNA (#3) removed her gloves and without performing hand hygiene opened the bedside drawer, retrieved a new brief, and left the room to retrieve more gloves. Upon returning to the room the CNA (#3) did not perform hand hygiene. The CNA donned new gloves, performed incontinence cares, removed her gloves and without performing hand hygiene assisted CNA (#4) to adjust the resident's brief and pants, and assisted the resident to the bed with the mechanical sit to stand lift. The CNA (#3) failed to perform hand hygiene before and after incontinence cares and glove removal. - Observation on 01/11/22 at 9:54 a.m. showed two CNAs (#8 and #9) provided incontinence care for Resident #35. The CNA (#8) cleansed the perineal area of liquid stool, removed her gloves and without performing hand hygiene opened the closet and nightstand drawers looking for more perineal wipes. The CNA (#8) used the two way radio to request more wipes.	F 880	was the survey findings. A Root Cause Analysis (RCA) was completed with frontline staff to identify and address the reasons for non-compliance related to hand hygiene processes during perineal cares. This RCA provided much discussion amongst the staff - which was positive and encouraging. Overall, the most pertinent observation from the CNA staff was that hand sanitizers are not conveniently located for ease of use during perineal cares. In addition, staff generally voiced that some have a difficult time “critiquing” their peers. Based on these two specific findings, more hand sanitizer dispensers will be placed in the resident rooms for easier access during personal cares of residents. In addition, scripting has been provided to staff to help the communication between co-workers to remain positive and encouraging. A staff enrichment training seminar is planned to be provided in the spring. During the in-service meeting held on 2/2/22, ICP and DON worked with staff to do activities specific to hand hygiene, along with videos/handouts on CDC’s lesson on clean hands, quizzes as well as group participation demonstration/conversation. Deficiency tags and concerns of each tag were reviewed as well. Our goal of this meeting was not only to re-educate our front-line staff but also to look at how to correct possible intra/interpersonal factors that have attributed to this deficient practice.	

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F 880	Continued From page 9 An unidentified staff member provided more wipes and the CNA (#8) completed the perineal care, removed her gloves and performed hand hygiene. - Observation on 01/10/22 at 3:21 p.m., showed Resident #40 resting in bed. CNAs (#3 and #4) donned gloves. The CNA (#3) removed the soiled brief, performed incontinence care, placed a new brief, removed gloves and without performing hand hygiene, donned new gloves. The CNA (#3) assisted with putting Resident #40's pants on and placed a mechanical lift sling under the resident. The CNA (#3) removed her gloves and assisted transferring Resident #40 into the wheelchair and touched several items before performing hand hygiene Observation on 01/11/22 at 8:27 a.m., showed two CNAs (#5 and #6) enter Resident #40's room and perform a check and change. The CNA (#6) performed incontinence care, removed soiled gloves, performed hand hygiene, placed a clean brief, and upon turning the resident found a soiled wipe. The CNA (#6) removed the soiled wipe with a bare hand, and without performing hand hygiene continued cares. The CNA touched multiple items before performing hand hygiene upon exiting the room. During an interview on 01/12/22 at 11:15 a.m., two administrative nurses (#1 and #2) stated they expected staff to perform hand hygiene after removing gloves or touching contaminated items and per policy.	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff hand hygiene or handwashing when moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate certified nursing staff on correctly completing hand hygiene after changing tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify these staff understands hand hygiene and handwashing, these staff will perform a successful return demonstration of identifying the need and correct procedure for performing hand hygiene and handwashing. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT)	

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F 880	Continued From page 10	F 880	members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 02/05/2022 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct	

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F 880	Continued From page 11	F 880	on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of certified nursing staff to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 02/05/2022	

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	355036	A. BUILDING _____ B. WING _____	01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIAN MANOR HEALTHCARE CENTER	**604 ASH AVE E GLEN ULLIN, ND 58631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880	F880: 1. It is the policy MMHCC to assure that all residents in our care, including Resident #35, #38 and #40 from the survey sample roster, and all the residents of MMHCC have a safe, sanitary and comfortable environment. MMHCC will continue to implement infection prevention and intervention measures as outlined as per facility policies and protocols. 2. Focusing on not only the 3 residents from the deficiency sampling, but rather all residents residing at MMHCC. We will be monitoring frontline staff who work with each resident to assure compliance. 3. Staff was reminded and re-educated on 12/20/21 as well as 1/10/22 regarding the importance of hand hygiene at all times, especially after duties such as glove removal during and after perineal cares. On 12/20/21, ICP and DON placed a visual cue (CDC Clean Hands Count graphic) at each hand sanitizer dispenser in resident□s rooms and other common areas. Staff was educated at that time to utilize this visual cue as a reminder to perform hand hygiene at the appropriate times during resident cares. Infection control audits of all staff have been on-going since our last survey and also during the COVID-19 pandemic. These audits have been over various areas of infection control □ such as PPE usage, proper disinfectation, hand hygiene, transmission-based precautions, etc. To address our current situation with	

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F 880	Continued From page 13	F 880	the F880 deficiency a new audit tool has been developed. Moving forward, these audits will be specially focused on hand hygiene during perineal cares. We have already done a Root Cause Analysis with our IDT team during our weekly IDT meeting on 1/17/22. DON and ICP are also going to conduct another Root Cause Analysis during our Nurse/CNA education meeting with our front-line staff regarding this topic (on 2/2/2022). Also, during this in-service meeting, ICP and DON will be doing activities specific to hand hygiene, along with videos/handouts on CDC□s lesson on clean hands, quizzes as well as group participation demonstration/conversation. Deficiency tags and concerns of each tag will be reviewed along with the POC. Our goal of this meeting is not only to re-educate our front-line staff but also to look at how to correct possible intra/interpersonal factors that have attributed to this deficient practice. DON/ICP reached out to Great Plains Quality Innovation Network on 1/26/22 for guidance on approaches to assist in auditing for and improving our compliance with hand hygiene. 4. Since our survey, we have continued to do staff audits, focusing on hand hygiene during cares. Our plan is to expand this to front-line staff assisting in these audits, starting after our educational meeting on 2/2/22. We will continue to have front-line nurses engage in this auditing process, in hopes to capture more staff across all shifts and wings. Monitoring of audit forms will be turned in	

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F 880	Continued From page 14	F 880	to DON/ICP and if any breaches in infection control are noted, front-line nurse will be interviewed to determine if further education is needed for involved staff. Such education will be documented on the monitoring form. Data collection will be entered into an Excel program. Audit sampling will be done at minimum of weekly for no less than 12 weeks, then monthly for no less than 3 months. Monitoring will not be discontinued until at least 3 consecutive months of sustained compliance are consistently met. Monitoring findings will be reported at quarterly QAPI/QA meetings. 5. Completion date: no later than 2/05/2022	