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 _____	C 03/13/2025

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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 03/10/25 and concluded 03/13/25, and included an extended survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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, review of facility policy,	F 609	F609:	4/3/25

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

Electronically Signed | 04/03/2025

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 609	Continued From page 1 review of the facility investigation report, and staff interview, the facility failed to report an incident of potential neglect to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #38) who experienced a burn from an electric heating pad. Failure to report an event of potential neglect to the SSA in the required time frame placed Resident #38 and other residents at risk for burns. Findings include: Review of the facility titled "ABUSE PROHIBITION PLAN" occurred on 03/11/25. This policy, dated December 2024, stated, "The resident has the right to be free from . . . neglect . . . Neglect includes the failure of the facility, its employees, or service providers to provide goods or carry out resident services as directed or ordered by the physician or other authorized personnel necessary to avoid physical harm, pain, mental anguish or emotional distress. Failure to give proper attention to residents, or failure to carry out resident services through indifference, disregard for patient care, or careless oversight are examples of neglect. . . . An alleged violation is a situation or occurrence that is observed or reported by staff . . . but has not yet been investigated. Alleged violations must be recorded and reported to the Administrator and/or Director of Nursing immediately. . . . Immediate reporting will be faxed or sent via email to the State Health Department . . . Immediate means as soon as possible, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. If the events that cause the allegation does not involve	F 609	1. The time frame for reporting an injury of resident #38 from an electric heating pad on 2/7/24 to the State Survey Agency (SSA) has long since passed (13 months) - a report was inadvertently not made at the time of the injury. 2. All Residents who reside at MMHCC have the potential of being at risk for neglect. If alleged violations are not reported timely to the SSA in accordance with their time frame requirements, these instances could go unreported and potentially result in a continuation of violations if the situation is deemed to be as such. 3. The policy for reporting suspected violations to the SSA has been reviewed and updated. Director of Nursing (DON) received more information on Facility Reportable Incidents at the NDLTC 2024. Since then, she has been more aware of the types of incidents that require reporting. Educational information was provided to all facility nurses on 4/2/25 to ensure they have an appropriate understanding of what does and does not need to be reported to the SSA. It will also be discussed upon at the next nurse's meeting. DON, Administrator or Designee will continue to review each incident report and report required incidents to the SSA via the ND Department of Health website as appropriate. DON will monitor incident reports and audit a random sampling to assure if an incident required reporting to the SSA, it has been. This will be done according to the following schedule:	

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F 609	Continued From page 2 abuse and does not result in serious bodily injury, it must be reported not to exceed 24 hours after discovery of the incident. . . . The Administrator or the Director of Nursing shall report the result of all investigations to the State Survey and Certification Agency within 5 working days of the incident. . . ." Review of Resident #38's medical record occurred on all days of survey. Physician's orders identified the following: * 11/01/23, "Apply hydrocollator [a heating device which stores temperature controlled moist hot packs] or heating pad [electric] to right hip for 20 minutes daily at bedtime . . ." * 02/08/24, "Bacitracin [anitbiotic topical ointment] TID [three times a day] to R [right] hip x [for] 7 days, cover w/ [with] Telfa [a non-stick wound dressing] after application. Dx [diagnosis]: 1st degree burn [a mild burn injury of the outermost layer of the skin] R hip. D/C [discontinue] order for heating pad, only use hot packs for up to 20 minutes at a time. . ." Review of the facility's incident report, dated 02/07/24 at 11:45 p.m., stated, " . . . Describe the Incident/Possible Causes: fragile skin, other: heating pad left on longer than 20 minutes (estimated 2.5 - 3 hours) CNA [certified nurse aide's name] called writer into room to show that heating pad was left on resident's right hip. Upon removal, a large reddened area was present. Heating pad setting was on medium. Usual application time is approximately 8:30 p.m. and heating pad was discovered in place at approximately 11:30 p.m. . . . Time: 03:33 AM [3:33 a.m.] Writer assessed area once again and most of the redness dissipated but still has some	F 609	4. Frequency of QA Monitoring: Weekly for four (4) full weeks: beginning 3/31/25 then Monthly for three (3) months and then quarterly. Following this schedule, If 100% compliance is not obtained then the QA will remain in effect. If concerns are noted with monitoring, immediate corrective action will be taken. The DON will submit a “report of the deficiency” along with the completed monitoring at the next QA/QAPI meeting tentatively set for 4/16/2025. Then at the QA/QAPI following quarterly meetings, only the monitoring results will be reported until the monitoring is completed. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 5. Completion date 4/2/2025.	

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F 609	Continued From page 3 blotches or reddened skin near top of pelvis . . ." A nursing progress note, dated 02/08/24 at 6:22 a.m., stated, "Right hip burn is already starting to form blisters and has one site that is peeling, skin periphery is reddened." Resident #38's medical record lacked evidence the facility reported the burn to the SSA as possible abuse/neglect. During an interview on 03/10/24 at 4:28 p.m., an administrative nurse (#1) confirmed the facility failed to report Resident #38's burn to the SSA	F 609		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		4/3/25

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F 625	Continued From page 4 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident or their representative chose to accept or decline a bed hold for 2 of 3 sampled residents (Resident #38 and #46) reviewed for hospitalizations. Failure to obtain a resident or their representative's bed hold choice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of the facility policy titled "Bed Hold" occurred on 03/13/25. This policy, dated December 2024, stated, "Notices of the . . . Bed Hold/Release notice will be given at each hospitalization . . . The resident or responsible party is to choose which they would like either to hold or release the bed . . ." - Review of Resident #38's medical record occurred on all days of survey and identified a hospitalization on 01/29/25. The record failed to identify if the resident and/or their representative accepted or declined a bed hold. An office staff member (#6) provided an undated and unsigned bed hold form for the hospital stay. The office staff member (#6) stated she emailed a copy of the bed hold form to Resident #38's	F 625	625 Corrective action was taken on 3/12/2025 1.) No patients were effected by the deficiency as all patients beds were held and patients were returned. 2.) All patients who were transferred had a potential to be effected. 3.) The policy was reviewed by the administrator and office manager. Education done on 3/18/25 via note put into ECS (our electronic charting system) to nurses and ward clerks. -- On the transfer date the responsible party will be asked by the HealthCare facility staff member calling to inform them of the necessary transfer, if they would like the bed held. Documentation will be done in the resident's nurses notes as to who the form was mailed to, date mailed. Record of the date the form was received and returned form will be scanned into the resident permanent electronic chart. If the form is not received in 2 weeks of mailing, a phone call will be made to the responsible party asking for the form to be completed returned. The office manager or designee will note on a copy of the Bed Hold/Release form what date the call was made to the responsible	

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F 625	Continued From page 5 representative on 01/30/25, had not heard back from the representative, and failed to contact the representative after sending the email. - Review of Resident #46"s medical record occurred on all days of survey and identified a hospitalization on 01/11/25. The record failed to identify if the resident or their representative accepted or declined a bed hold. A progress note, dated 01/12/25 at 6:58 a.m., stated, ". . . Bed hold/release form sent to [resident's power of attorney name]. . . ." The office staff member (#6) stated she emailed a copy of the bed hold form to Resident #38's representative on 01/12/25, had not heard back from the representative, and failed to contact the representative after sending the email. During an interview on 03/12/25 at 2:44 p.m., the office staff member (#6) confirmed the facility failed to contact Resident #38 and #46's representatives to accept or decline a bed hold during their hospital stays.	F 625	party, asking if they want the bed held or released, the answer will be noted on the form. 4.) Ongoing QA will be done by the business office or designee starting 3/27/2025. Monitoring will be done weekly for 1 year and reported on at the quarterly QA meeting. If 100 % compliance is not obtained then the QA will remain in effect until 100 % compliance achieved. 5.) Completion date will be 3/31/25	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 12 sampled residents (Resident #30). Failure to accurately complete the MDS	F 641	F641: 1. No residents were directly affected by this deficiency. The Director of Nursing (DON) was made aware of the error in coding Resident #30 Section A 1510 of his MDS during the last day of the survey, on 3/13/25. Immediately after receiving	4/3/25

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F 641	Continued From page 6 does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2024, page A-32, stated, ". . . Complete if A0310A = 01 . . . Annual assessment . . . Coding Instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . . ." Review of Resident #30's medical record occurred on all days of survey. The medical record included the diagnosis of paranoid schizophrenia. The facility failed to code the serious mental illness on the annual MDS, dated 07/07/24. During an interview on 03/13/25 at 12:10 p.m., administrative staff members (#1 and #5) confirmed staff failed to code Resident #30's MDS for a serious mental health illness.	F 641	this information, DON and MDS Coordinator reviewed resident's chart and past MDS to visualize the discrepancy. It was noted that on resident's Admission MDS (ARD of 11/7/22), section A 1500 was marked as "No," that resident had not triggered for a state level II PASRR. Resident's most current MDS with this section available was from 7/7/24. It was corrected on 3/13/25 after conferring via email with Kelly Beechie at the State Health Dept to confirm this was the correct action. 2. All Residents who reside at MMHCC who receive a diagnosis of a Serious Mental Illness have the potential of having their MDS scored incorrectly in section A1510. 3. On 3/24/25, DON and Social Worker reviewed all MMHC residents who have Level II determinations as well as all MMHC residents who have Schizophrenia diagnoses to assure proper Level of Care determination has been obtained and is on file. In addition, assurances completed that these residents are coded appropriately on Section A1500/A1510. An educational meeting was held with DON, MDS coordinators, ADON and Social Worker on 3/28/25 to discuss the F641 deficiency. Overview of Section A1500/A1510 completed along with RAI Manual coding review of Section A. Social Worker gave review of PASRR Level II requirements. 4. The Director of Nursing will be responsible for monitoring the correct coding of Section A of the MDS	

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F 641	Continued From page 7	F 641	Assessments. MDS coordinators were instructed to print out Section A for each completed Admission and Annual MDS assessments to give to the DON. The DON will then ensure the coding is correct. DON will monitor Section A by random selection of assessments according to the following schedule: 5. Frequency of QA Monitoring: Weekly for four (4) full weeks: beginning 3/31/25 then Monthly for three (3) months and then quarterly. Following this schedule, If 100% compliance is not obtained then the QA will remain in effect. If concerns are noted with monitoring, immediate corrective action will be taken (e.g. teaching with involved MDS Coordinator by DON or Designee and correction of MDS). The DON will submit a "report of the deficiency" along with the completed monitoring at the next QA/QAPI meeting tentatively set for 4/16/2025. Then at the QA/QAPI following quarterly meetings, only the monitoring results will be reported until the monitoring is completed. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. Completion date: 3/28/2025	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/3/25

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F 657	Continued From page 8 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 3 of 12 sampled residents (Resident #21, #22, and #38). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Nursing Care Plans" occurred on 03/12/25. This policy, dated December 2024, stated, "A nursing care plan directs the resident's nursing care . . . The Care	F 657	F657: 1. No residents were directly affected by this deficiency. Director of Nursing (DON) and Resident Care Coordinator (RCC) were notified by the survey team on 3/12/25 that residents #21 and #22 care plans did not reflect triggers and interventions related to history of PTSD. Also, Resident #38's care plan was lacking a problem, goal and intervention related to her oxygen use. 2. All Residents who reside at MMHCC have the potential of having an incomplete comprehensive care plan. Resident #38's care plan was updated by	

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F 657	Continued From page 9 plan should be written individually for each resident, making it resident-centered. . . . Planning is to be continuous (on-going) . . ." Review of the facility policy titled "Trauma Informed Care" occurred on 3/12/25. This policy, dated December 2024, stated, ". . . The facility will collaborate with resident trauma survivors . . . to develop and implement individualized care plan interventions. . . . Trigger specific interventions will identify ways to mitigate or decrease the effect of the trigger . . . and will be added to the resident's care plan. . . ." - Review of Resident #21's medical record occurred on all days of survey. Diagnoses included post-traumatic stress disorder (PTSD). The facility failed to update Resident #21's care plan to reflect triggers and interventions related to history of PTSD. - Review of Resident #22's medical record occurred on all days of survey. Diagnoses included PTSD. The facility failed to update Resident #22's care plan to reflect triggers and interventions related to history of PTSD. During an interview on 03/13/25 at 12:19 p.m., an administrative nurse (#1) confirmed the facility failed to update Resident #21 and #22's care plans to reflect triggers and interventions for PTSD. - Review of Resident #38's medical records occurred on all days of survey. The record identified a physician's order for oxygen use. Observations on all days of survey showed the resident wore oxygen per nasal cannula.	F 657	RCC immediately on 3/12/25. Social Worker updated Resident #21 and #22 care plans to include PTSD triggers and interventions as well. All MMHC residents who have Respiratory diagnoses or PTSD diagnoses care plans were checked to ensure they are accurate. 3. On 3/17/25 DON held discussion with MMHC's RCCs and Social Worker to review facility Care Plan Revision policy. All in attendance voice understanding that each resident's care plan is to be reviewed quarterly with their scheduled assessments and upon any new or changed conditions of their residents. DON will have each RCC review any respiratory care plan concerns with her when assessment reviews are completed. A copy of this care plan will be provided the DON and the RCC will sign off on a form that it was reviewed and carried out properly. Social Worker has reviewed and revised current policy for Trauma Informed Care. New Admissions to facility will continue to have a Trauma Assessment completed on them, it is a part of our Admission Process. Resident's who answer "Yes to both questions", 1 "Have you ever experienced some sort of trauma in your life?" 2. "Do you have reoccurring memories of the event?" will have a Trauma Care Plan written to address this trauma. Residents who have an active diagnosis of PTSD will automatically have a Trauma Care Plan written to address their trauma needs. DON will monitor the respiratory status	

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F 657	Continued From page 10 Resident #38's care plan lacked a problem, goal, and interventions related to oxygen use. During an interview on 03/12/25 at 11:55 a.m., an administrative nurse (#2) confirmed Resident #38's care plan lacked a specific problem for oxygen use.	F 657	care plans by random selection of assessments and Social Worker will monitor Trauma care plans according to the following schedule: 4. Frequency of QA Monitoring: Weekly for four (4) full weeks: beginning 3/31/25 then Monthly for three (3) months and then quarterly. Following this schedule, If 100% compliance is not obtained then the QA will remain in effect. If concerns are noted with monitoring, immediate corrective action will be taken (e.g. teaching with involved RCC by DON or Designee and correction of MDS). The DON will submit a “report of the deficiency” along with the completed monitoring at the next QA/QAPI meeting tentatively set for 4/16/2025. Then at the QA/QAPI following quarterly meetings, only the monitoring results will be reported until the monitoring is completed. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 5. Completion date: 3/17/2025	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		4/3/25

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	355036	A. BUILDING _____ B. WING _____	C 03/13/2025

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F 689	Continued From page 11 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision for 2 of 3 sampled residents (Resident #38 and #204) with orders for electric heating pad use. Failure to provide adequate supervision during heating pad use resulted in a burn for Resident #38 and placed Resident #204 and all other residents who use heating pads at risk for burns. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 02/07/24. The IJ was identified when a physician's order in Resident #38's medical record, dated 02/08/24, included a treatment for and a diagnosis of a first degree burn to the resident's right hip from an electric heating pad. This finding placed all residents who use an electric heating pad in immediate danger for burns. * 03/11/25 at 10:27 a.m., The survey team notified the administrator and the director of nursing (DON) of the IJ situation, provided the IJ template, and requested a plan for removal of the IJ. * 03/11/25 at 1:09 p.m., The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: * Reviewed all resident medical records for electric heating pad use. Found eight residents with orders. Two of the eight residents had electric heating pads in their rooms which the staff removed.	F 689	F689: 1. One resident (#38) was directly injured by this deficiency. No other residents were directly affected. All electric heating pads in the facility were immediately removed when this deficiency was brought to administration's attention, notice was sent to direct care staff regarding following transfer care plans on all residents especially #21, and all chemicals were removed from an unlocked cupboard on 2E and placed in a locked cupboard. (I had not included resident #41 in the note as I was not aware that she was going to be involved in the tag until I read the form CMS-2567). 2. All residents that reside at MMHC have the potential to be affected by possible injury resulting from use of electric heating pad use, those requiring transfer assistance and all residents who have access to unlocked chemicals. 3. Facility administration (DON/Administrator) determined that due to the potential risk of electric heating pad use, they will no longer be allowed under any circumstances in the facility. All staff, residents and responsible parties were notified by various methods. All electric heating pads in the facility were located, collected and disposed of in a garbage dumpster - except for resident #204's as it is her personal property (family picked it up that afternoon). This was accomplished in the late AM of 3/11/25 by DON, ADON and Resident Care Coordinators. In addition to the events	

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F 689	Continued From page 12 * Staff ensured all resident rooms free from electric heating pads. * All facility owned electric heating pads discarded. * Electric heating pad usage removed from all resident orders. * The updated electric heating pad policy stated, "As of 03/11/25 Electric Heating Pads are no longer allowed for use in this facility." * The admission handbook updated to reflect the new policy. * The facility's medical provider notified about the new policy. * Residents, families, and staff notified via electronic and/or paper communication about the new electric heating pad policy. * 03/11/25 at 2:40 p.m., The survey team verified the implementation of the removal plan as of 03/11/25 and the IJ removal. The deficient practice remained at a "G" scope and severity following the removal of the IJ. Findings include: Review of the facility policy titled "HEATING PAD" occurred on 03/10/25. This policy, dated December 2024, stated, ". . . Procedure . . . 3. Set the control to low and plug into . . . outlet. 4. After the pad warms up you may adjust the control to a warmer setting-watching closely that no increased redness or burns occur. 5. Begin timing the application. Remove heat pad after 15-20 minutes or as ordered. If resident is competent and wishes to use heating pad for more than 10-minute time limit . . . they must sign a 'Release from Responsibility' form. . . ."	F 689	listed in the removal plan, a form will be filled out by the resident/family on new admissions stating they understand we don't allow, and they didn't bring an electric heating pad. A staff reminder will be sent out periodically by the DON to assure they haven't seen any electric heating pads in the facility – in the off chance a family member brings one in. On 3/13 (the day of survey exit) DON sent a message to direct care staff reminding them of the necessity of using the care planned version of transfer assist for every resident. OT provided DON a listing of all residents who require pivot transfer assistance. Will do ongoing auditing with OT that transfers are occurring appropriately in-line with the care plan. Education was provided on 4/3/25 to all CNAs regarding proper transfer protocols and policies involving pivot and gait belts. Policies regarding the transfer/gait belt were reviewed and revised. A memo was sent to all staff on 3/13/25 by DON regarding proper chemical storage in locked areas. Weekly inspections of all residential areas and chemical storage areas will occur by the housekeeping department, which will be reviewed by the housekeeping supervisor. These topics will be covered with the entirety of the staff at our next meeting. The DON and housekeeping supervisor will be responsible to monitor and audit the areas included in this deficiency according to the following schedule: 4. Frequency of QA Monitoring: Weekly	

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F 689	Continued From page 13 - Review of the facility's incident report related to Resident #38's burn, dated 02/07/24 at 11:45 p.m., stated, ". . . Describe the Incident/Possible Causes: fragile skin, other: heating pad left on longer than 20 minutes (estimated 2.5 - 3 hours) CNA [certified nurse aide's name] called writer into room to show that heating pad was left on resident's right hip. Upon removal, a large reddened area was present. Heating pad setting was on medium. Usual application time is approximately 8:30 p.m. and heating pad was discovered in place at approximately 11:30 p.m. . . . Time: 03:33 AM [3:33 a.m.] Writer assessed area once again and most of the redness dissipated but still has some blotches or reddened skin near top of pelvis . . ." Review of Resident #38's medical record occurred on all days of survey. A provider visit note, dated 02/08/24, stated ". . . [Resident #38] . . . requested to have her right hip evaluated, as she and nursing noted that she has a burn on her right hip. Nursing notes that [Resident #38] does have orders to use an electric heating pad, that can be in contact with her skin for up to 20 mins [minutes]. [Resident] notes that she thought the heating pad was turned up too high yesterday and 'fried' her. Nursing notes that the heating pad was left on the patient for about 5 hours. . . ." Review of Resident #38's physician's orders identified the following: * 11/01/23, "Apply hydrocollator [a heating device which stores temperature controlled moist hot packs] or heating pad [electric] to right hip for 20 minutes daily at bedtime . . ." * 02/08/24, "Bacitracin [antibiotic topical ointment] TID [three times a day] to R [right] hip x [for] 7	F 689	for four (4) full weeks: beginning 3/31/25 then Monthly for three (3) months and then quarterly. Following this schedule, If 100% compliance is not obtained then the QA will remain in effect. If concerns are noted with monitoring, immediate corrective action will be taken (e.g. teaching with involved staff member by DON, supervisor or Designee). The DON and housekeeping supervisor will submit a “report of the deficiency” along with the completed monitoring at the next QA/QAPI meeting tentatively set for 4/16/2025. Then at the QA/QAPI following quarterly meetings, only the monitoring results will be reported until the monitoring is completed. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 5. Completion date: 4/3/2025	

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F 689	Continued From page 14 days, cover w/ [with] Telfa [a non-stick wound dressing] after application. Dx [diagnosis]: 1st degree burn [a mild burn injury of the outermost layer of the skin] R hip. D/C [discontinue] order for heating pad, only use hot packs for up to 20 minutes at a time. . ." * 02/12/24, "Bacitracin & [and] telfa to blisters R hip Bid [twice a day] until healed. . . ." Review of Resident #38's nursing progress notes, dated February 8-20, 2024, showed the following: * 02/08/24 at 6:22 a.m., ". . . Right hip burn is already starting to form blisters and has one site that is peeling, skin periphery [outer edge] is reddened." * 02/08/24 at 2:30 p.m., ". . . has two blisters but not puffy. . . ." * 02/08/24 at 10:00 p.m., ". . . on right hip, redness surrounding blistered area, approximately 2 [cm] [centimeters] x [by] 5 cm." * 02/09/24 at 1:52 p.m., ". . . Burns are blistered and fluid filled. Slightly reddened periphery. . . ." * 02/20/24 at 10:23 p.m., ". . . right hip blister, dry healed; will d/c treatment." The facility failed to monitor Resident #38's use of the heating pad which resulted in a burn. - Review of Resident #204's medical record occurred on all days of survey. A physician's order, dated 03/05/25, stated, ". . . Heating pad to areas of pain/discomfort x [for] 15-20 minutes as needed. May keep at bedside to use at own discretion . . ." Observation on 03/10/25 at 5:02 p.m. showed Resident #204 in her room with a heating pad on	F 689		

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F 689	Continued From page 15	F 689		

the high temperature setting located on her upper legs and knees. The resident stated she brought the heating pad from her home and confirmed the pad does not have an automatic shut off.

During interviews on 03/10/25 at 4:28 p.m. and at 5:33 p.m., an administrative nurse (#1) stated heating pad means electric heating pads, and some residents use heating pads at their own discretion. The administrative nurse (#1) also stated CNAs apply/remove heating pads and monitor the length of time the pad is in place and a nurse confirms the CNA completed the treatment and documents the treatment completion in the Resident's treatment administration record (TAR). The administrative nurse (#1) confirmed Resident #38's TAR failed to show a start and stop time for the heating pad use and Resident #204's TAR lacked documentation of electric heating pad use.

2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 2 of 3 sampled residents (Resident #21 and #41) observed during transfers. Failure to provide transfer assistance, utilize gait belts, and lock wheelchairs placed the residents at risk for falls and/or injury.

Findings include:

Review of the facility policy titled "Transferring Resident with Transfer (gait) Belt" occurred on 03/12/25. This policy, dated December 2024, stated, ". . . It is the policy of this facility to use a gait/transfer belt to guide and support residents

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F 689	Continued From page 16 who: require assistance with transfer . . ." - Review of Resident #21's medical record occurred on all days of survey. Diagnoses included weakness, ataxic gait (poor muscle control), difficulty walking, unsteadiness on feet, and dementia. A quarterly Minimum Data Set (MDS), dated 02/03/25, identified the resident required substantial/maximal assistance with bed to chair transfers. The care plan stated, "I have alteration in . . . mobility . . . hx [history] of falls . . . gait problems . . . unsteadiness on my feet . . ." Observation on 03/11/25 at 11:23 a.m., showed two CNAs (#3 and #4) entered Resident #21's room. Without staff assistance, the resident sat up in his bed, and in a hunched over position and an unsteady shuffled gait, placed himself into a wheelchair. The right brake of the wheelchair was not locked and the wheelchair moved backwards. Both CNAs (#3 and #4) failed to provide Resident #21 transfer assistance and failed to ensure both wheelchair brakes were locked. - Review of Resident #41's medical record occurred on all days of survey. Diagnoses included hemiplegia (paralysis to one side of the body), muscle weakness, dizziness, and repeated falls. A quarterly MDS, dated 01/08/25, identified substantial/maximal assistance required with transfers on and off the toilet. The CNA care card identified, ". . . medical staff recommends pivot [transfer] assist of one [staff] with gait belt . . ." Observation on of 3/11/25 at 11:00 a.m. showed a CNA (#3) positioned Resident #41's wheelchair	F 689		

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F 689	Continued From page 17	F 689		

in front of the toilet. The resident used a grab bar to pull herself to a partial standing position, and with an unsteady gait, hopped on her right toes towards the toilet. The residents left foot drug along the floor, and she stumbled during the transfer. The CNA (#3) failed to utilize a gait belt and provide Resident #41 transfer assistance.

During an interview on 03/13/25 at 12:20 p.m., an administrative nurse (#1) confirmed she expected staff to utilize a gait belt during Resident #21 and #41's transfers and expected staff to notify nursing of difficult transfers.

3. Based on observation, review of Safety Data Sheets (SDS), and staff interview, the facility failed to ensure an environment free of accident hazards in 1 of 3 open kitchen areas (200 wing). Failure to store chemicals in locked cupboards placed residents in this household at risk for injury.

Findings include:

Review of an untitled and undated facility policy occurred on 03/13/25. This policy stated, ". . . Housekeepers must keep a constant vigil out for chemicals that are within a resident's reach. If it says on the chemical product to keep out of reach of children the product MUST be stored . . . in the CNA storage room. . . ."

Observation on the morning of 03/13/25 identified chemicals in unlocked cupboards in an open kitchen area in the 200 wing. Residents frequented the area and could access the cupboards. The cupboards contained the following:

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F 689	Continued From page 18 * Underneath the sink, an uncovered can of Lysol Disinfectant Aerosol Spray. * Above the right side of the sink, three covered cans of Airworks Aerosol Air Freshener. * Above the microwave, two covered cans of Airworks Aerosol Air Freshener, one container of Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes, and one container of Clorox Healthcare Bleach Germicidal Wipes. Review of the SDS for the chemicals identified the following: * Lysol Disinfectant Aerosol Spray, ". . . CAUTION Causes moderate eye irritation. Do not spray in eyes, on skin or on clothing. . . . KEEP OUT OF REACH OF CHILDREN . . ." * Airworks Aerosol Air Freshener, ". . . Eye Contact: Causes eye irritation. Skin Contact: May cause irritation. Ingestion: Pain, nausea, vomiting and diarrhea. Inhalation: May cause nasal discomfort and coughing. . . ." * Clorox Healthcare Bleach Germicidal Wipes, ". . . KEEP OUT OF REACH OF CHILDREN . . . CAUTION: liquid causes moderate eye irritation. Do not get into eyes or on clothing. . . . Wash thoroughly with soap and water after handling . . ." * Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes, ". . . KEEP OUT OF REACH OF CHILDREN . . . CAUTION: Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling . . ." During an interview on 03/13/25 at 8:46 a.m., a staff member (#8) stated residents utilize the open kitchen area on Wing 200 as a "space outside of their rooms to relax and read."	F 689		

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F 689	Continued From page 19 During an interview on 03/13/25 at 8:52 a.m., an administrative nurse (#1) stated she expected staff to store aerosol sprays and disinfectant wipes in locked cupboards/areas.	F 689		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse,	F 851		4/3/25

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F 851	Continued From page 20 certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on review of the Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Long-Term Care Facility Policy Manual and staff interview the facility failed to submit direct care staffing information based on payroll data to the Electronic Staffing Data Submission PBJ for 1 of 4 reporting periods (Quarter #4). Failure to submit direct care staffing information may result in inaccurate representation of the level of staff in	F 851	851 PBJ plan of correction 1.) No residents were effected by this deficiency. 2.) PBJ is only submitted quarterly and will be submitted within 25 days of the end of the quarter. The report will be done by the payroll manager or office manager. Both have access to the PBJ site in the event that one person is not	

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F 851	Continued From page 21 the facility which can impact the quality of care delivered. Findings include: The June 2022, version 2.6 Electronic Staffing Data Submission Payroll-Based Journal (PBJ), pages 1-3, stated, ". . . Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate . . . Facilities that do not meet these requirements will be considered noncompliant and subject to enforcement actions by CMS [Centers for Medicare and Medicaid Services] . . ." Review of the PBJ Data Staff Report CASPER Report (a CMS report) 1705D FY (fiscal year) Quarter 4 (July 1 - September 30, 2024) occurred on 03/12/25, and stated, ". . . Failed to Submit Data for the Quarter . . . Triggered . . ." During a phone interview on 03/12/25 at 11:08 a.m., an office staff member (#7) confirmed the facility failed to submit staffing data for the reporting period listed on the report.	F 851	able to be here to complete the report. 3.) Education was conducted by administrator on 3/24/25 reviewing the PBJ reporting. A policy was put in place and was gone over with Payroll manager, office manager by the administrator. 4.) QA will be conducted by the office manager or designee starting 4/1/2025, quarterly for 1 year and reported to the QA committee. If 100 % compliance is not obtained then the QA will remain in effect until 100% compliance achieved. 5.) Corrective action will be completed by 4/10/2025.	