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 _____	01/31/2019

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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification started on 01/28/19 and concluded on 01/31/19.	F 000		
F 644 SS=F	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) for 4 of 4 sampled residents (Residents #5, #14, #18, and #40) with a status change related to new diagnoses. Failure to complete the PASARR screening may result in the resident not receiving necessary psychiatric services. Findings include:	F 644	F644: 1. It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #5, #14, # 18 and #40 from the survey sample roster and all the residents of MMHCC, Minimum Data Set (MDS) review/assessment on admission, annually or when a significant change occurs coordinate with the pre-admission screening and resident review (PASARR). MMHCC also assures that a PASARR	3/7/19

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

Electronically Signed | 02/18/2019

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F 644	Continued From page 1 - Review of Resident #5's medical record occurred on all days of survey. The record showed an initial Level I PASARR, completed on 04/27/12, with no diagnosis of dementia, Alzheimer's disease or a major mental illness (MMI). The facility added physician diagnoses of delusional disorders (PARANOIA) and visual hallucinations on 04/16/18; unspecified psychosis and major depressive disorder on 04/25/18; and vascular dementia without behavioral disturbance on 06/18/18. - Review of Resident #14's medical record occurred on all days of survey. The record showed an initial Level I PASARR, completed on 07/08/16, with no diagnosis of dementia, Alzheimer's disease, or a MMI. The facility added physician diagnoses of major depressive disorder, unspecified psychosis, and Alzheimer's disease on 02/27/18. - Review of Resident #18's medical record occurred on all days of survey. The record showed an initial Level I PASARR, completed on 05/11/17, with no diagnosis of dementia, Alzheimer's disease or a MMI. The facility added physician diagnoses of delusional disorders (Paranoid Ideations) on 08/11/17; unspecified psychosis and Alzheimer's disease on 04/25/18; vascular dementia without behavioral disturbance on 06/18/18; and major depressive disorder on 01/11/19. - Review of Resident #40's medical record occurred on all days of survey. The record showed an initial Level I PASARR, completed on 10/22/08, with no diagnosis of dementia, Alzheimer's disease, or a MMI. The facility added	F 644	Level I will be completed on residents with a status change related to a new diagnosis (Dx) that indicates a possible serious mental disorder, intellectual disability or a related condition that may require psychiatric services. 2. When the Social Worker (SW) was informed of the concern by the surveyor, the SW completed a Level I PASARR on Residents #5, #14, #18 and #40. The completed Level I's were submitted to ASCEND for review. The results from ASCEND on all four residents was noted as "Level II not indicated so prior LOC (level of Care) is still valid". 3. Following the survey exit on 01/31/19. The Director of Nursing (DON) met with the Resident Care Coordinators (RCCs) and the SW to discuss when it is necessary to complete a Level I PASARR. The following information was passed on to the RCCs and SW by the DON: a.) One of the surveyors did visit with the DON and an RCC and informed them of the following: that with the MDS review on admit, annually or with a significant change in status and Section I Psychiatric/Mood Disorder = 15900, 15950, 16000, 16100 and the resident is being actively treated for the DX and a Level I PASRR has not been completed, then one needs to be completed and submitted to ASCEND and any concerns noted will be addressed according to regulations and to ASCEND's recommendations.. b.) DON also gave the RCCs and SW a	

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F 644	Continued From page 2 physician diagnoses of psychophysical visual disturbances on 09/03/14; delusional disorders on 09/16/16; schizophrenia, unspecified on 01/23/17; and unspecified dementia with behavioral disturbance on 10/23/17. The facility failed to complete a new Level I PASARR rescreening/change in status assessment for the new diagnoses for Residents #5, #14, #18, and #40. During an interview on the afternoon of 01/30/19, a social worker (#3) confirmed staff failed to complete the required Level I PASARR rescreenings.	F 644	copy of the article “When is it necessary to complete a Level II PASARR?” from the Fall 2018 North Dakota Department of Health (NDDoH) Long Term Care Highlights newsletter to use for reference also. c.) SW was also informed that when doing an MDS she also needs to review Section I Psychiatric/Mood Disorder = 15900, 15950, 16000, 16100 and if those were marked by the RCC and the resident is actively being treated for the DX, does a Level I PASRR need to be completed and if so then complete one and submit it to ASCEND and address any concerns noted according to regulations and to ASCEND’s recommendations. d.) To assure that other residents with DXs of an MMI have met the requirement regarding a Level II PASARR, the SW will review all of the remaining in-house residents’ charts for DXs that may indicate that a Level II PASARR is needed and then complete a Level I PASARR on that resident and submit it to ASCEND and address any concerns according to regulations and recommendations from ASCEND. 4. No policy changes as the Resident Assessment Instrument (RAI) manual, that has the instructions as to how to complete the MDS and how to address concerns is considered the policy for the facility. 5. Individual in-services will be held with the Nurses and the Certified Nurses’ Aides (CNAs) on 02/20/19 at which time	

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F 644	Continued From page 3	F 644	the deficiency tags and concerns of each tag will be reviewed along with the Plan of Correction (POC) sent to the NDDoH. This deficiency will not be discussed in depth with the direct care nursing staff as this particular tag pertains to RCCs and the SW who complete the MDS. 6. To assure that this concern is avoided in the future the following interventions along with Quality Assurance (QA) or Quality Assurance & Performance Improvement (QAPI) monitoring will be conducted to assure the concerns with the tag are being addressed • The DON visited with the RCCs and SW as noted above in #3. • SW will review all of the remaining in-house residents' charts for DXs that may indicate that a Level II PASARR is needed and then complete a Level I PASARR on that resident and submit it to ASCEND and address any concerns according to regulations and recommendations from ASCEND. If a Level I PASRR is completed on a resident (e.g. already in-house, on admission, new DX concern etc.…) the SW is to give the DON a copy of that Level I PASARR. • When an MDS is completed for the following reasons: admission, annual, significant change in status, significant correction to prior comprehensive or there is a status change related to new diagnoses the RCCs and/or SW are to give the DON a copy of the following Sections from the MDS if they are checked. The sections are Section A Identification Information=A1500 PASRR	

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F 644	Continued From page 4	F 644	and A1510 Level II PASRR and Section I Active Diagnoses Psychiatric/Mood disorder = 15900, 15950, 16000 or 1610'. • Front office personnel that are responsible to add new diagnoses to the resident's chart from providers or psychiatry progress notes, have always made a copy of the diagnoses list from that progress note of that resident if a new DX is noted and give that copy to the RCCs so they are aware of the new diagnoses. Front office personnel were informed 01/31/19 to give a copy to the SW as well. • Regarding QA/QAPI Monitoring: The DON or Designee will be responsible for monitoring the interventions put in place as noted above. Monitoring will be as follows: Weekly for four (4) weeks: 02/03/19 thru 02/24/19 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2019) and then for two quarters (August and November 2019 and then for the two months of the next quarter December 2019 and January 2020) with QA/QAPI monitoring completed 01/31/20. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved RCC and SW by DON or Designee). The DON will submit a "report of the deficiency" along with the completed monitoring at the next QA/QAPI meeting tentatively set for 04/25/19. Then at the QA/QAPI quarterly meetings after 04/25/19, only the monitoring results will be reported to the committee through 01/31/20. In the	

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F 644	Continued From page 5	F 644	absence of the DON if any monitoring needs to be completed that will be done by a Designee. 7. Completion date 03/07/19	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		3/7/19

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F 756	Continued From page 6 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure the attending physician reviewed the consultant pharmacist's recommendations for 2 of 16 sampled residents (Residents #5 and #31). Failure of the physician to review the drug irregularities identified by the consultant pharmacist may result in the prolonged and unnecessary use of medications and may result in adverse consequences. Findings include: Review of a facility policy titled "Consultant Pharmacy Policy" occurred 01/30/19. This policy, updated October 2018, stated, "If a discrepancy is found, the DON [director of nursing] will forward the MRR [medication regimen review] to the responsible physician [or their designee] to be reviewed and addressed. . . ." - Review of Resident #5's medical record occurred on all days of survey. A "Physician Recommendation From Pharmacist" form, dated 07/03/18, showed a recommendation for crushing medications "with the following exceptions: Omeprazole capsule may be opened and contents mixed with 1 tablespoon of applesauce . . . Vitamin D 50,000 IU	F 756	F756 1. It is the policy of MMHCC to assure that Residents #5, and #31 from the survey sample roster and all the residents of MMHCC that may receive a Consultant Pharmacist Recommendation (CpR) that the recommendation is reviewed and signed by the Physician/Medical Director. 2. The physician reviewed the Physician Recommendation from the pharmacist for resident # 5 and agreed with the Family nurse practitioner's (FNP's) recommendations and signed off on the review. The physician reviewed the Physician Recommendation from the pharmacist for resident # 31 and agreed with the FNP's recommendations and signed off on the review. 3. An addition was made to the current Consultant Pharmacy Policy (CPP) updated October 2018 and that is as follows: If the MRR is reviewed and signed by the physician's designee (Family Nurse Practitioner/ FNP or a Physician's Assistant/ PA), the physician must also review and sign off on that MRR with his next weekly rounds or within 3 weeks of the FNP's/PA's review. The CPP update is now noted as	

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F 756	Continued From page 7 [International Units] capsules should be swallowed whole. Bisacodyl tablets are enteric-coated and should be swallowed whole. Gabapentin capsules should be swallowed whole or changed to the liquid formulation. . . ." A nurse practitioner responded to the recommendation. - Review of Resident #31's medical record occurred on all days of survey. A "Consultant Pharmacist Communication to Physician" form, dated 02/08/18, stated, "Both Aspirin and SSRI's [sic] [selective serotonin reuptake inhibitor-antidepressant] can inhibit platelets causing an increase in bleeding time. Please review. . . ." A nurse practitioner responded to the identified irregularity. The facility failed to ensure a physician reviewed and signed all irregularities identified by a pharmacist. During an interview on 01/30/19 at 2:20 p.m., an administrative nurse (#1) stated she forwarded irregularities identified by the pharmacist not related to psychiatric medications to the nurse practitioner.	F 756	02/07/19. 4. Individual in-services will be held with the Nurses and the CNAs on 02/20/19 at which time the deficiency tags and concerns of each tag will be reviewed along with the POC sent to the NDDoH. This deficiency will not be discussed in depth with the direct care nursing staff as this particular tag pertains to the DON who reviews the monthly MRRs. 5. Regarding QA/QAPI Monitoring: The DON or Designee will be responsible for monitoring the monthly MRRs to ensure that the reviews are signed by the physician. • The DON will continue to have the FNP/PA review the CpR (can also be referred to as drug regimen review(DRR) or medication regiment review (MRR)) that are non-psychiatric medication concerns and will then have the physician review the FNP/PA's decision with his next weekly rounds or within 3 weeks of the FNP/PAs review and makes changes if he feels necessary and sign off on the reviews. • This monitoring for QA/QAPI will be starting with the consulting pharmacy reviews of February 2019 and completed with the January 2020 consulting pharmacy reviews. If concerns are noted by the DON with the monitoring, immediate corrective action will be taken (e.g. teaching with the physician that when the MRRs are placed in his weekly rounds folder the MRR needs to be signed in the time frame as noted in the CPP). The DON will submit a "report of	

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F 756	Continued From page 8	F 756	the deficiency" along with the completed monitoring and a copy of the updated CPP at the next QA/QAPI meeting tentatively set for 04/25/19. Then at the QA/QAPI quarterly meetings after 04/25/19, only the monitoring results will be reported to the committee through 01/31/20. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 6. Completion date 03/07/19	
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 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;	F 880		3/7/19

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F 880	Continued From page 9 §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 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.	F 880		

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F 880	Continued From page 10 §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: Based on observation, review of facility policy, and staff interview, facility staff failed to follow standard infection control practices for 2 of 10 sampled residents (Residents #3 and #17) and 1 supplemental resident (Resident #61) observed receiving assistance with activities of daily living. Failure to follow infection control practices while assisting a resident to dine and during personal cares has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 01/30/19. This policy, last reviewed 01/17/19, stated, ". . . Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. . . . Hand Hygiene Table (when hands should be cleaned) . . . Between resident contacts . . . After handling contaminated objects . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . . ." DINING ASSISTANCE - Observation on 01/28/19 at 11:19 a.m. in the main dining room showed an unidentified staff person assisting Resident #61 to eat. The staff person wore gloves while handing food to	F 880	F880: 1. It is the policy of MMHCC to assure that Residents #3, #17 and #61 from the survey sample roster and all the residents of MMHCC have a safe, sanitary and comfortable environment. 2. Resident #61: Staff was informed via CNA/Nursing communication book after survey exit on 01/31/19 of the concern surveyors noted of finger food being handed to resident with a bare hand. In the note staff was reminded of the facility policy regarding hand hygiene. Reviewing the deficiency report on 02/08/19 the concern noted with resident #61 was CNA used a gloved hand to hand resident finger food, but CNA had touched another resident's spoon with that same gloved hand prior to without removing glove, performing hand hygiene and placing a new glove on. Staff was informed via CNA/Nursing communication book on 02/08/19 of this particular concern and reminded of the facility policy regarding this matter. • Resident #17: This concern was not mentioned at the survey exit, concern noted with deficiency report on 02/08/19. Staff was informed via CNA/Nursing communication book on 02/08/19 of this particular concern and reminded of the facility policy regarding this matter. • Resident #3: Staff was informed via	

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F 880	Continued From page 11 Resident #61 who ate/drank independently after staff placed a food/beverage in his hands. Still wearing the same gloves, the staff member turned to another resident who had been feeding herself with a spoon. The resident indicated to the staff member difficulty getting food onto her spoon. The staff member took the spoon, dished up the food, and fed it to the resident. The staff member turned back to Resident #61 and using the same gloved hand picked up half a sandwich, and handed it to the resident who ate the sandwich. The staff member failed to perform hand hygiene or change gloves between the two resident contacts. PERSONAL CARE HAND HYGIENE - Observation on 01/28/19 at 3:55 p.m. showed certified nurse aides (CNA) (#5 and #6) performed perineal cares for Resident #17 in her room. After removing his/her gloves, the CNA (#6) failed to perform hand hygiene before leaving the room. - Observation on 01/28/19 at 4:21 p.m. showed a CNA (#4) assisted Resident #3 in the bathroom with toileting and changing of brief/clothes. As the CNA (#4) obtained clean items, Resident #3 felt his clothes to check for wetness. Resident #3 identified to the CNA (#4) what items needed changing. Resident #3 stood holding onto the grab bar next to the toilet. When fully dressed, Resident #3 ambulated independently from the bathroom. The CNA (#4) failed to assist or cue Resident #3 to wash his hands prior to leaving the resident's room. During an interview on 01/31/19 at 8:32 a.m. an	F 880	CNA/Nursing communication book after survey exit on 01/31/19 of the concern surveyors noted of resident not being cued to wash his hands and reminded of the facility policy regarding this matter. 3. Individual in-services will be held with the Nurses and the CNAs on 02/20/19 at which time the deficiency tags and concerns of each tag will be reviewed along with the POC sent to the NDDOH This deficiency will be discussed in depth with the direct care nursing staff as well as facility policy review of hand hygiene. 4. Facility policy on Hand Hygiene is current so no changes are necessary to policy. 5. Regarding QA/QAPI Monitoring: The DON or Designee will randomly observe the following to assure that proper hand hygiene by staff is conducted according to policy. • resident #61's meal assistance along with other residents that are dependent/require supervision with their meals. • Resident #17's peri cares and Resident #3's bathrooming task along with other residents that are dependent/require supervision with these two particular care tasks. • Monitoring will be as follows: Weekly for four (4) weeks: 02/03/19 thru 02/24/19 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2019) and then for two quarters (August and November 2019 and then for the two months of the next quarter December 2019 and January 2020) with QA/QAPI	

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 _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 administrative nurse (#2) confirmed staff should not have handed Resident #61 a sandwich with the same gloves used to handle a possibly contaminated spoon and staff should have assisted Resident #3 with hand washing.	F 880	monitoring completed 01/31/20. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved staff by DON or Designee). The DON will submit a "report of the deficiency" along with the completed monitoring at the next QA/QAPI meeting tentatively set for 04/25/19. Then at the QA/QAPI quarterly meetings after 04/25/19, only the monitoring results will be reported to the committee through 01/31/20. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 6. Completion date 03/07/19	