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 _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 03/19/18 and concluded on 03/22/18.	F 000		
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 observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 5 sampled residents (Resident #15 and #33). Failure to ensure Section P (Restraints and Alarms) of the MDS accurately reflects the resident's current status/needs, has the potential to affect the accurate development of the comprehensive care plan and the care provided. Findings include: Observations during all days of survey showed Resident #15 and #33 with a code alert attached to their walkers. The Long-Term Care Facility RAI User's Manual, revised October 2017, page P 8-10 stated, ". . . P0200 . . . Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the	F 641	F641: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #15 and #33 from the survey sample roster and all the residents of MMHCC Minimum Data Set (MDS) review/assessments are coded accurately to reflect the resident's current status so a comprehensive care plan can be developed to assure the care provided for the residents is appropriate. This tag has the following concern: 1. Section P (Restraints and Alarms) of the MDS was not coded correctly for residents #15 and #33 from the survey roster. This concern is in relation to a Code alert alarm (wander/elopement alarm) being utilized with resident #15 and # 33 but not being coded on their most recent MDS by the Resident Care Coordinator(s) (RCCs). • Following the survey exit on 03/21/18. The Director of Nursing (DON) met with the RCCs to discuss the correct coding necessary for accurate completion of Section P (Restraints and Alarms). RCC's informed the DON that the	4/25/18

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

Electronically Signed | 04/19/2018

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F 641	Continued From page 1 staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. . . ." - Review of Resident #15's care plan occurred on all days of survey. This care plan stated, ". . . code alert on walker . . ." Review of Resident #15's annual MDS, dated 01/03/18, failed to show this resident wore a wander/elopement alarm during the seven day look-back period. - Review of Resident #33's care plan occurred on March 21, 2017. This care plan stated, ". . . code alert on walker . . ." Review of Resident #33's annual MDS, dated 01/29/18, failed to show this resident wore a wander/elopement alarm during the seven day look-back period. During an interview on 03/21/18 at 8:30 a.m. an administrative nurse (#2) agreed she failed to code the above sections of the MDS accurately.	F 641	correction MDS's were completed 03/21/18 and copies of that correction MDS information and section P were given to the DON. For the Quality Assurance Monitoring (QA), when the MDS is completed for any resident that has a code alert alarm, the RCCs were instructed to give the DON a copy of that Section P. The DON also informed the RCC's that she will randomly pull other MDSs they have completed on residents who do not have a wander /elopement alarm. This assures that Section P was marked correctly as a resident who has some other type of alarm could also be marked as having a wander/elopement alarm as all alarm use is addressed in Section P. 2. All Residents who reside at MMHCC have the potential of having their MDS scored incorrectly if the resident(s) require the use of any type of alarm that monitors resident movement and alerts the staff when movement is detected. To assure that this concern is avoided the following interventions were put in place. • The DON visited with the RCC's as noted above in #1. • After completion of an MDS of a resident where a wander/elopement alarm is utilized as noted in Section P0200 Alarms of the MDS: the RCC is to provide a copy of Section P to the DON to assure that Section P was marked correctly. 3. Individual in-services were held with the Nurses and the Certified Nurses' Aides (CNAs) on 03/27/18 at which time	

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F 641	Continued From page 2	F 641	the potential deficiency tags and concerns of each tag were reviewed. This was not discussed in depth with the direct care nursing staff as this particular tag pertains to RCCs who complete the MDS. This F tag was discussed again briefly at the Nurses' and CNAs in-service on 04/18/18 with a review of the plan of correction (POC) that will be sent to the North Dakota Department of Health (NDDoH). 4. With Quality Assurance (QA) or Quality Assurance & Performance Improvement (QAPI) monitoring the following will be conducted to assure the concerns with the tag are being addressed: • RCC's were instructed that any resident that has a Code alert (as noted with Resident #15 & #33 on the survey roster), when their MDS is completed to give the DON a copy of that Section P to assure that the section was coded correctly and if not coded correctly the RCC will need to do a correction MDS. • The DON will randomly pull other MDSs completed on residents who do not have a wander /elopement alarm to assure that Section P was marked correctly. The facility does utilize other alarms noted in Section P*P0200 (e.g. bed or chair alarm) that could also be inadvertently not marked by the RCC completing that MDS review. 5. Frequency of QA/QAPI Monitoring: Weekly for four (4) weeks: 03/25/18 thru 04/21/18 (that is 4 full weeks). Monthly for three (3) months (May-June-July 2018) and then quarterly (October 2018	

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F 641	Continued From page 3	F 641	and January 2019) with QA/QAPI monitoring completed 01/19/19. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved RCC 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 04/30/18. Then at the QA/QAPI quarterly meetings after 04/30/18, only the monitoring results will be reported to the committee through 01/19/19. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 04/25/18	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 2 sampled residents (Resident #39 and #51) with falls resulting in head injuries. Failure to perform neurological assessments following such falls has the potential for a head injury to go undetected and may lead to further complications. Findings Include:	F 658	F658: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #39 and #51 from the survey sample roster and all the residents of MMHCC receive care in accordance with professional standards following a fall with a head injury or a suspected head injury. This tag has the following concern. 1. If a resident has received a head injury with a fall a neurological	4/25/18

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F 658	Continued From page 4 Review of facility policy titled "CRANIOTOMY CHECKS/NEURO CHECKS" occurred on 03/21/18. This policy, dated 05/02/16, stated, " . . . UNWITNESSED FALL: . . . A check should be done immediately after the fall and then call a PA [Physician Assistant] or Doctor. . . . after initial neuro [neurological] check another check is due 30 minutes after the fall, one hour after the fall, two hours after the fall and then three hours after the fall. . . ." - Review of Resident #39's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The nurse's progress notes identified the following: *3/16/18 at 10:53 p.m., "fall not witnessed (neuro) . . . Time of incident: 7:45 pm. . . Resident stated that she fell and hit her head on the bed. . . ." Neurological [neuro] checks taken immediately after, after 1/2 hour, after 1 hour, and after 2 hours, showed "Pupils equal, round and react to light. Bilateral hand grasp firm . . . " *3/17/18 at 12:44 a.m., " . . . firm hand grip, bilaterally, able to move all extremities pupils: equal, round, reactive to light speech is normal . . ." The nursing staff failed to perform neurological checks 3 hours after Resident #39 fell, per facility policy. During an interview on 03/21/18 at 11:27 a.m., an administrative nurse (#1) confirmed staff failed to complete neurological checks 3 hours after fall on Resident #39 and staff completed the final	F 658	assessment (neuro checks) following the fall need to be completed according to the facility's policy/protocol. If the fall was unwitnessed by the facility staff and the resident is unable to tell the staff if he/she hit their head, neuro checks need to be conducted according to the facility policy/protocol. Neuro checks were conducted on resident #39 & #51 of the survey roster but not completed for all the time frames according to the facility's policy/protocol following a fall. • On 03/20/18 (day 2 of survey) the DON was informed by a member of the survey team of the concerns of neuro checks not being completed in a timely manner on residents #39 & #51. The DON did send a message to all the nurses via the facility's Electronic Charting System (ECS) on 03/20/18 of the importance to follow the policy/protocol for neuro checks with a fall either witnessed or unwitnessed. The time frames that the neuro checks need to be done following a fall with a head injury or suspected occurrence of a head injury were noted in this message. Also noted in this message: the DON suggested that follow up neuro checks should be conducted as a nursing measure on each shift (that would be 3 shifts) in the first 24 hours after the last neuro check (according to policy/protocol) was completed. 2. All Residents who reside at MMHCC have the potential of falling with the possibility of a head injury. The residents should receive care in accordance with	

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F 658	Continued From page 5 neorological check late per facility policy. - Review of Resident #51's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and anxiety. Resident #51's nurse's progress notes stated the following: * 01/07/18 Incident type: "fall not witnessed . . . Date of incident: 01/07/2018 . . . 07:45 PM . . . small bump on crown of head . . . ice pack applied . . . [Resident #51] tells me that she had stood up from her chair . . . says she 'blacked out' after she stood up, and fell against her nightstand - admits to hitting the back of her head, I did visualize a small quarter-size lump on the crown of her head, lightly bruised in color. . . Neuro [Neurological] checks 7:50 p.m. Pupils equal, round and react to light. Bilateral hand grasp firm. . . ." * 01/07/18 at 8:30 p.m. " . . . Alert Opens Eyes: Spontaneously, Speech: Clear, Ability to move: Right arm Left arm Right leg Left leg, Grasp: Equal, Pupils: Reacts on right, Reacts on left" * 01/07/18 at 9:00 p.m. " . . . Alert, but has been dozing in her chair, Opens Eyes: Spontaneously, Speech: Clear, Ability to move: Right arm Left arm Right leg Left leg, Grasp: Equal, Pupils: Reacts on right, Reacts on left" The nurse failed to complete neurological checks two hours and three hours after the fall as per facility policy. During an interview on 03/20/18 at 4:26 p.m., an administrative nurse (#1) stated she expects staff to complete neurological checks per policy.	F 658	professional standards following a fall with a head injury or a suspected head injury. To assure that this concern is avoided the following interventions were put in place. • The DON sent a message via ECS to all the nurses addressing this concern on 03/20/18 as noted above in #1. • On 03/22/18 (The following day of the Survey completion) the DON sent another message via ECS addressing the concerns of the survey which included that neuro checks with head or suspected head injuries are done in a timely manner. • Our computer technician placed a 'Follow Up "reminder in the Fall and Incident charting folder. If the neuro checks are necessary following a fall: the nurse can put the time in the "Follow Up" reminder and at that set time a message will appear on the nurses' computer screen that a neuro check is due. 3. Individual in-services were held with the nurses and the CNAs on 03/27/18 at which time the potential deficiency tags and concerns of each tag were reviewed. F tag 658 was discussed in depth with the nurses at their in-service on the said date. Nurses were given an updated copy of the policy/protocol for neuro checks with an unwitnessed fall that includes the addition of the nursing measure of follow up neuro checks on each shift (that would be 3 shifts) for the first 24 hours following the last neuro check. This F tag was also discussed again at briefly at the CNA's in-service and in depth at the Nurses' in-service on 04/18/18 with a review of	

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F 658	Continued From page 6	F 658	the plan of correction (POC) that will be sent to the NDDoH. At the Nurses' in-service, any concerns noted regarding this tag with the QA/QAPI conducted in the weeks of 03/25/18 thru 04/14/18 and any concerns noted on the days before the in-service (04/15/18 thru 04/17/18) were also discussed. 4. With QA or QAPI monitoring the following will be conducted to assure the concerns with the tag are being addressed: • All fall incident reports will be reviewed by the DON or Designee to assure if neuro checks were necessary they were conducted according to policy/procedure. • Any concerns noted with the incident report regarding neuro checks will be addressed to all nurses via ECS message (and the individual nurse that completed the incident report will be also notified via ECS or in person) at the time of that review by the DON or designee. Any QA/QAPI concerns will also be reviewed at the next scheduled monthly Nurses' in-services. 5. Frequency of QA/QAPI Monitoring: Weekly for four (4) weeks: 03/25/18 thru 04/21/18 (that is 4 full weeks). Monthly for three (3) months (May-June-July 2018) and then quarterly (October 2018 and January 2019) with QA/QAPI monitoring completed 01/19/19. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with nurses and/or individual nurse involved by the DON or	

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F 658	Continued From page 7	F 658	Designee). The DON will submit a "report of the deficiency" along with the completed monitoring at the next QA/QAPI meeting tentatively set for 04/30/18. Then at the QA/QAPI quarterly meetings after 04/30/18, only the monitoring results will be reported to the committee through 01/19/19. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 04/25/18	
F 689 SS=D	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: Based on record review, review of manufacturer's guidelines, and resident and staff interview, the facility failed to provide adequate supervision to prevent accidents for 1 of 1 sampled resident (Resident #60) who experienced a burn while using a cold/hot pack. Failure to ensure staff used a cold/hot pack appropriately resulted in an injury to Resident #60. Findings include: Review of manufacturer's guidelines for use of	F 689	F689: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Resident #60 from the survey sample roster and all residents of MMHCC have an environment that remains as free of accident hazards as is possible and receive adequate supervision and assistance devices to prevent accidents. This tag has the following concern. 1. Staff failed to ensure that a gel ice pack that was placed for #60 on 03/16/18 was completely intact with no leaking of gel. As a result, the pack opened and the	4/25/18

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F 689	Continued From page 8 "Reusable Cold/Hot Pack" stated, "Caution: For Hot or Cold Use: Check for leaks before use. Throw away if leaking . . . Do not lie on top of pack, as it could cause pack to break. Applying Cold Pack to Skin 1. Insert cold pack in cover or wrap. 2. Apply cold pack to desired area. . . . Suggested First Aid: If contents contact skin or eyes, remove pack immediately. Thoroughly flush with water. . . ." Review of Resident #60's medical record occurred on all days of survey. Diagnoses included fibromyalgia [chronic pain condition], osteoarthritis, and gout. The current care plan stated, "Potential alteration in comfort . . . related to . . . Chronic back, knee, and shoulder pain . . ." Approach . . . Nurse/Nurse Aide . . . attempt distraction, position changes, warmth, ice. . . ." Physician orders stated, " . . . 05/21/17 Apply ice pack to affected area as needed. . . . 02/22/18 heating pad as needed for pain . . . 03/18/18 Nurses to check blisters on right shoulder b.i.d (twice daily) . . . (nursing measure). During an interview on 03/19/18 at 1:41 p.m., Resident #60 stated she had a burn on her shoulder. The resident stated about two weeks ago staff brought in a pack (pointed to a cold/hot pack) and it did not have a cover on it and caused a burn. Nurse's progress notes stated the following: * 03/18/18 at 10:19 a.m. "Incident Type: unknown skin blister Date of Incident 03/18/18 Time of Incident 06:00 AM . . . Equip. [equipment] involved heating pad??? . . . Injury/treatment 2 blisters on right shoulder area . . . Possible Cause: fragile skin . . . Reported by RT	F 689	resident's skin on her right upper shoulder had contact with the gel from the ice pack causing skin irritation noted on 03/17/18 and then two small blisters were noted on 03/18/18 on the area. With the investigation of the incident by the DON on 03/19/18 through 03/21/19, the gel pack was wrapped with a towel when placed for resident but there was the possibility that the towel was removed by the resident or fell off the pack with resident #60 repositioning her shoulder. • On 03/19/18 The DON did place a note in the nursing department communication book for the nurses and the Certified Nurse Aides (CNAs) about the concern noted above in #1. The following items were addressed in that note. a.) Nursing staff was instructed that the only staff that can place a warm or ice/cold gel pack without talking to the charge nurse are the Restorative/Physical therapy (RT or PT) CNAs as that task/order is part of the residents' restorative/physical therapy care plan. If there is no Occupational therapy (OT) or Physical Therapy (PT) order, then the RT or PT aide needs to visit with the charge nurse. b.) Any time, resident requests to have an ice/cold or warm gel pack placed, the CNA is to talk to the charge nurse before placing the pack, so the need of the device can be assessed by the charge nurse. c.) The gel pack is to be checked for any leakage prior to placement and covered with a towel or gel pack protective cloth sack. The pack is to be in place 15 to 20 minutes and	

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F 689	Continued From page 9 [Restorative Therapy] [name] this AM that she discovered that resident had 2 intact, fluid-filled blisters on the right shoulder area. First blister measures 3 cm [centimeters] long by 0.8 cm wide, second blister appears circular with 0.9 cm diameter. RT staff reports that on Friday, March 16, she noted that resident has been using gel packs that are being warmed up with hot water in the sink and that resident has been using them constantly that day. Both blisters have mild redness along the immediate periphery, resident denies any tenderness to area with light palpation. RT staff also reports that on Friday, resident had the gel packs burst open 2x [two times] while she was using it. Staff involved Witnesses: RT staff [name] nurse [name] . . ." * 03/18/18 at 10:01 p.m. "Skin Condition: on right anterior shoulder area two small intact blisters present, pink periphery. * 03/18/18 at 10:06 p.m. "F/U [follow up] Incident: spoke with CNA [certified nursing assistant] [name] who was on duty last night. I asked CNA if she noticed any irritation at bedtime to the anterior shoulder site. She reports the area was light pink and she lotioned it with Vit [Vitamin] E (on 3/17/17) [sic]. . . ." 03/19/18 at 11:35 p.m. "2 blisters on right shoulder intact/fluid filled, thin red peripheral discoloration . . ." * 03/19/18 at 6:21 p.m. "Orders received pr (sic) [name] PT [Physical Therapist] for ice packs and heating pads tid [three times a day] * 03/19/18 at 9:34 p.m. ". . . (R) [right] shoulder blisters intact * 03/20/18 at 10:40 a.m. 'Complained of burning pain to right shoulder. Ice pack applied to area for 15 min. [minutes] . . ." * 03/20/18 at 10:42 a.m. "Blisters to back of right	F 689	then removed. d.) Following treatment, the gel pack needs to be removed from the room. e.) If a pack pops/breaks open while in use, that needs to be reported to the charge nurse immediately and assess if any of the gel from the pack got on the resident's skin and the pack needs to be tossed. • On 03/19/18, the DON also placed a large framed note on the freezer door where the gel packs are stored addressing the fore mentioned concerns from the note in the communication book, so staff is made aware every time of what they need to do when taking a gel pack from the freezer • The DON also sent a message to all the nurses via the facility's Electronic Charting System (ECS) on 03/19/18 of the gel pack concern and that the CNAs cannot take and place the gel packs without the permission of that resident's charge nurse. • On 3/21/18 The DON placed a note in the Nursing Communication Book summarizing the possible deficiencies noted with the survey exit. Again, in this note it was emphasized that a gel pack is not placed without the permission of the charge nurse and to make sure and inspect the gel pack for leaking before placement 2. All Residents who reside at MMHCC have the potential of a possible accident due to not receiving adequate supervision and assistance devices to prevent accidents. To assure that this concern is avoided, the following interventions were	

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F 689	Continued From page 10 shoulder are flat and do not have any fluid in them. They are OTA [open to air]. * 03/20/18 at 9:35 p.m. "No change noted with shoulder blisters." A report titled "Investigation of Injuries of Unknown Origin" stated, ". . . RT staff also reports that on Friday, resident had gel packs burst open 2x while she was using it. Injury/Treatment: 2 blisters on right shoulder area none needed [sic] . . . Actions/Teaching Done: continue to observe application of heating pads/heating packs. 03/19/18 Addendum: Chg [charge] Nurse [title] who completed the report - reported to me [at] this time 4:30pm that res. [resident removed the cover from the gel pack & uncovered pack was laying on her skin [sic]. . . Director of Nursing Statement . . . resident has an order for PRN [as needed] use of icepacks or heating pad. - OT [Occupational Therapy] evaluated situation along with writer - was reported that gel packs had broken - blisters may have been caused from the gel heating & Ice pack (sic) . . ." During an interview on the afternoon of 03/21/18, an administrative nurse (#1) stated she did not know if/when the CNA reported the burst gel packs to the nurse. The nurse (#1) further stated the NP [nurse practitioner] signed the incident report on 03/20/18 indicating she was aware of the incident and had no further orders.	F 689	put in place. • The DON informed CNA's and nurses of the concern as noted above in #1. • The facility's seamstress made more envelope type covers for the gel packs which totally encloses the pack making it difficult for the pack to fall out of the cover. Staff was informed to use these covers if feasible in place of towels. 3. Individual in-services were held with the nurses and the CNAs on 03/27/18 at which time the potential deficiency tags and concerns of each tag were reviewed. F tag 689 was discussed in depth with the nurses and CNAs at their in-service on the said date. A copy of the note placed on the freezer door with directions of gel pack use was also included in the nurses' and CNA's in-service packet. This F tag was also discussed again at Nurses' and CNA's in-service on 04/18/18 with a review of the plan of correction (POC) that will be sent to the NDDoH. At these in-services' any concerns noted regarding this tag with the QA/QAPI conducted in the weeks of 03/25/18 thru 04/14/18 and any concerns noted on the days before the in-service (04/15/18 thru 04/17/18) were also discussed. 4. With QA or QAPI monitoring the following will be conducted to assure the concerns with the tag are being addressed: • The DON or Designee will check the ice packs 3x's weekly to assure that all are in intact and will observe placement of packs by staff to assure the packs are covered. Any concerns noted will be	

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F 689	Continued From page 11	F 689	addressed to all nurses via ECS message and/or in the Nursing department communication book along with the note of concern to the staff. The individual staff member noted with the concern will also be spoken to by the DON or Designee. The PRN gel pack placement will also be reviewed by the DON or Designee to assure that the documentation is complete for the placement of the PRN gel pack. Any QA/QAPI concerns will be reviewed at the next scheduled monthly Nurses' and CNA in-services. 5. Frequency of QA/QAPI Monitoring: Weekly for four (4) weeks: 03/25/18 thru 04/21/18 (that is 4 full weeks). Monthly for three (3) months (May-June-July 2018) and then quarterly (October 2018 and January 2019) with QA/QAPI monitoring completed 01/19/19. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with nurses and/or individual nurse involved by the 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 04/30/18. Then at the QA/QAPI quarterly meetings after 04/30/18, only the monitoring results will be reported to the committee through 01/19/19. In the absence of the DON if any monitoring needs to be completed, that will be done by a Designee. *	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		4/25/18

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F 695 SS=D	Continued From page 12 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 supplemental resident (Resident #12) with orders for as needed (PRN) oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like many medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." Review of the Physician Standing Orders	F 695	F695: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #12 from the survey sample roster and all the residents of MMHCC who may require Oxygen therapy receive that therapy in accordance with professional standards of practice. This tag has the following concern: 1. Resident #12 from the survey roster had an order as needed (PRN) for Oxygen that was being used daily and the nurses failed to check Resident's Oxygen Saturation level (O2 SAT) as ordered. • Following the survey exit on 03/21/18. The DON posted a note at each Nurses' desk reminding nurses to thoroughly look at the PRN orders for Oxygen to assure that O2 SATS are being checked as ordered. The note also explained the concern with Resident #12 from the survey roster. • Resident #12's Oxygen order was reviewed with the Provider on 03/23/18 and the PRN order for O2 was	

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F 695	Continued From page 13 occurred on 03/21/18. The standing orders stated ". . . Oxygen (O2) PRN: Nasal Cannula at 2 - 5 L [liters] . . . Do initial O2 SAT [saturations] before starting O2. . . . " Review of Resident #12's medical record occurred on all day of survey. Diagnoses included history of pulmonary emboli and history of hypoxemia. Current physician's orders included apply oxygen 2 to 5 liters/min (minute) as needed to keep O2 sat > (greater) or equal to 90% (percent). Review of Resident #12's vital records showed staff checked Resident #12's O2 sats twice in the last month, even though the resident was wearing O2 daily. Observations throughout the day of 03/19/18, showed Resident #12 lying in her bed wearing oxygen via nasal cannula. The oxygen concentrator was set to 2 liters per minute. During an interview on 03/21/18 at 2:08 p.m., an administrative nurse (#1) stated she would expect staff to follow the physician's orders. The facility failed to consistently check Resident #12's oxygen saturations prior to applying the oxygen.	F 695	discontinued and an order for continuous O2 was written. 2. All Residents who reside at MMHCC have the potential of requiring Oxygen therapy. With the Oxygen therapy there is the possibility of the resident's O2 SAT not being monitored as ordered. To assure that this concern is avoided the following interventions were put in place. • The DON sent a message via ECS on 03/22/18 reminding the nurses that if any resident is on PRN O2 Oxygen to monitor the SATS as ordered. • The DON sent a message via ECS on 03/26/18 that the decision has been made that as a nursing measure, all O2 orders (continuous or PRN) will have an O2 SAT checked each shift unless the provider writes an order for the O2 SAT to be checked more often. • The Tag concern was discussed at the Nurses' In-service meeting on 03/27/18. The updated protocol/policy/procedure for O2 therapy & Oximeter monitoring was reviewed. The change made to the policy/procedure/protocol was the following addition: "As a nursing measure: If Oxygen Therapy is ordered continuous or PRN and O2 SAT will be checked once a shift unless ordered to be checked more often by the provider. • The evening of 03/26/18 & 03/27/18 was the monthly cleaning of the medication carts and the nurses that completed that task reviewed all the PRN O2 orders. If there was a PRN O2 order that was not used in 3 months, a note	

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F 695	Continued From page 14	F 695	was written for the provider to review that resident's PRN order for O2 and determine if the order could be discontinued. Those PRN orders noted were discontinued by the provider. All continuous O2 orders were also checked to assure that checking the O2 SAT on each shift was noted on the TAR. 3. Individual in-services were held with the Nurses and the Certified Nurses' Aides (CNAs) on 03/27/18 at which time the potential deficiency tags and concerns of each tag were reviewed. This was not discussed in depth with the CNAs as it is a nursing task. This F tag was discussed again at the Nurses' and CNAs in-service on 04/18/18 with a review of the plan of correction (POC) that will be sent to the North Dakota Department of Health (NDDoH). 4. With Quality Assurance (QA) or Quality Assurance & Performance Improvement (QAPI) monitoring the following will be conducted to assure the concerns with the tag are being addressed: • The DON or Designee will randomly review residents who have a PRN or continuous order for O2 to assure that the resident's O2 SATS are being monitored each shift. If there is a concern, that will be addressed with that individual nurse by the DON or Designee and addressed at the next nurses' in-eservice. 5. Frequency of QA/QAPI Monitoring: Weekly for four (4) weeks: 03/25/18 thru 04/21/18 (that is 4 full weeks). Monthly for three (3) months (May-June-July	

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F 695	Continued From page 15	F 695	2018) and then quarterly (October 2018 and January 2019) with QA/QAPI monitoring completed 01/19/19. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with the charge nurse involved with the concern by the 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 04/30/18. Then at the QA/QAPI quarterly meetings after 04/30/18, only the monitoring results will be reported to the committee through 01/19/19. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		4/25/18

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F 812	Continued From page 16 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on review of food temperature cooling logs, review of facility policy/procedure, and staff interview, the facility failed to ensure food items were stored, prepared, and served under sanitary conditions for 3 of 4 meat items prepared for the residents, staff, and visitors. Failure to ensure food items were cooled properly has the potential to result in foodborne illness for residents, staff, and visitors. Finding include: Review of the facility policy, "Safe Ways To Cool Food" occurred on 03/21/18. This policy, dated December 2009, stated, "Potentially hazardous foods shall be cooled rapidly from 135 degrees Fahrenheit to 41 degrees F [Fahrenheit] or below within 6 hours and during this time the decrease in temperature from 135 degrees F to 70 degrees F shall occur within 2 hours. If potentially hazardous foods are prepared from ingredients at ambient temperature then the ENTIRE process shall take no more than 4 hours to cool to 41 degrees F. Improper cooling of potentially hazardous foods is one of the leading causes of foodborne illness. . . ." Review of the facility procedure "Food Temperature Cooling Log" occurred on 03/21/18. This undated procedure, stated, ". . . Take the temperature of the food item and record the temperature and time in the column indicated. If greater than 135 degrees F, continue to monitor	F 812	PLAN OF CORRECTION FOR 2018 F812: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents, Staff, and Visitors are free from foodborne illness, by having food items cooled properly prior to serving. This tag has the following concerns: 1. According to the temperature cooling logs kept by the Dietary Staff, they failed to cool down meats to 70° per proper food handling requirements after 2 hours on three different occasions. • Corrective Action: Immediately following the final kitchen tour on 3/21/18, the Administrator, in the absence of the Dietary Manager, provided immediate training to day and evening staff to ensure the proper cooling temperature process was in place. A notice was put in the communication book notifying staff of the change. All cooled meats currently in the kitchen and in use were properly cooled 3/19/18 and verified that all cooled meats prior to the 19th were no longer available in facility. The Dietary Manager conducted an in-service March 28th 2018 on “Safe Ways to Cool Food”, according to (MMHCC) facility policy. We discussed the correct technique of cooling food items to a safe temperature focusing on the 70 degree, 2 hour requirement and reviewed proper documentation using the	

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F 812	Continued From page 17 food until temperature reaches 135 degrees F. . . . Record time when food item reaches 135 degrees F. . . . After one hour, record time and temperature of food item. . . . After two hours, the food item should be at 70 degrees F or below. . . . At 70 degrees F, the food should cool down to 41 degrees F within 4 hours. . . ." Review of Temperature Cooling logs showed: * 03/03/18 after two hours, the hams were still 90 degrees F * 03/16/18 after two hours the corned beef was still 90 degrees F, and reached 60 degrees F on the fourth hour * 03/17/18 after two hours the hams were still 90 degrees F, and reached 70 degrees F on the third hour During the final kitchen tour on the morning of 03/21/18, a dietary assistant (#3) stated she was unaware of proper cooling techniques.	F 812	temperature cooling log. Dietary manager will continue teaching at monthly in-services to ensure all dietary personnel are aware of the importance of temperature control, documentation and the prevention of foodborne illness. This F tag was discussed again briefly at the Dietary in-service on 4/18/18 with a review of the plan of correction (POC) that will be sent to the North Dakota Department of Health (NDDoH). 2. Identify Potential: All Residents, Staff, and Visitors have the potential of receiving a foodborne illness due to improper food cooling methods. 3. Measures taken to prevent recurrence: Dietary Manager will conduct audits 1x weekly for the 1st month to ensure that proper sanitation standards are followed. Dietary personnel will continue to train at monthly in-services for any new policy or practice implemented in the dietary department. Dietary personnel will use one of the following methods to cool down potentially hazardous foods: 1. Cut meats into smaller pieces and place in shallow pans 2 inches or less and place container in freezer or refrigeration unit. 2. Use the Ice bath method and stir frequently. 3. Use ice as an ingredient. 4. Butcher shop will cut ham into slices and staff will cut other meats in smaller sections prior to cooking. Dietary staff will document and monitor on the temperature cooling log as follows: 1.Record the date and food item in the	

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F 812	Continued From page 18	F 812	columns indicated. 2. Take the temperature of the food item and record the temperature and time in the column indicated. If greater than 135°F, continue to monitor food until temperature reaches 135°F. 3. Record time when food item reaches 135°F. Record location/method food began to cool down. 4. Continue to monitor food for proper cooling time and temperature. After one hour, record time and temperature of food item. Record location/method if different from above. 5. Continue to monitor food for proper cooling time. After two hours, the food item should be at 70°F or below. Record the time and temperature of food item. Record location/method if different from above. 6. Continue to monitor and record food for proper cooling time and temperature each hour. At 70°F, the food should cool down to 41°F within 4 hours. The initial 2-hour cooling time is the most critical time period since the food is passing through the temperature range that supports the most rapid microorganism growth. If food has not reached 70°F within two hours, or does not reach 41° after 6 hours, it must be reheated to 165°F for 15 seconds and then cooled again or thrown away. 4. Frequency of QA Monitoring: Dietary Manager will audit logs completed by dietary staff weekly for (4) weeks: 3/21/18 through the week of 4/20/18 (that is full 4 weeks). Monthly for (3) months (May-June-July 2018) and then quarterly (October 2018 and January 2019) with	

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F 812	Continued From page 19	F 812	QA monitoring completed 1/19/2019. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved staff by Dietary Manager or Designee). The Dietary Manager will submit a report of deficiency along with the completed monitoring at next QA meeting 4/30/18 and at the quarterly meetings after 4/30/18. Only the monitoring results will be reported to the QA committee through 01/19/19. In the absence of Dietary Manager if any monitoring needs to be completed that will be done by a designee. *	
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	F 880		4/25/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 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 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.	F 880		

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	355036	A. BUILDING _____ B. WING _____	03/21/2018

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F 880	Continued From page 21 §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: Based on observation, record review, and staff interview, the facility failed to follow infection control practices for 2 of 2 sampled residents (Resident #44 and #45) and 1 supplemental resident (Resident #26) related to urinary catheter care. Failure to properly secure the urine catheter bags and tubing off the floor placed residents at risk for infection and unnecessary harm/injury. Findings include: - Review of Resident #45's medical record occurred on all days of survey. Diagnoses included prostatic hypertension and urinary incontinence with indwelling foley catheter. The physician orders, dated 04/17/17, identified, "Monitor urinary output every shift. Irrigate as needed if plugged, change foley bag tubing as needed, change foley catheter bag 1 time a week." During observation on 03/19/18 at 9:53 a.m., Resident #45 sat in his reclining chair with his catheter bag, inside a cloth dignity bag, attached to the side of the chair. Approximately three to four inches of the tubing laid on the floor.	F 880	F880: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #25, #44 and #45 from the survey sample roster and all the residents of MMHCC have a safe, sanitary and comfortable environment. This tag has the following concern: 1. Residents #26, #44, and #45 have urinary indwelling catheters in place. The Foley tubing and bag are covered with a printed cloth dignity bag. The Foley bag has a Velcro strap attached that is utilized to attach the Foley bag to the wheelchair. The Foley bag and tubing were not strapped high enough on the wheelchair or RocKing chair (a larger type of wheelchair utilized for some residents who no longer are able to independently wheel themselves) therefore the Foley bag and tubing were dragging on the floor which puts the resident at risk for infection and unnecessary harm/injury. " On 03/20/18 the DON noted with two residents that their Foley bags were dragging on the floor from their wheelchair. The DON put a note in the Nursing Department Communication Book on 03/20/18 that the Foley bag and	

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F 880	Continued From page 22 During observation on 03/20/18 at 10:53 a.m., two CNA's (#6 and #8) assisted Resident #45 from his reclining chair to his wheelchair. One of the CNA's (#6) secured Resident #45's catheter bag and tubing to his wheelchair. Part of the bag/tubing continued to touch the floor. The CNA (#6) transported Resident #45 to/from the dining room with the bottom of his bag and the tubing dragging on the floor. - On the afternoon of 03/19/18, observation showed Resident #26 by the nurses' station in her wheelchair with her urine catheter bag, in a cloth dignity bag, attached to the wheelchair. The bottom of her catheter bag laid on the floor between the wheels of the wheelchair. On 03/20/18 at 11:26 a.m., observation showed Resident #44 in the dining room. Her urine catheter bag hung on the wheelchair with part of the urine bag in the cloth dignity bag touching the floor between the wheels of the wheelchair. - On 03/20/18 at 4:44 p.m., observation showed Resident #26's urine catheter bag and tubing in a cloth dignity bag drug on the floor under her wheelchair while she wheeled herself in the dining room. During an interview on 03/21/18 at 3:06 p.m., an administrative nurse (#1) stated she has observed Resident #44 and #45 transferred with their catheter bags and tubing dragging on the floor under their wheelchairs and agreed this posed an infection control concern.	F 880	tubing needs to be up off the floor and to make sure to Velcro the bag and tubing high enough on the bottom bars of the wheelchair to get the bag and tubing off the floor. It was noted that this concern is an infection control issue. " On 3/21/18 The DON placed a note in the Nursing Communication Book summarizing the possible deficiencies noted with the survey exit. In this note, the concern was readdressed again about the Foley bags and tubing cannot be dragging on the floor. 2.All Residents who reside at MMHCC may have the potential of requiring placement of a Urinary Indwelling Catheter. With the placement of a urinary indwelling catheter there is the possibility of the resident□s Foley bag and tubing not being properly placed on the wheelchair thus causing the bag or tubing to drag on the floor. To assure that this concern is avoided the following interventions were put in place. " Nursing staff was made aware as noted in # 1 above via notes in the Nursing Communication book. " Central Supply clerk ordered vinyl urinary drainage bag holders that can be attached to wheelchairs that keep the Foley bag and tubing from dragging on the floor. These bags are being utilized 3. Individual in-services were held with the Nurses and the CNAs on 03/27/18 at which time the potential deficiency tags and concerns of each tag were reviewed. This F tag was discussed in depth with the Nurses and the CNAs regarding the	

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F 880	Continued From page 23	F 880	safe, sanitary and comfortable environment that needs to be maintained for our residents. This F tag was discussed again at the Nurses and CNAs in-service on 04/18/18 with a review of the plan of correction (POC) that will be sent to the North Dakota Department of Health (NDDoH). 4. With Quality Assurance (QA) or Quality Assurance & Performance Improvement (QAPI) monitoring the following will be conducted to assure the concerns with the tag are being addressed: " The DON or Designee will randomly check on residents #26, #44, and #45 from the Survey roster along with the other residents who have indwelling urinary catheters to assure that the Foley bag and tubing are kept off the floor. If there is a concern, that will be addressed at that time with the CNAs by the DON or Designee and then addressed again at the next Nursing and CNAs in-services. 5. Frequency of QA/QAPI Monitoring: Weekly for four (4) weeks: 03/25/18 thru 04/21/18 (that is 4 full weeks). Monthly for three (3) months (May-June-July 2018) and then quarterly (October 2018 and January 2019) with QA/QAPI monitoring completed 01/19/19. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with the CNAs involved with the concern by the 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 04/30/18. Then at the	

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F 880	Continued From page 24	F 880	QA/QAPI quarterly meetings after 04/30/18, only the monitoring results will be reported to the committee through 01/19/19. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *	