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 _____	02/06/2020

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 and complaint survey started on 02/03/20 and concluded 02/06/20.	F 000		
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 observation, manufacturer's guidelines, review of facility instruction sheet, and staff interview, the facility failed to follow professional standards of practice in priming of insulin pens for 1 of 3 observations (afternoon of 02/04/20) of insulin administration. Failure to remove the needle shield prior to priming an insulin pen may result in the resident to receiving an inaccurate dose of insulin. Findings include: Review of the facility instruction sheet titled "BD Auto Shield Duo . . . Instructions for Use" occurred on 02/05/20. This instruction sheet, dated 10/08/14, stated, ". . . push and screw the Pen Needle on the pen in a clockwise direction until it meets resistance. Pull ONLY the Outer Cover straight off. Always check the flow in the Pen Needle before each injection by priming the device with an air shot. Dial 2 units point the pen up and press the button. A drop or stream of liquid should appear at the Needle tip, IF NOT, repeat as recommended by the pen's	F 658	F658: 1. It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Resident #6 from the survey sample roster and all the residents of MMHCC that receive insulin via pen, that the priming of the pen is completed properly to assure an inaccurate dose of insulin will not be given. 2. The Director of Nursing (DON) sent a message on 02/05/2020 via Electronic Charting System (ECS) addressing the necessity of removing the needle cover from the insulin pen prior to priming. 3. The current policy/procedure of insulin pen use was reviewed and updated with the most current illustrated instructions from BD Auto Shield Duo& This instruction sheet addresses and illustrates attaching the needle to the insulin pen and priming of the pen. 4. Nurses in-service was held on 02/19/2020 at which time the deficiency concern with Tag F658 was reviewed	3/3/20

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

Electronically Signed | 02/24/2020

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 _____	02/06/2020

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 658	Continued From page 1 instructions. . . ." Manufacturer information for NovoLog insulin found at www.nov-pi.com/novolgpdf, stated, ". . . Screw the needle tightly onto your FlexPen . . . Pull off the big outer needle cap. . . . To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. . . . press the push-button all the way in. . . . A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure . . . ." Observation on 02/04/20 at 4:56 p.m. showed a licensed nurse (#7) prepared an insulin pen for injection for Resident #6. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield before priming the insulin pen. With the shield still in place, the nurse was unable to visualize a stream or drop of insulin from the needle tip. During an interview on 02/05/20 at 5:00 p.m. an administrative nurse (#6) confirmed staff failed to correctly prime the insulin pen.	F 658	along with the Plan of Correction (POC). Procedure/policy was also reviewed. A competency evaluation addressing proper priming of the insulin pen was completed on each individual nurse in attendance at the in-service. Nurses absent at this in-service will have a competency evaluation completed on them by 03/03/2020. 5. Preparation of the insulin pen injection for Resident #6 from the survey roster along with other residents who receive insulin via a pen, will be randomly observed for proper priming of the insulin pen via Quality Assurance (QA) or Quality Assurance & Performance Improvement (QAPI). This monitoring will be conducted by the Director of Nursing (DON) or Designee. 6. QA/QAPI monitoring will be conducted as follows: " Weekly for four (4) weeks: 02/16/2020 thru 03/13/2020 (that is 4 full weeks) " Monthly for three (3) months (April-May-June 2020) " Quarterly for two quarters: July Quarter and October Quarter of 2020 with QA/QAPI monitoring completed by 12-31-2020 " 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 and updated policies at the next QA/QAPI meeting tentatively set for 04/30/2020.	

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 _____	02/06/2020

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 658	Continued From page 2	F 658	Then at the QA/QAPI quarterly meetings after 04/30/2020, only the monitoring results will be reported to the committee through 12/31/2020. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 7. Completion date 03/03/2020	
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 observation, record review, review of facility policy, and staff interview, the facility failed to provide sufficient supervision and/or assistive devices for 1 of 2 sampled residents (Resident #52) who required a mechanical lift to transfer. Failure to use the correct transfer method placed Resident #52 at risk for falls with injury. Finding include: Review of the facility policy titled "Transfers with a Mechanical stand or lift" occurred on 02/06/20. This policy, revised August 2019, stated, ". . . the CNA (certified nursing assistant) should report any issues with transfers to the charge nurse and or OT/PT (Occupational/Physical Therapist) . . . get approval for a decision to upgrade or	F 689	F689 1. It is the policy of MMHCC to assure that Residents #52 from the survey sample roster and all the residents of MMHCC that require any type of transfer assistance will receive adequate supervision and assistance as to prevent accidents. 2. Resident #52 from the survey sample roster was re-assessed on 02/05/2020 by the Occupational Therapist (OT) and Physical Therapist (PT) and resident□s transfers were upgraded to a mechanical lift transfer to prevent potential injury to the resident and/or Certified Nurses□ Aide (CNA) staff. Nursing staff was noted of the change in the transfer technique for	3/3/20

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 _____	02/06/2020

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 689	Continued From page 3 downgrade a mechanical device or go from a manual/assisted transfer to the use of a mechanical device or vice versa . . ." Review of Resident #52's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 01/14/20, identified the resident required extensive assistance from two or more staff members and was at risk for falls. The current care plan identified, ". . . [Resident #52] is at risk for falls . . . history of falls with injury . . . unsteady gait . . . dizziness . . . black outs . . . staff will report falls and changes . . ." The OT/PT notes, dated January 7- February 4, 2020, stated, ". . . recommend keeping at assist of 2 people . . . has had multiple falls in the past 4 weeks . . . stumbles after taking 1-2 steps . . . continues to be at an increased risk for falls . . . loss of balance while standing, balance problems when using walker or assistive devices . . . transfers continue to fluctuate due to her functional abilities . . ." On 02/04/20 at 3:22 p.m., observation showed two CNAs (#9 and #10) placed a gait belt around Resident #52's waist and attempted to stand/pivot her from the wheelchair to the toilet. The staff failed to tighten the gait belt around Resident #52's waist and the belt slip up into the arms/axillae.The resident's knees were bent and she failed to fully bear weight. One CNA (#9) held Resident #52 under her buttocks as the other CNA (#10) pulled the gait belt upward under her arms/axillae and the resident yelled out in pain. During the three transfer attempts, the CNAs (#9	F 689	this resident via ECS on 02/05/2020. 3. On 02/05/2020 the DON placed a note in the nursing communication book and via ECS which addressed difficult transfer issues and the necessity for the CNAs to stop the transfer and inform the charge nurse of the need for him/her to come and assess the situation. 4. The current policy/procedure was reviewed and updated; stressing the importance for the CNA to report any issue with transfers to the charge nurse and/or OT/PT. Title of the procedure was changed to Assessment for Upgrade or Downgrade in Transfer Method. 5. Individual in-services were held with the Nurses and the CNAs on 02/19/2020 at which time the deficiency concern with Tag F689 was reviewed along with the POC. 6. OT and PT will continue to assess and evaluate any transfer concerns with Resident #52 and all other residents. Transfer changes that are necessary will be discussed with the Resident Care Coordinators (RCC) and then nursing staff. Any upgrade or downgrade in residents transfer method will be noted in that resident□s Activities of Daily Living (ADLs). Notification of a transfer change with a resident will be sent by OT/PT via ECS and/or placed in the nursing communication book. Transfer issues and following the policy regarding changes in transfer will be monitored for QA/QAPI purposes. 7. QA/QAPI monitoring will be conducted as follows:	

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 _____	02/06/2020

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 689	Continued From page 4 and #10) repeatedly told Resident #52 to "stand up". On the fourth attempt, Resident #52 nearly fell on the floor after CNA (#9) transferred Resident #52 by lifting under the residents buttocks. The CNAs (#9 and #10) failed to report Resident #52's near miss to the Nurse and/or OT/PT staff. (After the surveyor notified the nurse regarding the resident's transfer, the record showed the OT/PT notes were updated). The OT/PT notes, dated 02/05/20 at 11:31 a.m., identified "the resident . . . assisted to toilet with 2 assist and gait belt . . . moaning and groaning and laid back down . . . at this point the transfer was not safe . . . tolerated EZ lift transfer well with 2 assist . . . the use of the EZ lift and commode may greatly aggravate the Resident . . . when needs to use the bathroom, staff will place the bed pan . . . Plan: EZ lift with 2 assist. Toileting: bed pan or check and change . . ." During an interview on 02/05/20 at 2:16 p.m., an administrative nurse (#5) stated she expects staff to report any transfer issues so residents can be promptly re-evaluated to prevent possible injury.	F 689	" Weekly for four (4) weeks: 02/16/2020 thru 03/13/2020 (that is 4 full weeks) " Monthly for three (3) months (April-May-June 2020) " Quarterly for two quarters: July Quarter and October Quarter of 2020 with QA/QAPI monitoring completed by 12-31-2020 " 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 and updated policies at the next QA/QAPI meeting tentatively set for 04/30/2020. Then at the QA/QAPI quarterly meetings after 04/30/2020, only the monitoring results will be reported to the committee through 12/31/2020. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 8. Completion date 03/03/2020	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		3/3/20

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 _____	02/06/2020

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 758	Continued From page 5 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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 _____	02/06/2020

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 758	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 3 sampled residents (Resident #14) who received an as needed (PRN) psychotropic medication. Failure to ensure the physician limited the use of PRN psychotropic medications to 14 days or extended the order including the rationale for the PRN psychotropic medications may result in residents' receiving an unnecessary medication and experiencing adverse effects. Findings include: Review of the facility reference sheet titled "Regulations with PRN Psych Med Orders" occurred on 02/05/20. This undated reference sheet stated, " . . . Looking at the Regulations for use of PRN psychotropic (antidepressants, antianxiety, hypnotics). The order has to be for 14 days and then re-evaluated by the provider. The order can be written again for a certain number of days and re-evaluated again. All the provider needs to do to extend the order is document the rationale for extending the PRN order. . . ." Review of Resident #14's medical record occurred on all days of survey. Diagnoses included dementia, hallucinations, psychosis, restlessness and agitation. A physician's order for Ativan (antianxiety medication), dated 12/04/19, stated, "1 mg [milligram] by mouth as needed BID [two times a day] for 90 days." The record lacked documentation regarding the	F 758	F758 1. It is the policy of MMHCC to assure that Resident #14 from the survey sample roster and all the residents of MMHCC drug regime are free from unnecessary psychotropic medications/PRN use. 2. In regards to the PRN Ativan order for Resident #14 from the survey sample roster, a clarification order was obtained on 02/05/2020 stating the rationale for the continuation of the med. 3. The DON sent a message to nurses on 02/05/2020 via ECS addressing the necessity of documentation addressing the rationale as to why a PRN psychotropic medication is warranted to be continued. 4. The procedure addressing PRN psychotropic med use was updated 02/05/2020 and placed in the provider□s folders for reference. 5. Nursing in-service was held on 02/19/2020 at which time the deficiency concern with Tag F658 was reviewed along with the POC. 6. For QA/QAPI purposes the DON or Designee will review all PRN psychotropic med orders to assure rationale for initial use of or continuation of is noted along with the order. With this review if concerns are noted teaching will be done with the nursing staff and providers by the DON or Designee. 7. QA/QAPI monitoring will be conducted as follows: " Weekly for four (4) weeks:	

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 _____	02/06/2020

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 758	Continued From page 7 rationale for extending the PRN Ativan. During an interview on 02/04/20 at 3:30 p.m., an administrative nurse (#6) confirmed the staff failed to ensure the provider indicated the rationale for extending the duration for the PRN Ativan on Resident #14.	F 758	02/16/2020 thru 03/13/2020 (that is 4 full weeks) " Monthly for three (3) months (April-May-June 2020) " Quarterly for two quarters: July Quarter and October Quarter of 2020 with QA/QAPI monitoring completed by 12-31-2020 " 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 and updated policies at the next QA/QAPI meeting tentatively set for 04/30/2020. Then at the QA/QAPI quarterly meetings after 04/30/2020, only the monitoring results will be reported to the committee through 12/31/2020. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. 8. Completion date 03/03/2020	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		3/3/20

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 _____	02/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8	F 880		

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

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

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

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 _____	02/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/31/19 Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection prevention protocols for 1 of 14 sampled residents (Resident #48) observed during perineal cares. Failure to perform proper hand hygiene and ensure proper glove use may result in the spread of infectious agents to residents, staff and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 02/06/20. This policy, dated August 2019, stated, "Hand hygiene is indicated and will be performed. . . . Between resident contacts. . . . after removing personal protective equipment [PPE], including gloves. . . . After handling items	F 880	F880: 1. It is the policy of MMHCC to assure that Resident #48 from the survey sample roster and all the residents of MMHCC have a safe, sanitary and comfortable environment. 2. Resident #48: Staff was informed via the nursing communication book on 02/05/2020 as well as 02/06/2020 in regards to the concerns about proper hand hygiene when peri cares are performed on a resident. 3. The current policy/procedure on hand hygiene as well as perineal cares were reviewed and no changes were necessary. 4. Individual in-services were held with the Nurses and the CNAs on 02/19/2020 at which time the deficiency tags and concerns of each tag were reviewed	

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 _____	02/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 potentially contaminated with blood, body fluids, secretions, or excretions. . . . After assistance with personal body functions . . . after sneezing, coughing, and/or blowing or wiping nose. . . ." Review of the facility policy titled "Perineal Care with Peri wash & washcloths or with disposable wipes" occurred on 02/06/20. This policy, dated August 2019, stated "Perform hand hygiene and put on gloves. . . . Change gloves if soiled with BM [bowel movement] and continue with perineal care. . . . Remove gloves following peri care. Assure resident is safely positioned then wash hands [soap and water or hand gel]. . . If ointment or cream is necessary to the perineum, put on new gloves, apply ointment/cream on the perineum form [sic] front to back. A new glove is to be used if more cream/ointment is to be applied. . . ." Observation on 02/03/20 at 4:33 p.m. showed two certified nursing assistants (CNAs) (#1 and #2) entered Resident #48's room to perform afternoon cares. The CNAs donned gloves and gathered the needed supplies to check and change Resident #48. The CNA (#1) opened Resident #48's brief finding a large amount of soft stool present. The CNA (#1) performed perineal care while the other CNA (#2) handed wipes to him/her. The CNA's (#1) gloves became soiled with stool, he/she wiped the gloves with disposable wipes and continued the perineal cares. Without changing gloves, the CNA (#1) then applied cream to Resident #48's coccyx area and groin. The CNA (#1) placed the clean brief on Resident #48, fastened it, and then removed the gloves. The CNA (#1) failed to perform hand hygiene after removing the gloves.	F 880	along with the POC. 5. QA/QAPI monitoring for this concern will be conducted by the DON/Designee with random observations of hand hygiene with peri cares on Resident #48 from the survey roster along with other residents that are dependent with this particular task. 6. QA/QAPI monitoring will be conducted as follows: " Weekly for four (4) weeks: 02/16/2020 thru 03/13/2020 (that is 4 full weeks) " Monthly for three (3) months (April-May-June 2020) " Quarterly for two quarters: July Quarter and October Quarter of 2020 with QA/QAPI monitoring completed by 12-31-2020 " 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 and updated policies at the next QA/QAPI meeting tentatively set for 04/30/2020. Then at the QA/QAPI quarterly meetings after 04/30/2020, only the monitoring results will be reported to the committee through 12/31/2020. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee 7. Completion date 03/03/2020	

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 _____	02/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

The CNAs (#1 and #2) transferred Resident #48 to the wheelchair via mechanical lift. The CNA (#1) combed Resident #48's hair, placed the oxygen cannula in Resident #48's nose before using the rooms alcohol based hand rub (ABHR) to clean his/her hands.

Observation on 02/04/20 at 3:47 p.m. showed two CNAs (#3 and #4) entered Resident #48's room to perform afternoon cares. The CNA (#4) donned gloves while the other CNA (#3) failed to don gloves to check Resident #48's brief. Both CNAs touched Resident #48's dry brief and perineal area. The CNA (#3) failed to perform hand hygiene after touching the resident's perineal area with bare hands. The CNA (#3) then wiped his/her nose on the collar of his/her shirt and again failed to perform hand hygiene.

During an interview on 02/05/20 at 4:45 p.m., an administrative nurse (#5) confirmed that she expected staff to change gloves when visibly soiled with stool, and worn when providing resident perineal care, and staff to perform hand hygiene per facility policy.

Failure to perform hand hygiene and ensure proper glove usage may result in the spread of infections to residents, staff and visitors.