STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING _____ B. WING _____	C 08/09/2023

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MAPLE MANOR CARE CENTER	**1116 9TH AVE LANGDON, ND 58249**

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 08/07/23 and concluded 08/09/23. The issues identified by the complainant were found to be in compliance.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		9/22/23

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

Electronically Signed | 09/01/2023

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F 582	Continued From page 1 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices, Centers for Medicare and Medicaid Services instructions, and staff interview, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form and Notice of Medicare Non-coverage (NOMNC) form two days in advance of discharge for 2 of 3 residents (Resident #23 and #38) discharged from Medicare Part A services. Failure to provide Medicare Part A letters/notices within the required time frame has the potential to limit the residents' right to an expedited review of service termination (NOMNC) and/or to exercise their rights to Medicare Part A services (SNFABN).	F 582	1.Residents #23 and #38 were identified as being affected by this practice. Affected residents have been reissued notice of NOMNC with corrected dates. 2.All residents covered by Medicare have the potential to be affected. 3.The current policy/procedure for Notice of Medicare/Medicaid Coverage/Liability is being reviewed and revised if necessary. Staff that are responsible for issuing NOMNC paperwork have been educated. 4.The MDS Coordinator will be responsible to monitor/audit. Audits will be reviewed by the administrator or designee and further discussion will take	

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F 582	Continued From page 2 Findings include: Review of [Medicare Advantage/Health Plan] Expedited Determination Notices (MA) webpage on 08/09/23, at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/instructions-for-notice-of-medicare-non-coverage-nomnc.pdf, stated, " . . . The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. . . ." Review of the Medicare notices provided by the facility on occurred on 08/09/23, and showed facility staff failed to provide the forms two calendar days before Resident #23's services ended on 06/30/23, and before Resident #38's services ended on 04/04/23. During an interview on 08/09/23 at 10:05 a.m., an administrative staff member (#2) confirmed she expected staff to provide termination of Medicare Part A services letters/notices to residents or resident representatives two days prior to the end of the resident's Medicare Part A services.	F 582	place at QAPI meetings to review and recommend any changes necessary. Quality assurance/monitoring will be implemented by 9/11. Audits will be performed on Medicare covered residents weekly x4 weeks, monthly x2 months, and quarterly thereafter, until 100% compliance is achieved.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		9/22/23

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F 623	Continued From page 3 Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F 623		

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F 623	Continued From page 4 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 5 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or their representative and/or the State Long Term Care Ombudsman written notice of transfer for 1 of 4 residents (Resident #30) with a recent hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights or inform the Ombudsman of the transfer. Findings include: Review of the facility policy titled "Transfer or Discharge Notice" occurred on 08/09/23. This policy, revised March 2021, stated, ". . . Under the following circumstances, the notice is given as soon as it is practicable but before the transfer . . . the resident and representative are notified in writing . . . A copy is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. . . ." Review of Resident #30's medical record occurred on all days of survey and identified a hospital transfer on 07/23/23. The resident's medical record lacked evidence the resident/representative received a copy of the transfer notice and the facility informed the State	F 623	1.Resident #30 was sent to the hospital without a transfer/discharge notice. Resident #30 was provided with the reasons for transfer/discharge in writing by the social services designee on 8/31/2023. Transfer/Discharge Notice will be scanned into the resident□s EMR, sent to the ombudsman, and given to cognitive resident. 2.All residents who may transfer outside the facility have the potential to be affected. 3.The current policy/procedure for Transfer/Discharge Notice is being reviewed and revised if necessary. Future residents will be provided the Transfer/Discharge notice prior to leaving the facility. Copies will be scanned into the EMR and faxed to the ombudsman. Social services or designee will document that copies were faxed to ombudsman and mailed to resident and/or representative. Nursing staff will be in-serviced on the resident transfer policy and all required elements on 9/13/2023. 4.The social services designee will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. All audits will be reviewed by the Administrator or designee and brought to	

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F 623	Continued From page 6 Ombudsman of the hospital transfer. During an interview on 08/09/23 at 12:35 p.m., administrative member (#1) stated, "We are unable to produce a copy of [Resident #30's name] transfer form."	F 623	QAPI for review and recommendation. Audits for transfer and discharge documentation will begin weekly x 4weeks, then monthly x2 months, and quarterly thereafter until 100% compliance is achieved.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 15 sampled residents (Resident #8 and #9). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION H: BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual, revised October 2019, page H-2 states, ". . . Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C) . . . "	F 641	1.Residents #8 and #9 were affected by this practice. Resident #9 MDS was corrected on 8/31/2023 to reflect admission to hospice in January. Resident #8 MDS was corrected to reflect indwelling catheter instead of ostomy on 8/16/2023. 2.All residents have the potential to be affected. 3.Staff that are responsible for MDS submissions have been educated. 4.The MDS coordinator will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. All audits will be reviewed by the Administrator or designee and brought to QAPI for review and recommendation. Audits will begin weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved.	9/22/23

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F 641	Continued From page 7 Review of Resident #8's medical record occurred on all days of survey. A physician's order, dated 05/18/23, identified the resident as having a suprapubic catheter. The annual MDS, dated 07/01/23, identified the resident as having an ostomy. During an interview on the afternoon of 08/09/23, two administrative staff members (#2 and #3) confirmed staff coded Resident #8's MDS incorrectly. SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2019, page O-5 states, ". . . Code residents identified as being in a hospice program . . . " Review of Resident #9's medical record occurred on all days of survey. A physician's order, dated 12/30/22, identified the resident admitted to hospice. The significant change MDS, dated 01/04/23, failed to reflect the resident received hospice services. During an interview on 08/09/23 at 3:35 p.m., an administrative staff member (#2) agreed staff coded Resident #9's MDS incorrectly.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the	F 644		9/22/23

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F 644	Continued From page 8 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, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #28) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual, revised 12/29/20, page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing	F 644	1.Resident #28 was affected by this practice. Resident #28 PASARR will be re-completed on 9/1/2023. 2.All residents or potential residents who have PASARRs completed have the potential to be affected. 3.The current policy/procedure for PASARR is being reviewed and revised if necessary. Staff that are responsible for requesting and reviewing PASARR will be educated by 9/11. 4.The social services designee will be responsible to monitor/audit. The MDS coordinator will monitor to assure that all submitted PASARRs were done appropriately. Quality assurance/monitoring will be implemented by 9/11. All audits will be reviewed by the Administrator or designee and brought to	

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F 644	Continued From page 9 facility staff must contact Maximus to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #28's medical record occurred on all days of survey. The record showed an initial PASARR completed November 2022, prior to the resident's admission to the facility, and identified a diagnosis of dementia and no mental illness. The resident's current diagnosis list identifies a diagnosis of anxiety disorder and schizophrenia as of admission to the facility. The record lacked evidence the facility completed a Level I screening/change in status assessment with the addition of the two diagnoses upon admission. During an interview on 08/09/23 at 3:52 p.m., two administrative staff members (#2 and #3) confirmed the facility failed to contact Maximus to update the Level I screen with the addition of the new diagnoses.	F 644	QAPI for review and recommendation. Audits will begin weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		9/22/23

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F 657	Continued From page 10 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the current status for 3 of 15 sampled residents (Resident #8, #17, and #35). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plans, Comprehensive Person-Centered" occurred on	F 657	1.Residents #8, #17 and #35 were affected by this practice. Resident #8 care plan was updated 8/10/2023. Residents #17 and #25 care were corrected on 8/31/2023. 2.All residents have the potential to be affected. 3.The current policy/procedure for updating of care plans is being reviewed and revised if necessary. The IDT team and nursing staff will be educated on care plans and revisions and the timeliness of completion on 9/13/2023.	

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F 657	Continued From page 11 08/09/23. This policy, revised March 2022, stated, ". . . care plans are revised as information about the resident and the resident's condition change. . ." -Review of Resident #8's medical record occurred on all days of survey. A progress note, dated 07/13/23, stated, ". . . does have positioning wedges, but continually rolls himself to different position . . ." Observations on 08/08/23 and 08/09/23 showed the resident utilized positioning devices (positioning wedges and leg spacer). The current care plan lacked information related to Resident #8's use of positioning devices. During an interview on 08/09/23 at 2:38 p.m., an administrative nurse (#3) confirmed the current care plan failed to reflect the resident's need for positioning devices. - Review of Resident #17's medical record occurred on all days of survey. Review of nursing progress notes showed the following: * 07/31/23 at 1:26 p.m., ". . . Resident is COVID-19 positive. . . . Resident moved to an empty household at this time to quarantine. . . ." * 08/07/23 at 2:30 p.m., ". . . Resident remains on isolation precautions. . . . " - Review of Resident #35's medical record occurred on all days of survey. Review of nursing progress notes showed the following: * 07/31/23 at 10:30 a.m., ". . . Binax covid test completed, positive result . . . " * 08/07/23 at 2:46 p.m., ". . . Resident remains on	F 657	4.The MDS coordinator will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. All audits will be reviewed by the Administrator or designee and brought to QAPI for review and recommendation. Audits will begin weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is achieved.	

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F 657	Continued From page 12 isolation precautions . . . " Observation on 08/07/23 at 2:16 p.m., showed an isolation cart in the hall outside of Resident #35's room, and a sign on the door which stated, "airborne precautions". During an interview on 08/09/23 at 10:20 a.m., two administrative nurses (#3 and #4) agreed Resident #17 and #35's care plans lacked problems, goals, and interventions related to COVID-19 and transmission based precautions.	F 657		
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.	F 756		9/22/23

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F 756	Continued From page 13 (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. §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 and staff interview, the facility failed to ensure the consultant pharmacist reported drug regimen irregularities for 2 of 5 sampled residents (Resident #18 and #25) selected for drug regimen review. Failure to report drug regimen irregularities and act upon recommendations may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included impulse disorder, major depressive disorder, anxiety disorder, and avoidant personality disorder. A "Fax Communication to Physician", dated 03/12/23, noted the resident has been on Abilify (antipsychotic medication) since 01/19/22. The medical record lacked	F 756	1.Residents #18 and #25 were identified as being affected by this practice. Resident #18 had a GDR addressed on 8/11/2023. Resident #25 had a GDR addressed on 8/11/2023. The consultant pharmacists were educated on 8/18/2023 on the need for GDR to be recommended in pharmacy reviews. 2.All residents who take medications have the potential to be affected. 3.The current policy for pharmacy services is being reviewed and revised if necessary. IDT team including consulting pharmacists and physicians will meet to discuss plans for appropriate recommendations and notification going forward. 4.The Director of Nursing will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. All audits will be reviewed by the	

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F 756	Continued From page 14 evidence to show the consultant pharmacist communicated the need for a gradual dose reduction (GDR) to the resident's physician at any time from January 2022 to March 2023. - Review of Resident #25's medical record occurred on 08/09/23. A "Fax Communication to Physician", dated 04/12/23, noted the resident has been on Seroquel (an antipsychotic medication) since 12/28/20. The medical record lacked evidence to show the consultant pharmacist communicated the need for a GDR to the resident's physician at any time within the past year. During an interview on 08/09/23 at 3:56 p.m., an administrative staff member (#3) confirmed the consultant pharmacist failed to communicate the irregularity to the staff.	F 756	Administrator or designee and brought to QAPI for review and recommendation. Audits will begin monthly x6 months, until 100% compliance is achieved.	
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; (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	F 758		9/22/23

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F 758	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 5 sampled residents (Resident #18 and #25) selected for medication regimen review. Failure to attempt a gradual	F 758	1.Residents #18 and # 25 were identified as being affected by this practice. GDR for both residents were addressed on 8/11/2023 by physicians and copies were scanned into EMR. 2.All residents with medications requiring	

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F 758	Continued From page 16 dose reduction (GDR) or identify contraindications for a GDR may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Tapering Medication and Gradual Dose Reduction" occurred on 08/09/23. This undated policy stated, ". . . Residents who use psychotropic medications shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs. . . . Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated. . . ." - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included impulse disorder, major depressive disorder, anxiety disorder, and avoidant personality disorder. A "Fax Communication to Physician", dated 03/12/23, noted that the resident has been on Abilify (antipsychotic medication) since 01/19/22. The medical record lacked evidence to show the provider attempted a GDR (or identified contraindications) at any time from January 2022 to March 2023. - Review of Resident #25's medical record	F 758	GDRs have the potential to be affected. 3.The current policy/procedure for GDRs is being reviewed and revised if necessary. The IDT team including consulting pharmacists and physicians will meet to discuss plans for appropriate GDR recommendations going forward. 4.The Director of Nursing will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. All audits will be reviewed by the Administrator or designee and brought to QAPI for review and recommendation. Audits will begin monthly x6 months, until 100% compliance is achieved.	

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F 758	Continued From page 17 occurred on 08/09/23. A "Fax Communication to Physician", dated 04/12/23, stated, ". . . Resident has been on Lorazepam [an antianxiety medication] since 5/3/22 and Seroquel [an antipsychotic medication] 50 mg [milligrams] since 12/28/20. Would you like to try any gradual dose reductions? . . ." The medical record lacked evidence to show the provider attempted a GDR (or identified contraindications) for the Seroquel within the past year. During an interview on 08/09/23 at 3:56 p.m., an administrative staff member (#3) confirmed the facility failed to attempt a GDR for the residents' medication.	F 758		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 868		9/22/23

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F 868	Continued From page 18 (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of Quality Assurance and Performance Improvement (QAPI) meeting minutes, facility policy, and staff interview, the facility failed to ensure participation by the medical director for 1 of 3 quarterly meetings (May 9, 2023) reviewed. Findings include: Review of the facility policy titled "Quality Assurance and Performance Improvement" occurred on 08/09/23. This policy, revised 01/20/23, stated, ". . . The QAPI Committee shall be interdisciplinary and shall: a. Consist at a minimum of: . . . The Medical Director or his/her designee . . . Meet at least quarterly . . ." Review of QAPI meeting minutes occurred on 08/09/23. The May 9, 2023 QAPI meeting minutes failed to identify the medical director attended the meeting or reviewed meeting	F 868	1.No residents were identified as being affected by this practice. 2.No residents have the potential to be affected by this practice. 3.The current policy/procedure for QAPI meetings is being reviewed and revised if necessary. 4.The executive director will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. Audits will be reviewed by the Administrator and brought to QAPI for review and recommendation. Audits will be done quarterly to ensure all appropriate signatures have been obtained.	

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F 868	Continued From page 19 minutes. During an interview on 08/09/23 at 1:48 p.m., an administrative staff member (#1) stated she could not find evidence the medical director attended the meeting or reviewed the minutes.	F 868		
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; §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	F 880		9/22/23

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F 880	Continued From page 20 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. §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:	F 880		

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F 880	Continued From page 21 HAND HYGIENE 1. Based on observation, review of professional reference, and staff interview, the facility failed to follow standards of infection control for 1 of 4 sampled residents (Resident #24) observed while receiving toileting assistance. Failure to follow infection control practices regarding hand hygiene during cares has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the Centers for Disease Control (CDC) document titled "When and How to Wash Your Hands," page 1, reviewed November 15, 2022, found at https://www.cdc.gov/handwashing/when-how-handwashing.html, stated, ". . . Washing hands can . . . prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to people when you: Touch your eyes, nose, and mouth with unwashed hands . . . eat food and drinks with unwashed hands. Touch surfaces or objects that have germs on them . . . Key Times to Wash Hands . . . before . . . eating food . . . After using the toilet . . ." Observation on 08/08/23 at 11:07 a.m. showed a certified nurse aide (CNA) (#6) assist Resident #24 with toileting. Resident #24 placed both her hands on the toilet seat to lower herself onto and off the toilet. After toileting, the CNA (#6) assisted Resident #24 to a table in the dining room and gave her a drink. The CNA (#6) failed to offer/provide Resident #24 hand hygiene after	F 880	1.Residents #24, #17, and #35 were affected by this practice. Residents #17 and #35 room signage was corrected on 8/9/2023. Education was provided to staff to encourage proper resident hand hygiene. 2.All residents who test positive for COVID-19 and are toileted have the potential to be affected. 3.The current policy/procedure for resident handwashing and COVID-19 precautions are being reviewed and revised if necessary. All staff will be educated at staff meeting on 9/6/2023 to offer resident hand hygiene. All staff will be educated at the staff meeting on 9/6/2023 regarding COVID PPE. 4.The Director of Nursing will be responsible to monitor/audit. Quality assurance/monitoring will be implemented by 9/11. Audits will be reviewed by the Administrator and brought to QAPI for review and recommendation. Audits will begin weekly x4 weeks, monthly x2 months, and quarterly thereafter until 100% compliance is	

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F 880	Continued From page 22 toileting or before giving the resident her drink. During an interview on 08/09/23 at 12:35 p.m., an administrative staff member (#1) stated she expected staff to offer hand hygiene to residents after toileting. TRANSMISSION BASED PRECAUTIONS 2. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards for 2 of 2 residents (Resident #17 and #35) on isolation precautions related to positive COVID-19 status. Failure to place visible isolation signage, close doors, and properly utilize personal protective equipment (PPE) for residents on isolation/transmission based precautions has the potential to spread the COVID-19 virus to other residents, staff, and visitors. Findings Include: Review of the facility policy titled "Isolation - Categories of Transmission-Based Precautions", occurred on 08/09/23. This policy, revised September 2022, stated, ". . . Transmission-based precautions are initiated when a resident develops signs and symptoms of an infection . . . When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door . . . so that personnel and visitors are aware of the need for and the type of precaution . . . The signage informs the staff of the type of CDC [Centers for Disease Control] precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. . . . " Review of the facility policy titled "Coronavirus	F 880		

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F 880	Continued From page 23	F 880		

disease (COVID-19) Identification and Management of Ill Residents", occurred on 08/09/23. This policy, revised September 2022, stated, ". . . Residents with signs and/or symptoms of COVID-19 (SARS-COV-2 infection) are identified and isolated to help control the spread of infection to other residents, staff and visitors . . . Residents with . . . confirmed SARS-CoV-2 infection are placed in a single-person room. The door will be kept closed . . . Staff who enter the room of a resident with . . . confirmed SARS-CoV-2 infection will adhere to standard precautions and use a NIOSH [National Institute for Occupational Safety & Health]-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (ie., goggles or a face shield that covers the front and sides of the face) . . ."

During the entrance conference interview on 08/07/23 at 1:33 p.m., an administrative nurse (#3) identified Residents #17 and #35 as COVID-19 positive and in transmission based precautions. She further identified Resident #17 as moved to the isolation unit, Household 100.

- Observation on 08/07/23 at 2:16 p.m., showed an isolation cart in the hallway outside of Resident #35's room, and a sign on the door stated, "Airborne precautions everyone must: clean their hands, including before entering and when leaving the room. Put on a fit tested N-95 or higher level respirator before room entry." The sign failed to identify the need for staff to apply gown and gloves prior to entering the room.

- Observation on 08/08/23 at 10:05 a.m., showed closed double doors to the Household 100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	**1116 9TH AVE LANGDON, ND 58249**

(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 24 hallway, previously identified as the designated COVID-19 unit, an isolation cart in the hallway outside the doors. The doors lacked signs that identified the isolation unit, instructions for PPE use, and/or instructions to see the nurse. - Observation on 08/08/23 at 10:16 a.m., showed a certified nurse aide (CNA) (#5) exited Resident #35's room wearing a gown, N95 respirator, goggles, and donned gloves from isolation cart, removed several large garbage bags from a roll of garbage bags laying on the isolation cart, and returned to the resident's room. - Observation on 08/09/23 at 10:13 a.m., showed the door to Resident #17's room open, and the resident sitting in the wheelchair. During an interview on 08/09/23 at 10:20 a.m., two administrative nurses (#3 and #4) confirmed they expected staff to remove all PPE prior to exiting a resident room, close the door for a resident in transmission based precautions and agreed they expected staff to post appropriate signs identifying the PPE needed to enter both Resident #35's room and the COVID isolation unit (Household 100) where Resident #17 was currently isolated.	F 880		