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 _____ APR 5 2010	03/18/2010

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 For the standard Medicare/Medicaid recertification survey started on 03/15/10 and completed on 03/18/10, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review.	F 000	ADL Care Provided for Dependent Residents: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that all residents who are unable to carry out services to maintain good nutrition, grooming and personal oral hygiene/health will receive assistance to do so.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, facility staff failed to provide oral cares for 4 of 5 sampled residents (Resident #3, #11, #12, and #13) who received nutrition via tube feeding and dependent on staff for total assistance with oral hygiene. This practice has the potential to increase the incidence or progression of respiratory diseases, contribute to halitosis, and affect the teeth and gums; as well as allowing the introduction of pathogens which could cause infections, including pneumonia. Findings include: - Review of Resident #13's medical record occurred on 03/17/10. Diagnoses included cerebral palsy, dysphagia, seizure disorder, and cerebral vascular accident (CVA). Resident #13 required three liters per minute of continuous oxygen through a nasal cannula. The resident received all nutrition through tube feeding and	F 312	*On 3/31/10 the Director of Nursing (DON) reviewed the Deficiency report From the State Health Dept. from the survey conducted 3/15 through 3/18/10 at MMHCC. For the F312 tab deficiency the following was put into place 4/1/10: 1. On all residents that required oral cares every two hours: the Certified Nursing Assistants' (CNA's) activity of daily living flow sheet (ADL's) charting for every two hour oral care will continue to state "Oral cares to be done q 2 hours during the day and when awake at night" and beginning 04/01/10 the charting will be done every two hours from 6AM through 10PM and the night shift will be just one time charting for the shift (as it was before) as the cares will be done only if resident is awake. Note that prior to this change the charting for this particular ADL was being done but only one time for the day shift and pm shift. 2. Effective April 01,2010 a Quality Assurance (QA) study will be implemented under the supervision of the DON to assure residents of MMHCC that require every two hour oral care as stated on the care plan are receiving that care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/31/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1 received nothing by mouth. A continuous formula of Jevity 1.2 Cal (a formula providing complete, balanced nutrition for tube feeding) at a rate of 35 milliliters per hour. Resident #13's annual Minimum Data Set (MDS), dated 02/17/10, identified severely impaired cognition and total assistance required for personal hygiene. Review of the Resident Assessment Protocol (RAP), dated 02/17/10, stated "Tube feeding: . . . mouth: fetid halitois (bad breath); in need of frequent oral cares . . ." Resident #13's care plan stated, "Potential for alteration in oral status . . . oral cares refer to daily CNA [certified nursing assistant] ADL [activities of daily living] flow sheet." The CNA charting flow sheet stated, "10/14/09 NPO [nothing by mouth] Oral Cares to be done q [every] 2 hours special instructions: use Lemon Glycerine Swab or moistened toothette q 2 hours or more often if nec [necessary] as is NPO. May use bite stix to keep mouth open." Observation on 03/17/10 at 11:05 a.m. showed Resident #13 in bed. The CNA (#2) stated she and another CNA put the resident in bed a short time before 11:00 a.m., and they planned on getting her up after dinner. Observation of cares provided for Resident #13 on 03/17/10 showed the following: * At 12:55 p.m., the CNAs (#1 and #2) transferred the resident from the bed to a semi-reclined wheelchair. The CNA (#2) applied vaseline to the resident's lips. The CNAs failed to provide oral cares. * At 3:20 p.m., the CNAs (#3 and #4) transferred the resident from the wheelchair to the bed. The	F 312	3.QA monitoring for this concern in regards to the charting by the CNA's will consist of the following: Daily for the month of April (04/01 to 04/30/10) one of the charge nurses for the day and evening shift and the charge nurse for the night shift will check that the oral cares on the residents of concern (Residents #3,#11,#12,& #13 and any future residents who may require every 2 hour oral cares) were charted as noted in #1 above. The nurse will check the ADL charting with the CNA's prior to the end Of the CNA's shift to assure that oral cares were completed as noted. Following the daily charting the monitoring of the ADL charting will then be randomly checked on a weekly basis by the DON for the four full weeks in the month of May)weeks of 5/02,5/09,5/16 and 5/23/10) Following weekly monitoring, monthly monitoring will be done for 1 month (June 2010) and then quarterly (September & December 2010) with QA monitoring for ADL charting completed 12/31/10. 4. QA monitoring for observation or oral cares on the residents of concern (Residents #3,#11,#12 & #13 and any future residents who may require every 2 hour oral cares) will consist of the DON doing random observations of oral cares on Residents #3,#11,#12 &#13 weekly for four full weeks in April (weeks of 04/04-04/11-04/18 & 04/25/10). Monthly for two months(May and June 2010) and then quarterly(September and	

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F 312	Continued From page 2 CNAs failed to provide oral cares. Observation on 03/18/10 at 8:30 a.m., showed the CNA (#2) provided oral care for Resident #13. The CNA (#2) stated oral cares are provided for Resident #13 every two hours but facility staff failed to provide these cares on 03/17/10 every two hours. - Resident #3's medical record review occurred on all days of survey. Diagnoses included, in part, cerebral vascular accident (CVA) with right hemiplegia, dysphagia, macular degeneration, and feeding tube placement. Resident #3 received nutrition through a feeding tube and could receive pudding once a day. The quarterly MDS, dated 01/18/10, identified no problems with short or long term memory, is independent in daily decision making, required total assist in eating with one person assist, extensive assist of one person for personal hygiene, and received nutrition through a feeding tube. Resident #3's care plan, updated 01/28/10, stated, "Provide oral care frequently. (q 2 hrs. [hours] or more often if necessary)." Observation of cares for Resident #3 identified the following: * 03/16/10 at 9:05 a.m. - The CNA (#10) provided peri cares, when finished the CNA failed to provide/offer oral cares to the resident. * 03/16/10 at 4:30 p.m. - Two CNA's (#12 and #13) transferred the resident from the wheelchair to bed, changed her brief and provided peri cares. Resident #3 then had a large emesis of tan liquid. The CNAs failed to provide oral cares after changing the resident's bedding and clothing.	F 312	December 2010) with QA monitoring for observation of oral cares completed 12/31/10. 5. If concerns with any of the afore mentioned monitoring is identified, immediate corrective action will be implemented. The DON will submit a report of the QA monitoring to the QA committee at each scheduled meeting. In the Absence of the DON and monitoring is due to be conducted, it will be done by a Resident Care Coordinator(copy of the monitoring forms are enclosed) 6.On April 07,2010, the separate monthly inservice for the Nurses and CNA's/CNA Helpers will be conducted (copy of the inservice addressing the concern is enclosed). At these inservices the facility's procedure for oral care (copy enclosed) will be reviewed. Nurses will be instructed to check at their report times that oral cares are being done and charted. The facility receives a monthly newsletter for the CNA's entitled "Nursing Assistant Monthly" that both the CNA's and Nurses review with their monthly inservice papers. For the April 07,2010 inservice papers the newsletter from September 2009 entitled "Oral Health" will be included (a copy is enclosed). It is an excellent newsletter addressing the importance of oral health and oral care for the elderly.	4/7/10

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F 312	Continued From page 3 * 03/16/10 at 4:38 p.m. - A staff nurse (#15) assessed Resident #3, turned off the Jevity feeding and failed to offer oral cares.. - Review of Resident #11's medical record occurred on 03/17/10. Diagnoses included dysphagia, history of bells palsy, Parkinson, inability to swallow from sialadenitis (inflammation of salivary glands), and aspiration pneumonia. The resident received all nutrition through a feeding tube and received nothing by mouth. Resident #11's quarterly MDS, dated 03/04/10, identified moderately impaired in daily decision making, extensive assistance of one or two persons with all ADL's, and eating did not occur. Review of the care plan, dated 03/04/10, stated; "No oral intake, provide oral cares frequently, q 2 hrs. or more often if necessary." On 03/17/10 at 4:10 p.m., observation showed a licensed nursing staff (#16) listened to Resident #11's bowel sounds, checked for residual, connected the Jevity 1.2 Cal formula to the feeding tube, and started the feeding tube at 55 ml (milliliter) per hour. When the resident talked during these cares, observation showed mucus strings on her lips. The nurse failed to provide oral cares. During an interview on 03/18/10, an administrative nursing staff member (#7) stated she would expect staff to provide the needed assistance with oral cares as indicated on the care plan. - Review of Resident #12's medical record occurred on March 17-18, 2010. Diagnoses included schizophrenia, seizure disorder, organic	F 312		

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F 312	Continued From page 4 brain syndrome with behavioral disturbance, dysphagia (difficulty swallowing), dysphasia (impaired ability to communicate), and mood disorder due to anoxic brain injury. The most recent MDS, dated 01/26/10, showed short and long term memory problems, severely impaired decision-making skills, sometimes makes self understood, sometimes understands others, extensive assist for personal hygiene, and totally dependent on staff for locomotion and eating. The MDS showed the resident received 76% to 100% of total calories through tube feedings and 1501 to 2000 cc/day (cubic centimeters per day) average fluid intake per day by feeding tube. Resident #12's care plan, dated 11/19/07, stated the staff provide oral cares every two hours and as needed. Resident #12's physician orders, dated 12/16/08, included NPO and Jevity 1.2 Cal at 60 ml an hour from 2:00 p.m. to 8:00 a.m. daily. On 03/17/10 at 11:11 a.m., observation showed two CNA's (#17 and #20) checked Resident #12's brief, repositioned him in bed, applied lip balm to his lips, but failed to provide oral cares. On 03/17/10 at 1:18 p.m., observation showed a licensed nursing staff member (#11) listened to Resident #12's bowel sounds, checked for residual, connected the Jevity 1.2 Cal formula to the feeding tube, and started the feeding tube pump at 60 ml per hour. This staff member failed to provide oral cares. On 03/17/10 at 1:26 p.m., observation showed two CNA's (#17 and #20) checked Resident #12's brief, repositioned him in bed, asked him about attending an activity, but failed to provide oral	F 312		

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F 312	Continued From page 5 cares. On 03/17/10 at 4:17 p.m., observation showed two CNA's (#18 and #19) checked and changed Resident #12's brief, performed pericares, assisted the resident per mechanical lift up in his chair, turned the TV on, gave the resident the call bell, but failed to provide oral cares. During an interview on the morning of 03/18/10, an administrative nurse (#7) stated she expected facility staff to adhere to the resident's care plan and provide oral cares every two hours. Failure to provide adequate oral hygiene as scheduled has the potential to lead to dry mouth, infections, gum disease, tooth decay, and/or halitosis, all of which affect the resident's comfort and health.	F 312		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, professional literature review, and staff interview, the facility failed to store dietary supplements in a safe manner in 4 of 4 medication carts and 1 of 1 medication room	F 371	Procure,Store/Prepare/Serve-Sanitary: it is the policy of MMHCC to assure that all residents' food/supplements are stored and distributed under sanitary conditions. *On 3/17/10 the DON was informed by Survey team leader of the stated concerns noted in this tag. The DON immediately went to the nurses' station to remove the scoops. The team leader and another surveyor were in the nurses station at the time and the DON placed gloves on to remove the scoops from the containers and did ask surveyors aforementioned if staff could wear gloves to handle the scoops and both said no because even with gloved hands the handles are still susceptible to contamination.	

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F 371	Continued From page 6 (200 wing, 200 east, 300 wing, and 400 wing). Failure to follow safe food sanitation practices has the potential to result in foodborne illness and can affect all residents who receive dietary supplements. Finding include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding sanitary conditions which states the intent of this requirement is to ensure that the facility: follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes. "Food Contamination" refers to the unintended presence of potentially harmful substances, including, but not limited to microorganisms, chemicals or physical objects in food. The 2005 FDA (Food and Drug Administration) Food Code, Public Health Reasons, page 376 states, "Preventing contamination from equipment, utensils, and linens. Pathogens can be transferred to food from utensils that have been stored . . . have not been cleaned and sanitized. They may also be passed on by consumers or employees directly, . . . Some pathogenic microorganisms survive outside the body for considerable periods of time. Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contamination. The handles of utensils, even if manipulated with gloved hands, are particularly susceptible to contamination."	F 371	DON asked if the scoops would be placed in a plastic bag, would that suffice and both surveyors said that would be adequate. All scoops were removed, disinfected, rinsed and air dried and then placed in plastic bags labeled as the scoop for the Protein Whey, Benefiber and Prevalite. *At the shift change on March 17th all the nurses from Dayshift and PM shift were notified of the concern and what the DON had done. A note was also placed in the communication book (a copy of that is attached). The DON added to the monthly Med Care Cleaning Checklist that the plastic bags for the scoops are to be changed and if scoops were found in the containers, a note is to be left for the DON so immediate corrective action can be implemented. (Copy of the Med Cart Cleaning Checklist is enclosed). Note that the monthly med cart cleaning is done by a group of nurses. * The following initial QA monitoring has been completed and a copy of the report for the next scheduled QA meeting has been enclosed as well as a copy of the monitoring form. The DON checked the carts and med cupboard the following dates, March 18,19,22,23,24,25, (DON gone 3/26,)29,30,31 and no concerns were noted. The monitoring will now be done permanently on a monthly basis with the Med Cart Cleaning as noted above	

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F 371	Continued From page 7 Inspection of the medication room and medication carts for 200, 200 east, 300, and 400 wings occurred on 03/17/10 at 2:25 p.m. with a staff nurse (#9). The inspection identified a plastic scoop inside containers of dietary supplements as follows: * nurses station; 100% Whey protein powder had two scoops in the powder. * 400 wing medication cart; container of Benifiber powder. * 300 wing medication cart; container of Benifiber powder. * 200 wing medication cart; container of Prevalite (cholestyramine) powder. * 200 east medication cart; container of Benifiber powder. Scoops stored inside supplement containers creates the potential for the transfer of bacteria from handles of scoops to the food product. When interviewed on the morning of 03/17/10, an administrative staff member (#7) agreed scoops should not be left in containers of dietary supplements and could easily be an infection control issue.	F 371	The next monthly cart cleaning is scheduled for April 13,2010. Any concerns noted with the med cart cleaning will be addressed immediately as afore mentioned and then discussed again with the next nurses monthly inservice. This tag concern will also be discussed again at the April 07,2010 inservice (a copy of that inservice paper addressing the concern is enclosed.	4/7/10