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 _____	04/28/2011

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

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Division of Health Facilities

(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 survey started on 04/25/11 and completed on 04/28/11, the sample included four (4) residents for complete review, ten (10) residents for focused review, and three (3) closed records for review.	F 000		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272	F272 It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that all residents' Minimum Data Set (MDS) information is collected in the full seven (7) day look back period as described in the Resident Assessment Instrument (RAI) specified by the State. *On April 27, 2011 Team Leader met with the DON (Director of Nursing) and Administrator for report and they were informed of the concern with A2300 Assessment Reference Date (ARD) being the same as Z0500B date (date signed as assessment as complete). With these two dates being the same the ARD does not capture all the information from the 7 day look back period through the end of the day (midnight) on the 7th day. A pattern was noted with this concern and that it would be cited. It was explained to the Team Leader as to why both dates were noted the same and that was to avoid having to complete 2 assessments when the due date of State Prospective Payment assessment (PPS) and the federal (OBRA) assessment were not in the same time frame of the state PPS schedule. The Team Leader voiced understanding as to why it was done but that the full 7 day look out period has to	

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

5/23/11

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 272	Continued From page 1 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility failed to use the entire required days of observation when completing the Minimum Data Sets (MDSs) on 9 of 14 sampled residents (Residents #2, #4, #5, #6, #7, #10, #11, #12, and #14). Failure to collect assessment information for the entire required observation period may result in an incomplete and/or inaccurate assessment of the resident's performance and health status. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page A-23 and Z-8 state, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations and events through the end of the day (midnight)	F 272	be captured. The DON and RCCS (Resident Care Coordinator/s) voiced understanding of the concern to the Team Leader and on April 28, 2011 the following was put in place. 1. The MDS schedule for the Month of May 2011 was reviewed to assure. that none of the MDS's to be completed would have the same date for the ARD and Z0500B. 2. The DON began the quality assurance monitoring on May 02, 2011 and monitored all MDS's to be completed from May 02, 2011 through May 20, 2011 to assure that the ARD and Z0500B date were not the same. This report was completed May 19, 2011 as no MDS reviews were. due on May 20, 2011. A copy of this report is enclosed and a copy will be presented at the Quarterly Quality Assurance (QA) Meeting on May 24, 2011. No further monitoring of this issue will be conducted as there is nothing to be gained by doing so as it was thoroughly understood that the full 7 day look back period is necessary and that in the future two assessments will be necessary if the due dates for PPS and OBRA reviews do not fall within the same time frame.	05-24-11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	Continued From page 2 of the ARD . . . For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as completed by the RN assessment coordinator . . ." - Record review for Resident #2, #4, #5, #6, #7, #10, #11, #12, and #14 occurred between April 25th and April 28th of 2011. Review of these records revealed the facility staff failed to collect MDS assessment information on the last day of the assessment period, as the RN (registered nurse) Assessment Coordinators signed and dated each assessment as completed on the last observation day (the ARD). This resulted in facility staff failing to collect assessment information on the last day of the observation period, as required. For Resident #2, #4, #5, #6, #7, #10, #11, #12, and #14, review of the ARD and the date of completion on the MDSs (MDS 3.0 item Z0500B or MDS 2.0 item R2b) identified the following: * Resident #2 - annual assessment - ARD and Z0500B date of 01/04/11 * Resident #2 - quarterly assessment - ARD and Z0500B date of 10/04/10 * Resident #4 - quarterly assessment - ARD and Z0500B date of 04/01/2011 * Resident #5 - quarterly assessment - ARD and R2b date of 09/17/10 * Resident #5 - annual assessment - ARD and Z0500 date of 12/17/10 * Resident #6 - quarterly assessment - ARD and Z0500 date of 12/27/2010 * Resident #7 - 5-day assessment - ARD and Z0500 date of 04/21/11 * Resident #10 - annual assessment - ARD and Z0500 date of 11/30/10	F 272	**ADDITION TO POC (F272)** The DON will do additional QA monitoring to assure that the ARD & the Z0500B dates are not the same. Random monitoring of completed MDS's will be done throughout the month of June and July 2011 with the QA monitoring being completed July 31, 2011. If concerns are identified, immediate corrective action will be implemented by the DON. The results of the monitoring will be presented at the August 2011 QA meeting. DON-Director of Nursing 06-DA-11	06-17-11

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F 272	Continued From page 3 * Resident #10 - quarterly assessment - ARD and Z0500 date of 02/16/11 * Resident #11 - annual assessment - ARD and Z0500B date of 03/16/2011 * Resident #12 - quarterly assessment - ARD and Z0500 date of 10/06/10 * Resident #12 - quarterly assessment - ARD and Z0500 date of 01/06/11 * Resident #12 - annual assessment - ARD and Z0500 date of 04/06/11 * Resident #14 - quarterly assessment - ARD and Z0500B date of 12/13/10 On 04/26/11, two administrative nursing staff members (#2 and #3) verified the facility staff failed to collect MDS assessment information on the last day of the assessment period, as the RN (registered nurse) Assessment Coordinators signed and dated the above assessments as completed on the last observation day (the ARD) prior to midnight.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	F278 It is the policy of MMHCC to assure that the MDS assessments reflect the accuracy of the residents' status. *On 04/27/11 & 04/28/11 surveyors visited in length with the RCC'S that did the MDS on residents #9 and #11 in regards to the scoring of these residents' use of the seat belt alarm in Section P-Restraints. Team leader also visited in length with the RCC'S and did teaching in regards to why the devices should have been scored as a restraint on the MDS being viewed and suggested that during the look back period the resident needs to be asked daily during that period if he/she can open their belt, it needs to be consistent that the resident	

needs to be consistent that the resident

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F 278	Continued From page 4 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility staff failed to accurately complete the restraint section of the Minimum Data Set (MDS) for 2 of 3 sampled residents (Residents #9 and #11) identified by the facility as utilizing a physical restraint. Failure to accurately complete portions of the MDS for sampled residents does not allow each resident's comprehensive assessment to reflect care provided consistent with their individual needs and problems. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and page Z-6 states,	F 278	can open the device and if not then the device needs to be scored as a restraint. RCC'S voiced understanding of proper scoring for Section P-Restraints. To assure that this section is properly scored in the future the following has been put in place. 1. On May 02, 2011 a form was developed for the RCC'S as a monitoring tool during the look period of the MDS. (A copy of the form is enclosed) 2. On May 02, 2011 resident's who have a safety device (e.g. seat belt, Velcro belt or seat belt alarm) in place were identified and none had an MDS due in May 2011. Enclosed is a copy of who those residents are and when their next MDS review date/month is along with a notation for the RCC'S that the form needs to be completed in the look back period. No completed form only the form itself will be presented at the quarterly QA meeting on May 24, 2011 along with the QA study form completed on May 20, 2011 (A copy of the QA study is enclosed). There will be no further monitoring of this concern by the DON for future QA meetings as there is nothing to gain by doing so. The RCC'S were instructed thoroughly on how to score Section P-Restraints of the MDS by the Team Leader from the Survey team, who is also the RAI coordinator for North Dakota.	

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F 278	Continued From page 5 ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification process * the quality measures used for public reporting * research and policy development . . ." Each person completing a section of the MDS is required to sign the Attestation Statement (Z0400) on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds . . ." On the afternoon of 04/25/11, an administrative nurse (#1) provided the survey team with a list of residents who utilize a physical restraint. The list included Resident #9 and Resident #11. - Review of Resident #11's medical record occurred on April 27-28, 2011. Resident #11's restraint assessment, dated 01/07/11, stated, ". . . A sentinel seatbelt alarm was started while in w/c [wheelchair] on 04-15-2009 for safe w/c positioning & to remind her to await transfer help. Up until last several months, resident had been able to readily open her seatbelt alarm so was not counted as alarm. Resident no longer able to open since October [2010] . . ."	F 278	It is noted on the form that if the RCC is having difficulty determining if a device is a restraint after reviewing the RAI manual instructions for scoring Section P Restraints then she should contact the State RAI (MDS) Coordinator for her input. **ADDITION TO POC (F278)** The DON will do additional QA monitoring to assure proper scoring of Section P-Restraints. Random monitoring of completed MDS's Section P will be done throughout the month of June & July 2011 with the QA monitoring being completed July 31, 2011. If concerns are identified, immediate corrective action will be implemented by the DON. The results of the monitoring will be presented at the August 2011 QA meeting. DA Director of Nursing 06-02-11	05/24/11 06-17-11

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F 278	Continued From page 6 Observations on April 27-28, 2011 showed Resident #11 with a seat belt restraint on when in her wheelchair. Resident #11's quarterly MDS, dated 12/19/10, identified no restraint used in chair or bed. During an interview on 04/28/11 at 10:00 a.m., an administrative nurse (#3) verified Resident #11 has not been able to open her seat belt restraint upon command since October 2010; and therefore, staff should have considered it a restraint and should have coded it on Resident #11's MDS, dated 12/19/10. - Review of Resident #9's medical record occurred on all days of survey. Resident #9's quarterly MDS, dated 04/20/11, as well as a significant change MDS dated 02/02/11, failed to identify the use of a trunk restraint. Observations throughout the survey showed Resident #9 seated in his wheelchair with a seat belt restraint around his waist. On 04/27/11 at 9:50 a.m., Resident #9 released his seat belt after being asked by the surveyor to remove it. On 04/27/11 at 4:35 p.m., the surveyor again asked Resident #9 to release his seat belt. The resident stated, "Why can't I?" and made no attempt to release the seat belt. Resident #9's ability to release the seat belt varied based on the time of day. During an interview on 04/27/11 at 10:30 a.m., an administrative nurse (#1) stated Resident #9 cannot always open his seat belt upon command; therefore, staff should consider it as a restraint.	F 278		

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F 278	Continued From page 7 During an interview on 04/28/11 at 10:00 a.m., an administrative nurse (#2) stated that after Resident #9's fracture in January 2011, he could not always open the seat belt on command. She stated she did not code it as a restraint because he opened it when she asked him, but she had only asked him one time during the MDS assessment reference periods. The staff member stated she should have coded the seat belt as a restraint on Resident #9's 02/02/11 and 04/20/11 MDS assessments.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 procedure, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 4 sampled residents (Resident #4 and #8) who required a gait belt for transfers. Failure to use gait belts appropriately has the potential for residents to experience falls, injuries, and/or pain. Findings include: Review of the facility policy titled "Transferring	F 323	**F 323** It is the policy of MMHCC to assure that residents receive adequate supervision and assistance devices to prevent accidents. * On 04/27/11 the DON was informed by one of the surveyors the concern of resident #8 not having a transfer belt on with a transfer that ended in this resident being lowered to the floor. On 04/28/11 the team leader also visited with the DON in regards to a transfer belt not being placed on resident #4 with a transfer. The following was put in place on 04/27/11 after my visit with a surveyor about the concerns with the transfer belt. 1. A note was placed in the CNA (certified nurse assistant) and nursing communication notebook on April 27, 2011 and again on April 28, 2011 following the exit report by the survey team (copy of those two entries enclosed) addressing transfer belt use. Nursing staff inservices were held on May 18, 2011 and the transfer belt was	

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F 323	Continued From page 8 Resident With Transfer Belt" occurred on 04/28/11. This undated policy stated, "Any resident who may fall or become unsteady on transfer should be transferred using a transfer belt. CNAs [certified nursing assistants] are expected to have transfer belt on their person at all times while on resident unit . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dizziness, Parkinson's, recurrent transient ischemic attacks, and osteoarthritis. The resident's record showed the resident has a history of falls. Review of Resident #8's current quarterly Minimum Data Set (MDS), dated 03/01/11, identified the Brief Interview for Mental Status (BIMS) summary score of fifteen, indicating intact cognition. The quarterly MDS showed the resident required extensive assistance of one staff member for transfers. A "Nurse's Note" dated 04/21/11, stated, "Late Entry for: 04/19/11 Time: 11:07 PM . . . During transfer on the evening of the 19th, [Resident #8] began to slide down, CNA able to assist her slowly to slide down to the floor to prevent injury . . . uncertain if transfer belt was used during transfer, will inform staff that [Resident #8] needs to be transferred with transfer belt/gait belt due to extensive assist needed with transfers. . . ." After further investigation, an administrative nurse (#1) confirmed staff failed to use a gait belt during the transfer. Review of Resident #8's care plan showed at the time of the incident on 04/19/11, Resident #8 transferred "with extensive assist of one."	F 323	addressed at both the Nurses inservice and the CNA'S inservice and the Procedure/Policy "Transferring Resident with Transfer belt" was also reviewed. Enclosed is a copy of the inservice notes for the CNAS' and Nurses', the attendance record of those two meetings and a copy of the Procedure/Policy "Transferring Resident with Transfer belt" **3.**Effective May 19, 2011 A QA program was implemented under the supervision of the DON to assure residents of MMHC are transferred in a safe manner. The DON will perform random monitoring of gait belt transfers weekly for four weeks (May 19 through June 10, 2011, monthly for three months (July-August-September) and then quarterly December 2011 with QA monitoring being completed 12-30-11. If concerns are identified immediate corrective action will be implemented, concerns will be addressed that day in the nursing department (dept.) communication book and at the next nursing dept. inservice meetings. The DON will submit a report of the monitoring results 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 an RCC. On May 19 and May 23, 2011 the DON observed transfers on Resident #4 and #8 and the transfer belt was placed	

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F 323	Continued From page 9 Observations on all days of survey showed Resident #8 was unsteady and took small, shuffling steps when transferring. During an interview on 04/27/11 at 11:00 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt anytime they assist residents with transfers, even if it is not listed on their care plan. The staff member (#1) agreed a gait belt should have been used with Resident #8's transfer/fall on 04/19/11. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included hemiplegia, demyelinating disease of the central nervous system, Parkinson's, macular degeneration of the retina, and osteoarthritis. Review of Resident #4's current quarterly MDS, dated 04/01/11, identified the resident required extensive assistance of one staff member for transfers. The resident's record showed the resident has a history of falls. During observation on the morning of 04/25/11, two CNAs (#5 and #12) assisted Resident #4 with transfers from her bed to her wheelchair, from her wheelchair to the toilet, and from the toilet back to her wheelchair. Observation showed the CNAs placed a forearm under Resident #4's armpits to assist with the transfer. CNAs (#5 and #12) failed to utilize a gait belt during these transfers. Observation showed one CNA wearing a gait belt around her hips and another gait belt present in the resident's room laying on a dresser. During an interview on the morning of 04/27/11,	F 323	on the residents and used with the transfer (enclosed is a copy of those completed monitor sheets). These findings will be presented at the QA meeting on May 24, 2011 (enclosed is a copy of the QA study form).	05/24/11

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F 323	Continued From page 10 an administrative nurse (#1) stated her expectation was for staff members to use a gait belt anytime they assist unsteady residents with transfers.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and facility policy review, the facility failed to ensure 1 of 5 sampled residents (Resident #9) receiving an antipsychotic	F 329	**F329** It is the policy of MMHCC to assure that residents' drug regimens are free from unnecessary drugs. *On 04/28/11 surveyors questioned the DON if Resident #9 in the resident sample had a Pharmacy review for the use of the Risperdal as the last time the med was reviewed for a possible dose reduction was in March of 2010 and the med was to have a yearly review for possible dose reduction in March of 2011 and nothing could be found in the chart. The DON reviewed the resident's progress notes from March of 2010 to March of 2011 nothing was mentioned in the progress notes about a dose reduction for the Risperdal. All residents meds are reviewed monthly by the facility's Consulting Pharmacist and the Pharmacist will send "Consultant Pharmacist Communication to Physician" forms to MMHCC (these Forms are also noted as `drug reviews') for the Physician or PA (Physician's assistant) to review. No drug review was found for the Risperdal for March of 2011. The facility's policy/procedure on "Psychoactive Medication Monitoring" was reviewed (copy of policy/procedure enclosed) and the Risperdal use was not reviewed by the Physician according to policy and the other concern with this tag was that there was no documentation or not enough adequate documentation by the physician or PA to justify why a dose reduction was not done in the past year. The DON notified the Consulting Pharmacist of this concern on 04/28/11 and he did review the Risperdal use for Resident #9 with his April 26, 2011 reviews as he noted the review had not been generated for review in March 2011 (copy of that review is enclosed). The following will be put in place and reviewed with the QA meeting on May 24, 2011.	

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	355036	A. BUILDING _____ B. WING _____	04/28/2011

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F 329	Continued From page 11 medication received a gradual dose reduction (GDR). Failure to attempt a GDR (unless contraindicated) in an effort to discontinue antipsychotic use may result in residents receiving unnecessary medications and experiencing adverse drug effects related to these medications. Findings include: Review of the facility policy titled "Guidelines for Psychoactive Medication Monitoring" occurred on 04/28/11. This undated policy stated, ". . . Residents who use antipsychotic drugs should be reviewed for possible gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. . . . All medications are reviewed by a physician at least once every 30 days for the first 90 days after admission, and at least once very [sic] 60 days thereafter as required by law. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Current medications included Risperdal (an antipsychotic) 0.25 mg (milligrams) twice a day, initiated on 03/09/10. Physician's progress notes since 03/09/10 failed to identify a GDR attempt of Risperdal within the past year. The progress notes also failed to identify specific contraindications for a GDR of Risperdal.	F 329	1. The physician for this resident is also our medical director and attends the QA meetings. The DON will review at the QA meeting with the physician the importance to address the use of antipsychotic meds as well as any psych meds in regards as to why he feels the coed(s) is necessary and why a dose reduction is or is not feasible. This concern should be addressed in an occasional progress note as well as on the drug review sheet he receives from the consulting pharmacist. This same concern was reviewed with PA on 04/28/11 by the DON. 2. The RCC's always receive copies of the current progress notes to review and they will monitor that the documentation for psychoactive med use is adequate and if not they will bring that to the attention of the physician or PA. 3. The DON will monitor the documentation on the drug review sheets as well and if the documentation is a concern, the DON will review that with the physician or PA. 4. There will be no short term monitoring of this concern as you would do for QA. This will be the facility's practice from now on starting May 24, 2011 and this will always be monitored as noted in #2 and #3. Therefore no further QA monitoring will be necessary as when concerns are noted they will be addressed as soon as possible with physician or PA. **ADDITION TO POC (F329) REFER TO PAGE 15.** RB - Director of Nursing 06-02-11	05/24/11
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended	F 363	F363. 1. Staff has been instructed to use the 2 oz ladle instead of a scoop for gravy.	

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F 363	Continued From page 12 dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's menu and serving size guide, and staff interview, the facility failed to meet nutritional needs of residents by serving incorrect portion sizes during 3 of 3 observations of tray line (04/26/11 noon and evening meals and 04/27/11 noon meal). Failure to use the correct serving size may contribute to inadequate nutrition and/or weight loss and affects all residents who eat meals served from the facility's kitchen. Findings include: Observations of tray line occurred on 04/26/11 at 11:05 a.m. and 5:00 p.m., and on 04/27/11 at 11:00 a.m. with the following inconsistencies noted between scoop sizes used to serve residents and the facility's menu: * Mechanical soft chicken served with a 1.5 ounce (oz) scoop, the menu indicated a 3 oz scoop * Mashed potatoes served with a 1/3 cup scoop, the pureed diet menu indicated a 1/2 cup scoop, and the other diet menus indicated a 1/4 cup scoop * Peas served with a 1.5 ounce scoop, the menu indicated a 2 oz scoop * Gravy served with a 1.5 ounce scoop, the menu indicated a 2 oz scoop * Carrots (pureed and regular) served with a 1.5	F 363	2, Menus are in the process of being revised because some of the amounts stated on the menus are too large servings for our residents. Food Service of America will be in charge of the calculations and printing of these menus. Probable date of completion of revised menus June 2nd,2011 3. Following our survey a note was placed in the dietary communication book addressing that the amount stated on the menus must be the amount served and that the 2 oz ladle needs to be used instead of the scoop (see enclosed copy of note from dietary communication book dated 4-28-11). This same information will be reviewed at the dietary inservice on June 23,2011. 4. Quality Assurance will be done on serving size for our quarterly meeting May 24,2011 (copy of QA enclosed) **ADDITION TO POC (F 363)** The dietary supervisor will do additional QA monitoring to assure that residents receive the proper serving size of food. Random monitoring will be done the month of June & July 2011 with QA monitoring being completed July 31, 2011. Results of the monitoring will be reported At the August 2011 QA meeting. CD Director of Nursing 06-02-11	05/24/11 06-17-11

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F 363	Continued From page 13 ounce scoop, the menu indicated a 2 oz scoop * Pureed bread with ham salad served with a 3 oz scoop, the menu indicated a 4 oz scoop * Pureed beef stew served with a 3/4 cup scoop, the menu indicated a 1 cup scoop * Green beans (pureed and regular) served with a 1.5 oz scoop, the menu indicated a 2 oz scoop During an interview on 04/28/11 at 10:40 a.m., a dietary supervisor (#16) stated the portion sizes listed on the menu were correct, and staff should follow the menu when serving meals.	F 363		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility's consultant pharmacist failed to identify medication regimen irregularities for 1 of 5 sampled residents (Resident #9) receiving an antipsychotic. Failure to recognize and report medication irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications.	F 428	**-F428** It is the policy of MMHCC to assure that residents' drug regimens are reviewed at least once a month by a licensed pharmacist. *On 04/28/11 surveyors questioned the DON if Resident #9 in the resident sample had a Pharmacy review for the use of the Risperdal as the last time the med was reviewed for a possible dose reduction was in March of 2010 and the med was to have a yearly review for possible dose reduction in March of 2011 and nothing could be found in the chart. The DON could not find a "Consultant Pharmacist Communication to Physician" form (these forms are also noted as `drug reviews') for the Physician or PA (Physician's assistant) to review. The DON notified the Consulting Pharmacist of this concern on 04/28/11 and he did review the Risperdal use for Resident #9 with his April 26, 2011 reviews as he noted the review had not been generated for review in March 2011 (copy of that review is enclosed). The following will be put in place and reviewed with the QA meeting on May 24, 2011. 1. The Consulting Pharmacist has a report in his software program that allows him to print a date range for patients due for a psychotropic dose evaluation and this report can be generated for a whole year (a copy for the remaining year from April 2011 to December 2011 is enclosed).	

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F 428	Continued From page 14 Findings include: Review of the facility policy titled "Guidelines for Psychoactive Medication Monitoring" occurred on 04/28/11. This undated policy stated, ". . . Residents who use antipsychotic drugs should be reviewed for possible gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. . . In addition, all psychotropic drugs are reviewed on an individual basis monthly by the consultant pharmacist according to the Federal Regulations. Reports from the consultant pharmacist are then given to the resident's physician/PA [physician's assistant] for review. . . " Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Current medications included Risperdal (an antipsychotic) 0.25 mg (milligrams) twice a day, initiated on 03/09/10. The facility's consultant pharmacist reviewed residents' medications monthly. Resident #9's record lacked evidence to indicate the pharmacist recommended a gradual dose reduction (GDR) of Risperdal within the past year. In an interview on the morning of 04/28/10, a supervisory nursing staff member (#1) confirmed that the pharmacist had not made any recommendations related to a GDR of Resident #9's Risperdal.	F 428	2. A report can also be from month to month/or what is due the next month. These reports will be utilized on a permanent basis as it is a good tool to use for monitoring drug review dates. 3. The DON will use this report to review the consultant sheets received from the pharmacist to assure that resident's in need of review were indeed addressed with a drug review sheet for the physician or PA. If a drug review sheet is not noted, the DON will notify the consultant of the concern. 4. . There will be no short term monitoring of this concern as you would do for QA. This will be the facility's practice from now on starting May 24, 2011 and this will always be monitored as noted in #1 and #2. Therefore no further QA monitoring will be necessary as when concerns are noted they will be addressed as soon as possible with the Consulting Pharmacist, PA. **ADDITION TO POC (F329)** The DON will do additional QA monitoring of the monthly consulting pharmacist review sheets & an occasional Dr's Progress note to assure residents' drug regimens are free from unnecessary drugs. Monitoring will be done the months of June & July 2011 with QA monitoring being completed July 31, 2011. If concerns are identified, immediate corrective action will be implemented by the DON. The results of the monitoring will be reported at the August 2011 QA meeting. SD Director of Nursing 06-02-11 **ADDITION TO POC (F428)** The DON will do additional QA monitoring to assure resident's drug regimens are reviewed at least once a month by a licensed pharmacist. Monitoring of the pharmacist's med review report sheet will be done the month of June & July 2011 with QA monitoring being completed July 31, 2011. If concerns are identified, immediate corrective action will be implemented by the DON. Results of the monitoring will be reported at the August 2011 QA meeting. SD Director of Nursing 06-02-11	05/24/11 06-17-11
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F441 It is the policy of MMHCC to assure that ~~the Infection Control Program is designed to~~	06-17-11

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F 441	Continued From page 15 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. * On 04/28/11 surveyors informed the DON that with their care observations, staff did not wash or gel their hands after they removed their gloves after completing peri care and that staff placed dirty linen on a resident's bedside table and did not disinfect the bedside table with a disinfectant wipe after the dirty linen was removed. The following was put in place on 04/28/11 after my visit with a surveyor about the infection control concerns noted with the survey. 1. A note was placed in the CNA (certified nurse assistant) and nursing communication notebook on April 28, 2011 following the exit report by the survey team (copy enclosed) addressing the hand washing concern. 2. Nursing staff inservices were held on May 18, 2011 and the infection control issues were addressed at both the Nurses inservice and the CNA'S inservice and the following Procedures/Policies were reviewed "Pericare with disposable washcloth (with emphasis put on #10 of the procedure)", "Pericare with disposable washcloth and/or periwash with washcloth (with emphasis put on #12 of the procedure)" and "General cleaning and maintenance of equipment (with emphasis put on #1)". Enclosed is a copy of the inservice notes for the CNAS' and Nurses', the attendance record of those two meetings and a copy of the Procedure/Policy fore mentioned. 3. Effective May 19, 2011 A QA program was implemented under the supervision of the DON to assure the infection control issues with the survey were addressed properly. The DON will perform random monitoring of these issues with hand washing/gelling after glove removal following pericares and disinfecting of the over the bed tables or night stands after care is given (e.g. dirty linen removed, or basin with water for pericares or other cares etc...) weekly for four weeks (May 19	

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F 441	Continued From page 16 by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow acceptable infection control standards for 5 of 10 sampled residents (Resident #1, #2, #3, #4, and #9) observed receiving personal cares. Failure to perform hand hygiene after completing pericares and failure to properly sanitize resident care equipment has the potential to spread infections throughout the facility. Findings include: Review of the facility policy titled "PERICARE WITH DISPOSABLE WASHCLOTH" occurred on 04/28/11. This undated policy stated, "MALE PERINEAL CARE . . . 10. Remove gloves following pericare. Assure resident is safely positioned and then wash hands before carrying out other duties. . . ." Review of the facility policy titled "PERICARE WITH DISPOSABLE WASHCLOTH AND/OR PERIWASH WITH WASHCLOTH" occurred on 04/28/11. This undated policy stated, ". . . FEMALE PERINEAL CARE . . . 12. Remove gloves following pericare. Assure resident is safely positioned and then wash hands before carrying out other duties. . . ." Review of the facility policy titled "INFECTION CONTROL GENERAL POLICIES" occurred on 04/28/11. This undated policy stated, ". . . GENERAL CLEANING AND MAINTENANCE OF EQUIPMENT a. It is the policy of this facility that all resident care equipment will be cleaned and decontaminated after use and will be prepared for	F 441	through June 10, 2011, monthly for three months (July-August-September) and then quarterly December 2011 with QA monitoring being completed 12-30-11. If concerns are identified immediate corrective action will be implemented, concerns will be addressed that day in the nursing department (dept.) communication book and at the next nursing dept. inservice meetings. The DON will submit a report of the monitoring results 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 an RCC. On May 19, 2011 the DON observed pericares on resident #3 and #5 and on May 23, 2011 pericares were observed on resident #3 and on #12 (enclosed is a copy of those completed monitor sheets). These findings will be presented at the QA meeting on May 24, 2011 (enclosed is a copy of the QA study form).	05/24/11

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F 441	Continued From page 17 reuse by the same or another resident. Equipment will be cleaned and decontaminated according to manufacturer's recommendation. 1. All equipment and supplies will be cleaned and decontaminated immediately after use . . . 3. Equipment is first cleaned of surface soil with soap and water or facility disinfectant. 4. Equipment is then decontaminated with an EPA-and facility-approved disinfectant. . . ." - Observation on 04/25/11 at 3:00 p.m. showed two certified nursing assistants (CNAs) (#4 and #5) changed Resident #3's incontinence garment while she remained in bed. After performing pericares, a CNA (#5) placed the towel she used to cleanse the perineal area on the resident's bedside table. A CNA (#4) wiped down the bedside table with a moist perineal wipe. After performing pericares, a CNA (#5) changed her gloves without performing hand hygiene, provided total assistance with oral cares, applied emollient cream to Resident #3's lips, and then both CNAs (#4 and #5) washed their hands. The staff members failed to perform hand hygiene immediately after completing pericares and failed to appropriately disinfect the bedside table. - During an observation on 04/26/11 at 11:25 a.m., two CNAs (#4 and #6) changed Resident #3's incontinence garment while she remained in bed. After completing pericares, a CNA (#4) changed her gloves without performing hand hygiene, provided total assistance with oral cares, applied emollient cream to Resident #3's lips, and then the CNA (#4) washed her hands. The CNA (#4) failed to perform hand hygiene immediately after completing pericares and prior to performing oral cares.	F 441		

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F 441	Continued From page 18 - An observation on 04/26/11 at 3:40 p.m. showed two CNAs (#7 and #8) changed Resident #3's incontinence garment while she was in bed. After completing pericares, a CNA (#8) removed her gloves, applied a clean incontinence garment, adjusted her clothing, boosted the resident up in bed, placed soft hand splints to both hands, turned Resident #3 to her side, placed a pillow under and between her ankles, covered the resident up, and then washed her hands. The CNA (#8) failed to perform hand hygiene immediately after completing pericares. - Observation on 04/26/11 at 3:25 p.m. showed two CNAs (#9 and #10) toileted Resident #2 using the EZ stand mechanical lift. A CNA (#9) performed pericares, changed gloves without performing hand hygiene, transferred the resident to her recliner, took her gloves off, adjusted Resident #2's clothing, offered the resident water, covered her with a blanket, elevated the resident's legs, and then the CNA (#9) washed her hands. The CNA (#9) failed to perform hand hygiene after performing pericares immediately after ensuring the resident's safety. - On 04/26/11 at 11:30 a.m., observation showed two CNAs (#19 and #20) assisted Resident #1 with toileting in his bathroom. The CNA (#19) applied clean disposable gloves, wiped the resident's rectal area, removed her soiled gloves, and assisted the other CNA (#20) with dressing and transferring the resident into his recliner chair. The CNA (#19) continued to assist Resident #1 by reclining his chair, covering him with a blanket, moving the bedside table over by his recliner, opening the bedroom window	F 441		

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F 441	Continued From page 19	F 441		

curtains, turning on the television, and placing a metal bell (used to call staff for assistance) and the television remote control on his bedside table. The CNA (#19) then cleansed her hands using soap and water. The CNA (#19) failed to perform hand hygiene after pericare and before handling items in the resident's room.

- On 04/27/11 at 9:25 a.m., observation showed two CNAs (#13 and #15) assisted Resident #1 with toileting in his bathroom. The CNA (#13) applied clean disposable gloves, wiped the resident's rectal area, removed her soiled gloves, and assisted the other CNA (#15) with dressing and transferring the resident into his wheelchair. The CNA (#13) continued to assist Resident #1 by applying his seat belt, combing his hair, and moving the bedside table over by his reclining chair. The CNA (#13) then cleansed her hands using soap and water. The CNA (#13) failed to perform hand hygiene after pericare and before handling items in the resident's room.

- On 04/26/11 at 10:10 a.m., observation showed a CNA (#4) assisted Resident #4 with toileting in her bathroom. The CNA (#4) applied clean disposable gloves, wiped the resident's perineal area, removed her soiled gloves, and assisted the resident with dressing and transferring into a wheelchair. The CNA (#4) continued to assist Resident #4 by putting the wheelchair footrests in place, moving the bedside table close to her, turning on the television, putting the call light in an accessible place, cleaning her eye glasses, and moving her container of water and her television remote control. The CNA (#4) then cleansed her hands using soap and water. The CNA (#4) failed

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 _____	04/28/2011

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 441	Continued From page 20 to perform hand hygiene after pericare and before handling items in the resident's room. - On 04/26/11 at 4:50 p.m., observation showed a CNA (#8) assisted Resident #4 with toileting in her bathroom. The CNA (#8) applied clean disposable gloves, wiped the resident's perineal area, removed her soiled gloves, and assisted the resident with dressing and transferring into a wheelchair. The CNA (#8) continued to assist Resident #4 by removing the gait belt, adjusting her clothing, putting her wheelchair footrests in place, and flushing the toilet. The CNA (#8) then cleansed her hands using soap and water. The CNA (#8) failed to perform hand hygiene after pericare and before handling items in the resident's room. - On 04/27/11 at 10:15 a.m., observation showed two CNAs (#11 and #14) assisted Resident #4 with toileting in her bathroom. Resident #4 had been incontinent of bowel. The CNA (#11) applied clean disposable gloves, wiped the resident's rectal area, removed her soiled gloves, and assisted the other CNA (#14) with dressing and transferring the resident into her wheelchair. The CNA (#11) continued to assist Resident #4 by wheeling her up to the bed, applying the gait belt, transferring her into the bed, and covering her with blankets. The CNA (#11) then cleansed her hands using soap and water. The CNA (#11) failed to perform hand hygiene after pericare and before handling items in the resident's room. - Observation on 04/25/11 at 4:16 p.m. showed a CNA (#17) assisted Resident #9 in the bathroom. She provided perineal care to Resident #9, who had a moderate amount of bowel movement (BM)	F 441		

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F 441	Continued From page 21 in the toilet. Upon completion of perineal cares, the CNA removed her gloves, transferred the resident to his wheelchair with a mechanical lift, placed foot pedals on the wheelchair, and fastened the resident's seat belt around his waist. She gave the resident a drink of water and then washed her hands. The CNA failed to perform hand hygiene immediately after performing perineal care and ensuring the resident's safety. - Observation on 04/26/11 at 8:45 a.m. showed a CNA (#18) assisted Resident #9 in the bathroom. The resident was incontinent of urine and also voided in the toilet, and the CNA provided perineal care. Upon completion, the CNA removed her gloves, transferred Resident #9 to his wheelchair with a mechanical lift, placed foot pedals on the wheelchair, and brought the resident to the TV lounge. She then gave the resident a snack and some coffee. The CNA failed to perform hand hygiene immediately after performing perineal care and ensuring the resident's safety. During an interview on 04/28/11 at 10:00 a.m., an administrative nurse (#1) stated staff should not place dirty linen on residents' bedside tables, and if they did, staff need to disinfect the bedside table with a disinfectant wipe. The staff member (#1) also stated she expected staff to wash their hands with soap and water or with hand sanitizer immediately after completing pericares, after ensuring the residents' safety.	F 441		
F 494 SS=B	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4	F 494	F494 To assure that all the CNA's licenses are current the following has been put in place:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2011
FORM APPROVED
OMB NO. 0938-0391

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F 494	Continued From page 22 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure a nurse aide (Individual A) working with residents in the facility remained certified. Individual A provided 1,033 hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include:	F 494	-Will run a report that includes all CNAs license expiration dates monthly. Any employee that has an expiration date of 30 days in the future will be notified to re-certify and be informed that they cannot work as of the date of expiration. -A calendar task reminder has been set up that will remind Payroll Clerk to run the afore mentioned report on the 15th of each month. A copy of this report will be given to DON for quality assurance review. First report to the QA Committee will be on May 24, 2011 at the quarter QA meeting. -This correction has been started as of 4-27-11 and above report run and all license expiration dates checked. **ADDITION TO POC (F494)** Do note that the monitoring report that will be printed on the 15th of each month as previously mentioned in the POC for this tag will be a permanent practice/procedure. The DON & Secretary will do additional QA monitoring to assure that all CNAS have a current CNA license. Random monitoring will be done the month of June & July 2011 with QA monitoring Being completed July 2011. If concerns are identified, immediate corrective action will be implemented by the DON. The results of the monitoring will be presented at the August 2011 QA meeting. Director of Nursing 06-02-11	05/24/11 06-17-11

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F 494	Continued From page 23 Individual A contacted the state nurse aide registry on 04/27/11 to renew his certification. The state nurse aide registry file review identified Individual A's certification expired 08/18/10. On 04/27/11, nurse aide registry personnel contacted the facility regarding the CNA's expired certification. A facility administrative nurse (#1) indicated information would be provided regarding the dates and hours worked by Individual A since 08/18/10. During an interview on the afternoon of 04/27/11, an administrative nurse (#1) verified Individual A worked from 08/18/10 through 04/18/11 without certification. On 04/28/11, the administrative nurse (#1) provided information to the survey team that was on-site. The information identified Individual A worked with residents in the facility, while he lacked nurse aide certification, for a total of 1,033 hours between 08/18/10 and 04/18/11.	F 494		