STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355036	A. BUILDING _____ B. WING _____	03/28/2012

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 March 26, 2012 and completed on March 28, 2012, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	Plan of Correction for 2012 Survey F164: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that all residents' care is provided in a manner that will not cause an infringement of the resident's rights, does not lead to a loss of resident's dignity and promotes privacy. March 28, 2012 the following was put in place to assure that dignity and privacy is maintained for residents #5, #6 & #8 from the survey resident roster as well as all residents of MMHCC: 1. A note was placed in the Certified Nurse Assistant (CNA) and nurses department (dept.) communication notebook on March 28, 2012 after our exit review with the survey team addressing the privacy concern (copy of the 03/28/12 note is enclosed). 2. March 29, 2012 the Director of Nursing (DON) reviewed the current care procedure/policies and all care procedures do have a statement that states "Provide privacy" or "Provide privacy. Close the door and pull privacy curtain." (Copies of 3 different care procedures enclosed to show statement). No revisions on procedures/policies were necessary. 3. Effective April 02, 2012: a quality assurance (QA) program was implemented by and under the supervision of the DON to assure residents #5, #6 & #8 of the sampled residents and all residents of MMHCC have privacy provided with their cares. Frequency of QA monitoring: Weekly for one month-April 02 through April 27, 2012, Monthly for three months (May-June-July 2012) and then quarterly (October 2012 & January 2013) with QA monitoring completed January 31, 2013 (Copies of completed QA monitoring and a blank copy of the QA study form are enclosed). If concerns are noted with the monitoring/observations immediate corrective action will be taken (e.g. teaching with staff member involved in the task, if necessary a note in the CNA & nursing dept. communication book etc..) The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. These findings will be presented at the quarterly QA meeting on May 30, 2012. 4. Nursing staff in-services were held on April 18, 2012 and privacy concerns were addressed at both the Nurses in-service and the CNA'S in-service (Enclosed is a copy of the in-service notes for the CNAS' and Nurses' along with the attendance record of those two meetings	5/30/2012
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/27/12

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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide privacy for 3 of 11 sampled residents (Resident #5, #6, and #8) observed during staff-assisted toileting. Failure to provide care in a manner that promotes privacy is an infringement on the residents' rights and may lead to a loss of dignity. Findings include: - Observation of Resident #5 on 03/26/12 at 1:50 p.m. showed the resident sitting on the toilet with the bathroom door and the door to the hallway open. A certified nurse aide (CNA) (#6) standing in the resident's room stated she assisted the resident to the toilet. - Observation on 03/27/12 at 11:35 a.m. showed a CNA (#1) assisting Resident #8 with toileting. Both the resident's bathroom door and the door to the corridor remained open while the resident used the bathroom. - Observation on 03/27/12 at 11:47 a.m. showed a CNA (#2) assisting Resident #6 with toileting. Both the resident's bathroom door and the door to the corridor remained open while the resident used the bathroom. During an interview on 03/28/12 at 2:40 p.m., an administrative nurse (#3) stated she expected staff to close residents' doors to provide privacy when assisting residents with cares.	F 164		

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to provide care in a manner and environment that maintained or enhanced dignity for 2 of 2 supplemental residents (Resident #16 and #17) regarding assistance during meals. Failure to feed residents in a dignified manner did not maintain or enhance the residents' dignity, self worth, or esteem. Findings include: Review of the facility policy "Feeding the Dependent Resident" occurred on 03/28/12. This undated policy stated, ". . . Procedures for Feeding: . . . wipe mouth frequently with napkin . . .Staff sits down with resident to feed. Does not feed resident while standing upright. . . ." Observations of 11:00 a.m. meal on 03/27/12 showed the following: * An unidentified certified nursing assistant (CNA) stood over Resident #17 while feeding the resident throughout the meal. * A CNA (#9) assisted Resident #16 to eat and wiped food and drink off the resident's lips, chin, and/or neck using the resident's cover-up. The	F 241	F241: It is the policy of MMHCC to assure that the care for residents is provided in a manner and in an environment that maintains or enhances the residents' dignity and respect in full recognition of his/her individuality. March 28, 2012 the following was put in place to assure that the care environment maintains the dignity of residents #16 & #17 from the survey resident roster as well as all of residents MMHCC: 1. A note was placed in the Certified Nurse Assistant (CNA) and nurses department (dept.) communication notebook on March 28, 2012 after our exit review with the survey team addressing the dignity concern (copy of the 03/28/12 note is enclosed). 2. March 29, 2012 the Director of Nursing (DON) reviewed the current care procedure/policy that addressed "Feeding the Dependent Resident" The procedure was revised so that all the dignity issues with feeding a resident were combined under one number instead of being listed separately. A copy of the revised section along with a copy of the previous section are enclosed (this same copy was included in the CNA & nursing in-service papers for April 18, 2012). 3. Effective April 02, 2012: a quality assurance (QA) program was implemented by and under the supervision of the DON to assure residents #16 & #17 of the sampled residents and all residents of MMHCC have a care environment that maintains their dignity. Frequency of QA monitoring: Weekly for one month-April 02 through April 27, 2012, Monthly for three months (May-June-July 2012) and then quarterly (October 2012 & January 2013) with QA monitoring completed January 31, 2013 (Copies of completed QA monitoring and a blank copy of the QA study form are enclosed). If concerns are noted with the monitoring/observations immediate corrective action will be taken (e.g. teaching with staff member involved in the task, a note in the CNA & nursing dept. communication book etc..) The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. These findings will be presented at the quarterly QA meeting on May 30, 2012. 4. Nursing staff in-services were held on April 18, 2012 and privacy concerns were addressed at both the Nurses in-service and the CNA'S in-service (Enclosed is a copy of the in-service notes for the CNAS' and Nurses' along with the attendance record of those two meetings).	5/30/12

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F 241	Continued From page 3 CNA failed to use a napkin to clean food from the resident's face and neck. Observation of the noon meal on 03/28/12 showed a CNA (#10) assisted Resident #16 to eat and wiped his lips, chin, and/or neck using the resident's cover-up. The CNA failed to use the available napkin. During this time, the CNA (#10) wiped uneaten food off of the spoon using the resident's cover-up, and then proceeded to feed ice cream with the same spoon. The CNA failed to clean off the utensil in a dignified manner. During an interview on 03/28/12 at 3:00 p.m., an administrative nurse (#3) confirmed that a napkin should be used to wipe food from the resident's face, and a cover-up should not be used to clean a utensil or the resident's face. This staff nurse also stated staff are to sit next to a resident while providing feeding assistance and not stand over them.	F 241		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	F274: It is the policy of MMHCC that a comprehensive assessment may be completed on any residents that have a significant change (SC) in their status, either improvement or decline. This will be determined by the Interdisciplinary team (IDT) after review of the definition of "Significant Change in Status Assessment" (SCSA) from the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, October 2011. March 29, 2012 the following was put in place to assure that other residents would not be affected by this same deficient practice.	

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F 274	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete a comprehensive assessment for 2 of 2 sampled residents (Resident #4 and #5) within 14 days after the residents experienced a significant change in their physical and/or mental condition requiring interdisciplinary review. Failure to complete a comprehensive assessment in response to physical declines, new pressure ulcers at Stage II or higher, and changes in mood/behavioral symptoms and/or continence, placed the residents at risk for continued decline and the potential lack of appropriate interventions to restore or maintain physical function. Findings include: The CMS Long-Term Care Facility RAI User's Manual, Version 3.0, October 2011, page 2-20 through 2-23 states, "Significant Change in Status Assessment . . . is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. . . . Decline in two or more of the following: . . . Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom	F 274	1. On 03/29/12, the MMHCC resident roster was reviewed by the IDT (Resident Care Coordinators (RCCS) and the Director of Nursing (DON) and there was one resident the IDT had a concern about and that was Resident 1548. His nurses' notes etc... were reviewed thoroughly. The IDT then thoroughly reviewed the SC section in the RAI manual (Page 2-20 through 2-23) and it was then decided that resident 1548 was showing a decline in his ADL status and was displaying an overall deterioration. The IDT decided to observe resident's status for the next 14 days to see if there was any potential for improvement. On 04/10/12 the IDT met and reviewed resident's status again and it was decided that a SCSA was to be completed (Enclosed is a copy of Resident 1548's quarter (qtr.) review from 02/19/12, the care plan note entry of 03/29/12 & 4/10/12 and the SCSA of 04/10/12). 2. On 03/29/12: Resident #4 had a correction request completed for the qtr. MDS of 03/12/12 and that MDS was then noted as a SCSA (enclosed are copies of those three items). The SCSA process was then done with the triggered care areas reviewed and addressed as necessary. 3. On 03/29/12: Resident #5 had a correction request completed for the qtr. MDS of 03/22/12 and that MDS was then noted as a SCSA (enclosed are copies of those three items). The SCSA process was then done with the triggered care areas reviewed and addressed as necessary. 4. Effective March 29, 2012: a quality assurance (QA) program was implemented by and under the supervision of the DON to assure that if again resident #4 & #5 of the sampled residents and any resident of MMHCC has a possible SC in their status that they will be evaluated by the IDT using the SCSA guidelines of the RAI manual. This will be accomplished by: * The IDT will meet weekly (full weeks of the month) and review the resident roster to assess if any changes have been noted in a resident and if so, do they meet the SCSA guidelines? This will be done as a QA for six months, April through September 2012, with the QA being done September 28, 2012. (Copy of the completed QA form for April is enclosed)	

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F 274	Continued From page 5 frequency . . . Any decline in an ADL [Activity of Daily Living] physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment . . . Resident's incontinence pattern changes . . . Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status . . ." - Review of Resident #5's medical record occurred on all days of survey. Current diagnoses included Alzheimer's dementia with Sundowning, insomnia, osteopenia, and a right humerus fracture on 11/17/11. Resident #5's medical record included a care note, dated 11/18/11, stating, " . . . resident had a fall . . . has a contusion on the right shoulder and a fracture to the right humerus . . . She is right handed. . . OT [occupational therapy] and PT [physical therapy] will be assessing . . . I am not going to do a significant change of condition as we will adjust the care plan as needed and the condition should be acute. We will address the concern of pain . . . and again adjust ADL's and care plan as needed." An admission Minimum Data Set (MDS), dated 10/06/11, identified Resident #5 as needing limited assistance of one person for the following Activities of Daily Living (ADLs): bed mobility, transfer, walking in room and in corridor, and locomotion on and off the unit. Quarterly MDSs, dated 12/22/11 and 03/22/12, identified Resident #5 required extensive assistance of one person for the following ADLs: bed mobility, transfer, walking in room and in corridor, and locomotion on and off the unit.	F 274	*When the RCCS are doing the monthly scheduled MDS's the MMHC computer program known as ECS (Electronic Charting System) has a "pop up" note that appears on the screen when the MDS is completed. This note states that possible significant changes have been noted. At this time the RCC will review that MDS with the rest of the IDT and it will then be decided if that particular assessment meets the SCSA guidelines or not. A log of those monthly MDS's will be kept and each MDS that is completed for that month will be noted if there was a change in resident's status or not. If there was, did it meet the SCSA guidelines; will there be a 14 day determination period etc... "The final decision must be based upon the judgment of the IDT" (from Page 2-22 of SCSA guidelines of the RAI manual). "MDS assessments are not required for minor or temporary variations in resident status-in these cases, the resident's condition is expected to return to baseline within 2 weeks" (from Page 2-22 of SCSA guidelines of the RAI manual). If a SCSA is not necessary the RCC will make that note on the log (that same note will also be in the care plan notes for that MDS review). The monthly log will be part of the QA monitoring for six months: April through September 2012, with the QA being done September 28, 2012. The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. These findings will be presented at the quarterly QA meeting on May 30, 2012. (Copy of the log thus far for the MDS reviews for April 2012 is enclosed). These QA interventions for SCSA will be a good practice for the IDT to continue on a permanent basis.	05/30/12

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F 274	Continued From page 6	F 274		

During an interview on 03/28/12 at 3:00 p.m., an administrative nurse (#3) agreed the decline in Resident #5's ADL capabilities does require a significant change MDS.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with behavioral disturbances, paranoia, anxiety, and peripheral vascular disease.

A note included in the quarterly review, dated 03/13/12, stated ". . . will not do a significant change - monitoring concerns as they occur, skin conditions occur [with] ongoing fashion and condition remains unstable - probably continue to have changes."

Resident #4's quarterly MDS, dated 03/12/12, showed a decline in the following two areas: frequent incontinence of bowel and two new Stage II pressure ulcers. The admission MDS, dated 12/19/11, showed continence of bowel and no pressure ulcers. The quarterly MDS showed an improvement in the following multiple areas: five mood symptoms occurring never or 1 day of the 14-day lookback period, a depression severity score of 0, verbal and other behavioral symptoms occurring 1-3 days in the 7-day lookback period, and rejection of care occurring 1-3 days in the 7-day lookback period. The admission MDS showed the same five mood symptoms occurring 7-11 days, a depression severity score of 16 indicating moderately severe depression, verbal and other behavioral symptoms occurring 4-6 days, and rejection of care occurring daily.

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F 274	Continued From page 7 The facility failed to consider Resident #4's bowel incontinence, new pressure ulcers, and improvement in moods and behaviors as a significant change, therefore limiting staff's ability to develop a comprehensive plan of care to meet the resident's needs.	F 274		
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. 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.	F 278	F278 It is the policy of MMHCC to assure that the MDS assessments reflect the accuracy of the residents' status. During the survey process surveyors visited in length with the RCC'S that did the MDS on residents #4, #6 and #11 in regards to the scoring of the toileting program. The RAI manual pages H-3 through H-8 that addresses the Toileting program (TP) were thoroughly reviewed. The reason the RCC's scored the fore mentioned residents as being on a TP was because they were being prompted for bathrooming and this was keeping them mostly continent. As an example in the TP information from the RAI manual, prompted voiding is noted. After much discussion it was decided that even though prompted voiding is noted as an example for TP, it truly is not a TP therefore residents #4, #6 and #11 would need to have their most current MDS corrected. Resident #6 was not noted on the Matrix as being on a TP but with her most recent MDS (02/14/12) she was mistakenly noted as being on a TP (see enclosed note to one of the surveyors). Three residents on the Matrix (residents #'s 1437, 1336 &1447) were not noted on their most current MDS to be on a TP but the RCC's would have marked them as such with the next MDS review therefore their current MDS did not have to be corrected. The following residents #'s 1571, 1174, 1467, 1463, 1599 &1194 were noted on their most current MDS as being on a TP therefore a corrected MDS was completed (copies of those MDS pages that pertain to the former and corrected MDS are enclosed on residents noted with TP on current MDS). March 29, 2012 the following was put in place to assure that this section is properly scored in the future.	

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F 278	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflect the residents' status for 3 of 3 sampled residents (Resident #4, #6 and #11) identified on a toileting plan. Failure to accurately assess residents and code the MDS accordingly may affect the level of care provided to the residents and limit the facility's ability to develop and implement individualized care plans consistent with the residents' needs and functional status. Findings include: The Long-Term Care Facility RAI User's Manual, October 2011, page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ." Page Z-6 states, ". . . 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	F 278	1. Corrected MDS's were completed as fore mentioned. 2. Effective March 29, 2012: a quality assurance (QA) program was implemented by and under the supervision of the DON to assure that if any resident of MMHCC will be scored as a TP, the definition & the criteria of the Urinary Toileting program, pages H-3 throughH-8, of the RAI Manual will be reviewed thoroughly. If necessary to help with that decision making, the State MDS Coordinator will be contacted for her input. *When the RCC's are doing the scheduled monthly MDS's, on that same log that is being utilized to monitor the SCSA, they will make note if each resident reviewed was on a TP or not. *The monthly log will be part of the QA monitoring for six months: April through September 2012, with the QA being done September 28, 2012. The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. These findings will be presented at the quarterly QA meeting on May 30, 2012. (Copy of the log thus far for the MDS reviews for April 2012 is enclosed as well as the completed QA for the month of April). These QA interventions for a TP will be a good practice for the IDT to continue on a permanent basis.	5/30/12

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F 278	Continued From page 9 * The Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities . . . * the data-driven survey and certification process * the quality measures used for public reporting . . ." Review of the undated facility policy "Toileting Program (Routine)" occurred on 03/28/12. This policy stated, ". . . Procedure: . . . 8. Do initial assessment for bowel and bladder retraining, on admission. 9. If bowel and bladder re-training is unsuccessful, if resident is not a candidate for bowel/bladder re-training, or if bowel and bladder have been established this program can be/should be used. 10. Take resident to bathroom at least q [every] 2 hrs [hours] or at time established to prevent incontinence . . . 11. Take to bathroom . . . after meals, naps, and awaken at night before usual incontinence occurs (between 10 pm and 2 am) . . . 13. Changes in bowel and bladder habits are reviewed quarterly and as needed." - Review of Resident #11's medical record occurred on all days of survey and medical diagnoses included benign prostatic hyperplasia (BPH) (an enlarged prostate). Resident #11's "Bladder Assessment Form" identified the resident " . . . began bladder assessment 08/31/11. . . . Almost always has incont [incontinence] [with every] check or is incont [incontinent] [with] transfer down onto the toilet & then will still void on toilet. . . . Prompting by staff [every] 2 [hours] & if awake [at night] - no real pattern to incont so specific times not an option for the plan. . . ."	F 278		

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Review of Resident #11's quarterly MDSs dated 11/03/11 and 02/08/12 identified the resident as frequently incontinent of urine and on a urinary toileting plan.

Resident #11's current urinary care plan stated, "PROBLEM . . . Alteration in urinary function . . . history of incontinence . . . related to decreased mobility & cognition . . . BPH . . . APPROACH . . . Scheduled voided [sic] about [every] 2-3 [hours] whether or not sensation is present. . . ."

Observation on 03/28/12 at 10:10 a.m. showed two certified nurse assistants (CNAs #4 and #5) assisted Resident #11 to the toilet and changed his incontinent product. CNA #4 stated the resident's brief was wet and that the resident is "always a little wet."

During an interview on 03/28/12 at 3:00 p.m., an administrative nurse (#3) confirmed the facility incorrectly coded Resident #11 as having a urinary toileting program.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia with behavioral disturbances.

Resident #4's admission MDS, dated 12/19/11, showed a trial of a urinary toileting program was completed on admission with the response to the trial "unable to determine." The admission MDS and a quarterly MDS, dated 03/12/12, showed the resident on a current toileting program or trial and showed the resident frequently incontinent.

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Resident #4's Bladder Assessment Form, dated 12/20/11, stated, ". . . I do not feel [with] his cognitive state, behaviors, poor understanding that he is a candidate for a retraining program. Current toileting program: routinely toileted by staff q 2-3 hr and if awake q noc [night]."

The care plan, dated 12/22/11, included "PROBLEM: Alteration in urinary elimination due to poor awareness of voiding task resulting in incontinence. RELATED TO: Cognitive deficit. . . ." The current ADL [Activity of Daily Living] CNA [certified nurse aide] care plan for toileting stated "prompt every 2-3 hours and as needed, and if incontinent - change [brief] . . ."

Observations on 03/26/12 at 4:30 p.m., 03/27/12 at 10:15 a.m. and 1:20 p.m. showed staff removed a wet brief before placing the resident on the toilet. The resident also voided in the toilet during the 1:20 p.m. toileting.

A quarterly review, dated 03/13/12, stated, ". . . Discontinue use of pullups as not containing incontinence and is in a brief. Staff routinely toilet and toileting on his request also."

The facility instituted a routine toileting program versus an individualized toileting program based on Resident #4's individual toileting patterns, and inaccurately identified the resident as participating in a scheduled toileting program.

- Review of Resident #6's medical record occurred on March 26-27, 2012. The most recent quarterly MDS, dated 02/13/12, identified the resident as being on a toileting program. The corresponding summary review for the 02/13/12

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F 278	Continued From page 12 quarterly MDS stated, ". . . Continence: Is frequently incontinent of bowels and bladder. I [staff member completing MDS] visited with her [Resident #6] about bladder retraining and she is not interested. She said she will let them [staff] know when she wants to go, they don't have to remind her. She is poorly motivated . . ." During an interview on 03/27/12 at 12:00 p.m., an administrative nurse (#3) stated staff incorrectly coded Resident #6's 02/13/12 quarterly MDS, as the resident was not on a toileting program at that time.	F 278		
F 323 SS=E	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: #1. Based on record review, review of facility policy, and staff interview, the facility failed to adequately assess and document 3 of 3 sampled residents' (Resident #1, #3, and #10) ability to safely smoke without supervision. Failure to provide a safe environment by ensuring residents who smoke can do so safely based on a consistent assessment process, reassessment with changes in resident status, and documentation of the assessment results, places residents who smoke at risk for burns or other	F 323	323: It is the policy of MMHCC to assure that residents receive adequate supervision and assistance devices to prevent accidents. This tag has two concerns noted: Cigarette Smoking Safety for Residents & Transfer Belt use. A. Cigarette Smoking Safety: On 03/28/12 surveyors visited with the DON and RCC's in regards to smoking safety for our residents who do smoke. The concern was that no initial assessment and follow-up assessments from the initial assessment were being conducted. Information from CMS was provided to the DON from a surveyor on the revisions for F 323 (memo from CMS dated 11/10/11) in regards to smoking. March 29, 2012 the following was put in place to assure that resident #1, #3 & #10 of the survey roster as well as the other residents of MMHCC that smoke are capable of smoking in a safe manner. • A "Safe Smoking Evaluation" was developed by the DON and reviewed by the IDT (RCC's, DON & Administrator). The IDT approved the evaluation and on the back of this evaluation is where any concerns noted with the assessment will be noted. • A policy/procedure was developed by the DON using F323 information and the fore mentioned memo from CMS as a guideline. This policy was approved by the IDT for smoking concerns (A copy of the policy is enclosed). RCC's reviewed this policy/procedure with each smoking resident (this is noted as #1 on the smoking evaluation). The policy was attached to the Nurses' and the CNA's April 18, 2012 in-service packet and was reviewed with the staff by the DON on 04/18/12.	

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F 323	Continued From page 13 injuries, and places all residents, staff, and visitors at risk for injury. Findings include: Review of the facility policy titled "Resident Smoking Policy" occurred on 03/28/12. This policy, not dated, stated, "Residents may smoke only in the smoking hut or by the nurses station in certain situations . . . Residents who require total assistance with smoking and residents who are unable to maintain a safe environment with smoking independently will not be allowed to smoke. . . . For safety purposes; smokers are to wear a smoking apron if specified by the RCC [Resident Care Coordinator]. If resident refuses to wear a smoking apron a Release of Responsibility needs to be in place and signed by the resident and/or responsible party. If resident is able to maintain a safe and responsible environment, which is determined by RCC, DON [Director of Nursing] and Administrator, he/she may keep their own lighter and cigarettes. . . ." - Review of Resident #1's medical record occurred March 26-28, 2012. The record lacked an assessment of Resident #1's smoking ability. The record showed Resident #1 signed a "Release of Responsibility" at the time of admission identifying the resident would wear a smoking apron indoors, but not outdoors. The facility admitted Resident #1 approximately two years ago. Record review identified Resident #1 experienced two separate injuries which staff concluded were cigarette burns in January 2012. Incident reports, dated 01/01/12 and 01/20/12, indicated Resident	F 323	• Visitors smoking policy was developed by the DON and this was reviewed and approved by the Administrator. The visitors smoking policy and the concern addressing visitors not wanting to pass through the smoking room to the back patio were posted on the wall by the smoking room entrance (copy of that is enclosed). • Effective April 11, 2012: a QA program was implemented by and under the supervision of the DON to assure that if any resident of MMHCC who smokes is able to do so in a safe manner. RCC's were given the "Safe Smoking Evaluations" and the Smoking policy/procedure and informed that the initial assessments need to be completed on our residents who smoke by 04/25/12 (copies of those evaluations for our seven (7) residents who smoke are enclosed). These residents will be evaluated every quarter or sooner if any change in their status occurs that may indicate they are no longer able to smoke safely. Frequency of QA monitoring: Initial assessments completed by April 25, 2012. Then quarterly (July, October 2012 & January 2013) the DON will check with the RCC's if any concerns are noted. QA monitoring will be completed January 31, 2013 (A copy of the QA study form that has been initiated is enclosed and will be completed fully for the May QA meeting on May 30, 2012). If concerns are noted between quarters with any resident who smokes, immediate corrective action will be taken by the IDT (e.g. re-evaluation of the smoking resident, smoking ceased if concerns noted according to procedure etc...). The DON will submit a report to the QA Committee at each scheduled quarterly meeting.	5/30/12

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#1 sustained a blister to a finger and a wound to the top of a thigh. Nursing documentation showed a staff member visited with the resident on 01/23/12 about smoking and indicated staff would observe the resident smoking for a week. Documentation showed two days of staff observation during the next week. During an interview, on the morning of 03/28/12, an administrative nurse (#3) stated staff determined cigarette burns caused the injuries based on the location of the blister and the wound. Staff failed to assess Resident #1's ability to safely smoke which may have resulted in injuries to the resident.

- Review of Resident #3's medical record occurred March 26-28, 2012. A physician order, dated 11/25/11, stated, "Check that wearing cover cushion on Roho [wheelchair cushion] bid [twice daily] (will be considered refusal of care due to cigarette smoking, refuses to wear apron, burns holes in Roho cushion cover)." Resident #3's current care plan indicated ". . . allowed to smoke - needs use apron - often refuses . . ." The resident's current CNA [certified nurse aide] care plan listed ". . . check inside cushion cover and under cushion for cigarette butts . . ."

Resident #3's nurses notes revealed the following:
* 11/25/11 at 2:26 p.m. -"I approached resident as to why he has been consistently refusing to allow the Roho Cushion covers we have made for his Roho. Resident replied 'I'm not using those [expletive] things.' Showed resident multiple burn holes on his present cushion cover (the one that comes with the cushion). . . . Refusal to wear this will be considered a refusal of care as this is a

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F 323	Continued From page 15 safety issue due to the danger of cigarette smoking and him refusing to also wear the apron. . . . I also noted resident has burn holes in his shirt and shorts. . . ." * 12/02/11 at 11:31 a.m. - ". . . had two pair of black shorts . . . that are missing but these may have been thrown as he often has cigarette burns in his clothing (refuses to wear smoking apron . . .)" * 02/22/12 at 10:53 p.m. - "Resident retrieved cigarette butt from ashtray that was still lit; was smoking it and claimed it was his despite just wheeling into the smoking room seconds prior to observation . . ." Resident #3's record lacked an initial assessment and periodic assessments of Resident #3's ability to smoke safely. - Review of Resident #10's medical record occurred March 27-28, 2012. Medical diagnoses for Resident #10 included legal blindness, chronic obstructive pulmonary disease (COPD), dementia, and anxiety. Information obtained from an administrative nurse (#12) during the initial tour of the facility on the morning of 03/26/12, identified Resident #10 as a "smoker." A form titled "Release of Responsibility," dated 03/26/10, signed by an administrative nurse and Resident #10, stated, "I visited in resident's room [with] him re: [regarding] smoking safety issues - He says he will continue to smoke [and] keep smoking [and] is aware of the risks of fire. I told him he could start himself on fire. He said he won't. I told him that if he does we will be using a fire extinguisher on him that is specifically to be used on people." An additional entry on this form,	F 323		

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F 323	Continued From page 16 dated 09/08/10, stated, "[Resident #10's name] most often allows us to place the smoking apron over his lap - but sometimes not . . . ." Resident #10's care plan stated, "Problem: Potential altered respiratory status, risk of respiratory infection and safety related to: COPD . . . cigarette smoking, refuses occ [occasionally] to wear smoking apron," and "Approach . . . Smokes in designated area in building or outdoors . . . cigarettes are allotted by nurse . . . ." Resident #10's record showed no evidence the facility completed an assessment to determine if the resident is physically capable to safely smoke. During an interview on 03/28/12 at 1:40 p.m., an administrative nurse (#3) stated the facility has "no initial assessment for smoking. If a resident is alert, aware, and dexterity is good, than the resident can smoke. If issues come up later, we look at the issues to see if we need to change the right to smoke." #2. Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 3 of 6 sampled residents (Resident #6, #8, and #12) observed being transferred with a gait belt. Failure to use gait belts appropriately has the potential for residents to experience falls, injuries, and/or pain. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON APRIL 28, 2011.	F 323		

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F 323	Continued From page 17 Findings include: Review of the facility policy titled "TRANSFERRING RESIDENT WITH TRANSFER BELT" occurred on 03/28/12. This undated policy stated, "POLICY: Any resident who has poor weight bearing on transfer should be transferred using a transfer belt . . . 3. Have belt snug at resident's waist for comfortable and safe transfer. Fingers of CNA's [certified nurse aide's] hands can be comfortably slipped between resident and belt . . ." - Review of Resident #6's medical record occurred on March 26-27, 2012. Diagnoses included degenerative joint disease and tremors. The quarterly Minimum Data Set (MDS), dated 02/13/12, identified the resident required extensive assistance of one staff member for transfers. The current CNA "care card" (an abbreviated care plan located on the door of each resident's bathroom) identified the resident transferred with her walker and extensive assistance of one staff member. Observation on 03/27/12 at 9:33 a.m. showed a CNA (#9) transferring Resident #6 from her bed to her wheelchair, from the wheelchair to the toilet, and from the toilet back to her wheelchair. The gait belt hung loosely around the resident's waist during all of the transfers. The CNA (#9) held onto the loose gait belt with one hand, and lifted under the resident's left arm with her other hand when assisting the resident to stand from the bed and the toilet.	F 323	A. Transfer belt safety: It is the policy of MMHCC to assure that residents receive adequate supervision and assistance devices to prevent accidents. • On 03/28/12 surveyors visited with the DON and RCC's in regards to concerns they noted with transfer belt use on residents #6, 8 &12 (of the survey roster). These residents were not transferred in a safe manner with our policy not being followed. The following was put in place on 03/28/12. • A note was placed in the CNA and nurses dept. communication notebook on March 28, 2012 after our exit review with the survey team addressing the transfer belt concern (copy of the 03/28/12 note is enclosed). • March 29, 2012 the Director of Nursing (DON) reviewed the policy entitled "Transferring Resident with Transfer Belt" and one revision was made and that is as follows: "A transfer belt is also in each resident's room in the bathroom and in the bathing areas (a copy of this policy is enclosed with the revision highlighted in pink). • Transfer belts were ordered from Posey and have been placed in the bathrooms (a copy of the invoice and a picture of what was ordered is enclosed). • Nursing staff in-services were held on April 18, 2012 and transfer belt usage was addressed at both the Nurses in-service and the CNA's in-service with the policy being reviewed (Enclosed is a copy of the in-service notes for the CNAS' and Nurses' along with the attendance record of those two meetings). • At the CNA in-service on 04/18/12 in addition to the review of our transfer belt use policy, our Occupational Therapist M.R., presented an in-service on proper gait belt use, transfer training, proper lifting under the arms and then return demonstration a copy of M.R.'s syllabus is enclosed).	

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F 323	Continued From page 18 During an observation on 03/27/12 at 11:47 a.m., a CNA (#2) assisted Resident #6 to transfer from her wheelchair to the toilet, from the toilet to her wheelchair, and from her wheelchair to her bed. The CNA failed to use a gait belt when assisting the resident with all transfers. During the transfers, the CNA (#2) lifted under the resident's left arm to assist her to stand from the toilet and again from her wheelchair. - Review of Resident #8's medical record occurred on March 26-27, 2012. Diagnoses included osteoarthritis, Parkinson's disease, and dementia. The annual MDS, dated 01/30/12, identified the resident required extensive assistance of one staff member for transfers. The current CNA "care card" identified the resident transferred with extensive assistance of one staff member and a gait belt, or may use sit-to-stand mechanical lift. Observation on 03/27/12 at 11:35 a.m. showed a CNA (#1) transferring Resident #8 from her wheelchair to the toilet, from the toilet back to the wheelchair, and from the wheelchair to the resident's bed. The gait belt hung loosely around the resident's waist as the CNA grasped onto the belt. The CNA failed to tighten the gait belt during the transfer. - Review of Resident #12's medical record occurred on March 27-28, 2012. Diagnoses included Parkinson's disease, degenerative disc disease of the spine with stenosis, chronic pain, and osteoarthritis. The quarterly MDS, dated 01/01/12, identified the resident required extensive assistance of one staff member for	F 323	• At the CNA in-service on 04/18/12 the staff was also informed of the ramifications that will occur if the policy is not followed and that is as follows: For the next year or until our next survey whichever comes first the following will occur: 1. The first time the DON sees a CNA not using a transfer belt at all or not using it correctly and not lifting a resident properly under the arm the CNA will receive a verbal warning about their technique. 2. If found the second time not using a transfer belt or not using it correctly and not lifting a resident properly under the arm, the CNA will receive a written warning. 3. If noted the third time, the CNA will be written up again AND put on two weeks suspension-that is two weeks off with no pay and this will give them time to think about whether or not they are going to follow policy/procedure. 4. If they decide to not follow procedure the fourth time, the CNA's position is terminated 5. There will be no excuses. OUR RESIDENTS DESERVE TO BE CARED FOR IN A SAFE MANNER." Note: this was in the CNA's in-service papers and a copy of those in-service notes is enclosed.	

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	355036	A. BUILDING _____ B. WING _____	03/28/2012

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

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F 323	Continued From page 19 transfers. The current CNA "care card" identified the resident transferred with limited or extensive assistance of one or two staff members, depending on the resident's weight bearing status for the shift. Observation on 03/28/12 at 11:40 a.m. showed two CNAs (#8 and #12) transferring Resident #12 from her wheelchair to her bed using a gait belt. During the transfer, the CNA (#12) held on to the gait belt with one hand, and lifted under the resident's left arm with her other hand. During an interview on 03/28/12 at 2:40 p.m., an administrative nurse (#3) stated she expected staff to use a gait belt anytime they physically assist a resident, the gait belt should be "nice and snug," and staff should not lift residents under their arms.	F 323	• As of 04/26/12 the DON has not had to give any type of warning as fore mentioned. • Effective April 02, 2012: a quality assurance (QA) program was implemented by and under the supervision of the DON to assure residents #6, #8 & #12 of the sampled residents and all residents of MMHCC are transferred in a safe manner. . Frequency of random QA monitoring: Weekly for one month-April 02 through April 27, 2012, Monthly for three months (May-June-July 2012) and then quarterly (October 2012 & January 2013) with QA monitoring completed January 31, 2013 (Copies of completed QA are enclosed). If concerns are noted with the monitoring/observations immediate corrective action will be taken (e.g. teaching with staff member involved in the task, if necessary a note in the CNA & nursing dept. communication book etc..) The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. These findings will be presented at the quarterly QA meeting on May 30, 2012.	5/30/12
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441	F441: It is the policy of MMHCC to assure that the Infection Control Program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. * On 03/28/12 surveyors visited with the DON in regards to concerns they noted with their care observations: staff did not wash or gel their hands after they removed their gloves after completing peri care on residents #5, #6, #8, #11 & #12 and staff continued on with cares for the resident and only washed or gelled their hands when they were ready to leave the resident's room. Staff also did not wash the resident's hands. The following was put in place on 03/28/12. *A note was placed in the CNA and nurse's dept. communication notebook on March 28, 2012 after our exit review with the survey team addressing the hand washing (a copy of that note is enclosed). *March 29, 2012 DON reviewed the current peri care procedure and one revision was added and that was that resident's hands are to be washed after peri-cares (copy of the procedure is enclosed and the revision is highlighted in pink).	

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F 441	Continued From page 20 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 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/28/11. Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to follow infection control practices for 5 of 10 sampled residents (Resident #5, #6, #8, #11, and #12) observed assisted with toileting. Failure to perform hand hygiene after completing perineal cares does not ensure a safe and sanitary environment to prevent the transmission of disease and infection.	F 441	*Effective April 02, 2012: A QA program was implemented by and under the supervision of the DON to assure residents #5, #6, #8, #11 & #12 of the sampled residents and all residents of MMHCC that the infection control issue with the survey was addressed properly. The DON will perform random monitoring of the hand washing/gelling after glove removal following peri-cares. Frequency of QA monitoring: Weekly for one month-April 02 through April 27, 2012, Monthly for three months (May-June-July 2012) and then quarterly (October 2012 & January 2013) with QA monitoring completed January 31, 2013 (Copies of completed QA monitoring). If concerns are noted with the monitoring/observations immediate corrective action will be taken (e.g. teaching with staff member involved in the task, if necessary a note in the CNA & nursing dept. communication book etc..) The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. These findings will be presented at the quarterly QA meeting on May 30, 2012. *Nursing staff in-services were held on April 18, 2012 and hand washing after peri-cares was addressed at both the Nurses in-service and the CNA'S in-service (Enclosed is a copy of the in-service notes for the CNAS' and Nurses' along with the attendance record of those two meetings). At the CNA in-service on 04/18/12 the staff was also informed of the ramifications that will occur if the policy is not followed and that is as follows: For the next year or until our next survey whichever comes first the following will occur: 1. The first and second time the DON sees a CNA not washing his/her hands after per-care according to policy they will receive a verbal warning. 2. If noted a third time not washing their hands after peri-care according to policy, the CNA will receive a written warning 3. If noted the fourth time they will be put on two weeks suspension-that is two weeks off with no pay and this will give them time to think about whether or not they are going to follow policy/procedure. 4. If noted the fifth time their position will be terminated.	5/30/12

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F 441	Continued From page 21 Findings include: Review of a policy and procedure titled "Handwashing" occurred on 03/28/12. This undated policy stated, ". . . 4. Handwashing should always follow the removal of gloves . . . 12. Remove gloves following pericare. Assure resident is safely positioned and then wash hands (soap and water or hand gel) before carrying out other duties . . . " - Observation of Resident #5's personal cares occurred on 03/26/12 at 1:30 p.m. The resident urinated in the toilet, and a certified nursing assistance (CNA #6) donned gloves and provided perineal care. The CNA removed her gloves and without performing hand hygiene, assisted the resident to walk back to her recliner, handed the resident a water glass, moved the bedside table next to the resident, brushed the resident's hair, and placed a call bell next to the resident prior to performing hand hygiene. - Observation of Resident #11's personal cares occurred on 03/28/12 at 10:10 a.m.. The resident urinated in the toilet, and a CNA (#4) donned gloves and provided perineal cares. The CNA removed her gloves, assisted the resident back to his wheelchair, removed an EZ stand sling from behind the resident, reached under the resident's shirt to pull down his undershirt, tucked in the resident's shirt in the back and front, adjusted the foot pedals on the wheelchair and placed a towel over the resident's shoulder. The CNA (#4) then used hand sanitizer to clean her hands. - Observation of Resident #11's personal cares occurred on 03/28/12 at 11:54 a.m.. The resident	F 441		

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F 441	Continued From page 22	F 441		

urinated in the toilet and a CNA (#11) donned gloves and provided perineal cares. The CNA removed her gloves, raised the resident's bed, using an EZ lift lowered him onto the bed, removed the EZ lift sling, took off the resident's shoes, placed heel covers on the resident, assisted him to lay down, elevated the head of bed, placed a pillow under his right side and between his calves, covered him with a blanket, and lowered the bed to the floor prior to performing hand hygiene.

- Observation on 03/27/12 at 11:35 a.m. showed a CNA (#1) assisting Resident #8 with toileting. After the resident voided into the toilet, the CNA (#1) completed perineal cares, removed her gloves, transferred the resident from her wheelchair to her bed, took the resident's glasses and shoes off, covered her with a blanket, adjusted her bed, and placed her call light. The CNA (#1) then exited Resident #8's room and went to assist another resident in a near-by room. The CNA (#1) failed to perform hand hygiene after completing perineal cares.

- Observation on 03/27/12 at 11:47 a.m. showed a CNA (#2) assisting Resident #6 with toileting. The CNA (#2) performed perineal cares, removed her gloves, transferred the resident from her wheelchair to her bed, removed her shoes and glasses, covered her with a blanket, placed her oxygen cannula and call light in reach, adjusted her bed, and then washed her hands. The CNA (#2) failed to perform hand hygiene after completing perineal cares.

- On 03/28/12 at 10:20 a.m., two CNAs (#7 and #8) assisted Resident #12 with toileting. The

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F 441	Continued From page 23 resident voided and had a bowel movement in the toilet. The CNA (#8) performed perineal cares, changed her gloves, applied cream to the resident's buttocks, changed her gloves, applied a clean brief, and then removed her gloves. The CNA (#8) then assisted the resident out of the bathroom, applied foot pedals to her wheelchair, handed her some tissues, combed the resident's hair, gave her the call light, and handed her a glass of water prior to washing her hands. During an interview on 03/28/12 at 2:40 p.m., an administrative nurse (#3) stated she expected staff to perform hand hygiene immediately after completing perineal cares, after ensuring the residents' safety.	F 441		