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 _____	01/25/2017

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/22/17 and completed on 01/25/17, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of policies/procedures, and staff interview, the facility failed to provide care for 3 of 12 sampled residents (Resident #2, #3, and #6) and 1 supplemental resident (Resident #16) in a manner that maintained, enhanced, and respected each resident's dignity and individuality. Failure to remove a gait belt after cares and scraping food from residents mouths with a spoon when feeding does not preserve the residents personal dignity or enhance the residents quality of life and places them at risk of embarrassment or emotional harm. Findings include: - Review of the facility policy "TRANSFERRING RESIDENT WITH TRANSFER BELT" occurred	F 241	F241: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #2, #3, #6 and #16 from the survey sample roster and all residents of MMHCC are treated and cared for in a manner and in an environment that protects and promotes their resident rights, preserves their dignity and respects their individuality. This tag has the following two concerns: 1.) Failure to remove a gait belt after cares. This was noted with two (2) residents. A. Resident #16: It is this resident's request to keep the gait belt on around her waist after cares are completed. This has been resident's request since her admission 05/27/11. Resident is capable	3/1/17

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

Electronically Signed | 02/15/2017

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F 241	Continued From page 1 on 01/25/17. This undated policy stated, ". . . Any resident who may fall or become unsteady on transfer should be transferred using a transfer belt. . . . Assist resident with transfer . . . Position resident comfortably and remove belt. . . ." Observations during the initial tour, on 01/22/17 at 9:30 a.m., showed the following: * Resident #2 sitting on the edge of bed with a transfer gait belt secured around her abdomen. * Resident #16 sitting in the wheelchair with transfer gait belt secured around her abdomen. - Review of the facility policy "FEEDING THE DEPENDENT RESIDENT" occurred on 01/25/17. This undated policy stated, ". . . Do not scrape food off the resident's chin with a spoon, you wipe resident's mouth off with a napkin . . ." Observations showed the following: * 01/23/17 at 11:13 a.m. a certified nurse assistant (CNA) (#1) fed Resident #3 and scraped food with a spoon from Resident #3's chin and fed it to Resident #3. * 01/23/17 at 11:20 a.m. - a CNA (#7) fed Resident #6, scraped excess food four times from her chin/face, and fed it back to her. * 01/24/17 at 11:20 a.m. a CNA (#2) fed Resident #3, scraped food with a spoon from the resident's chin, and fed it back to him. During an interview on 01/25/17 at 10:30 a.m. an administrative nurse (#3) confirmed food should not be scraped from the face. An administrative nurse (#3) confirmed Resident #2 and Resident #16 should have the gait belt removed when transfers are completed.	F 241	of voicing her needs and if staff attempts to take the belt off she will inform staff that it is her request to keep the belt on during the day and to take it off at bedtime. When she feels she is ready for a change in belt color she will come to the supply clerk and ask to see what belts are in stock and will then choose a new belt for herself. The concern is that her request to keep the belt on after cares and during the day was inadvertently not placed on resident's careplan. This is now careplanned. B. Resident #2: This resident is also capable of voicing her needs. After the concern was brought to our attention at the survey exit on 01/25/17 the Resident Care Coordinator (RCC) visited with resident. The RCC asked resident if she preferred to keep the belt in place after cares or taken off and it is the resident's request to have the belt removed after cares which the facility's policy is. After the survey exit on 01/25/17 the nursing staff was notified by the Director of Nursing (DON) via the Nursing Staff communication book that per Resident #2's request the gait belt is to be removed following her cares. The DON also noted in the communication book that the facility's procedure for Transfer/Gait belt use states "position resident comfortably and remove the belt" C. Transfer Belt use procedure was revised to address concern of the Tag: The following was added as #7: "If a resident requests to have the transfer/gait belt stay in place after cares are	

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F 241	Continued From page 2	F 241	completed, his/her request will be respected and the Resident Care Coordinator (RCC) will careplan resident's request. Resident's request will be reassessed quarterly by the RCC with the MDS review or sooner if deemed necessary". 2.) Second concern with this tag: Scraping food from the resident's chin with a spoon was noted with Resident #3 and #6 from survey sample. Following the survey exit on 01/25/17 the Nursing staff was notified by the DON via the Nursing Staff communication book that scraping food from resident #3 and #6's (or any resident who is fed) mouth or chin with a spoon is a dignity issue and inappropriate. Staff was also informed with this note of what our policy "Feeding the Dependent Resident" states "Do not scrape off the resident's chin with a spoon, you wipe resident's mouth off with a napkin and that may need to be done frequently. Extra napkins are at the resident's place setting". 3.) Resident who reside at MMHCC who require use of a transfer/gait belt have the potential of having the belt left in place after care and those residents who are dependent in eating have the potential to have food scraped from their chin with a spoon. To assure that the facilities policy for these two (2) concerns are followed and residents' dignity and individuality is maintained the following interventions were put in place. A. Individual in-services were held with the nurses and the CNAs on 02/08/17 at	

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F 241	Continued From page 3	F 241	which time the deficiency tag and concerns were reviewed and policies related to these F tag concerns were reviewed. Nurses were informed if they observe these concerns to remind the CNA of the policy and CNAs were also informed if they observe these concerns with a co-worker to remind that CNA of the policy. B. With Quality Assurance (QA) monitoring the following will be conducted to assure the concerns with the tag are being addressed: the DON or Designee will randomly observe the following: * Resident #2 as well as other residents who require a transfer/gait belt use to assure the belt was removed after cares. *If Resident #16's transfer/gait belt is kept on after cares per resident's request. *Resident #3 and #6"s as well as other residents who are dependent with eating to assure food was not scraped from their chin/mouth with a spoon but cleansed from the area with a napkin(s). 4.) Frequency of QA Monitoring: Weekly for four (4) weeks: 01/29/17 thru the week of 02/19/17 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2017) and then quarterly (August and November) with QA monitoring completed 11/30/17. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved staff by DON or Designee). The DON will submit a report of the deficiency along with the completed monitoring at the next QA meeting tentatively set for 04/24/17. Then at the quarterly meetings after	

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F 241	Continued From page 4	F 241	04/24/17 only the monitoring results will be reported to the QA committee through 11/30/17. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 03/01/17	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278		3/1/17

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F 278	Continued From page 5 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure accuracy of the coding of the Minimum Data Set (MDS) for 10 of 13 sampled residents (Resident #1, #3, #4, #5, #6, #8, #9, #10, #11, and #13). Failure to include all the days of the look back period when completing the MDS and to accurately complete Section E (Hallucinations) (Resident #13) and Section P (Restraints) (Resident #8) does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION Z0400 The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page A-31 stated, ". . . 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 . . ." Therefore, the earliest you can code	F 278	F278: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #1,#3, #4, #5, #6, #8, #9, #10, #11 and #13 from the survey sample roster and all residents of MMHCC Minimum Data Set (MDS) review/assessments are coded accurately and include the proper time frame of observation in order to reflect the resident's current status so a comprehensive care plan can be developed to assure the care provided for the residents is appropriate. This tag has the following three concerns: 1.) Section Z0400 the Attestation Statement. This was noted with #1, #3, #4, #5, #6, #8, #9, #10, #11 and #13 from the survey sample roster. A. Certain sections of the MDS (sections C, D, J and Q) may require a staff interview in order to complete the section. If necessary to conduct an interview with the staff, certain areas in each of these sections need to be dated as complete after the Assessment Reference Date (ARD) to assure the accuracy of Section Z0400. • Following the survey exit on 01/25/17 the interdisciplinary team (IDT) which consists of the Resident Care	

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F 278	Continued From page 6 items with a look-back period and attest to the accuracy in Z0400 would be the day after the ARD. Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed . . . and the date completed . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. - Review of Resident #1's medical record occurred on all days of the survey. An annual MDS with an ARD date of 12/04/2016 identified the following: * Sections/Items C1310, Q0400 and Q0600 completed with a Z0400 date of 12/01/2016. - Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS with an ARD date of 12/19/16 identified the following: *Section/Items in J0100 A, J0100 B, J0100C, J0800, J0850, J1100, J1400, J1550, and J1800 completed with a Z0400 date of 12/19/16. - Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS with an ARD date of 01/09/17 identified the following: * Sections/Items in J0100, J1100-J1500, J1800, and J1900 completed with a Z0400 date of 01/09/17.	F 278	Coordinators (RCCs), activity director, dietary supervisor, social worker (SW), Occupational therapist (OT) and the DON met to discuss the completion dates of these sections and the inaccuracy concern of Z0400. The RAI manual along with information the survey team provided to understand the necessity of dating certain areas after the ARD date was reviewed and discussion was held and the IDT voiced understanding the concern. The DON advised the RCCs if they have any questions or concerns in regards to the dates of sections C, D, J, Q and Z0400 they are to contact the State RAI Coordinator J. C. for clarification. The SW was also instructed to have the RCC/DON check that she filled out Section E correctly before the RCC saves the MDS as completed. The RCC's were also informed that they need to have another RCC/DON check that they scored section P correctly before saving the MDS as completed. • DO NOTE that correction MDSs cannot be done for residents #1,#3, #4, #5, #6, #8, #9, #10, #11 and #13 from the survey sample roster because the dates for section Z0400 are set dates that are not changeable. B. Section E (Behavior) on Resident #13's MDS dated 12/07/16 had Hallucinations marked. In the look back period for this MDS no hallucinations were noted. Hallucination area was inadvertently marked. A correction MDS was completed 01/26/17. C. Section P (Restraints) on Resident #3	

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F 278	Continued From page 7 - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS with an ARD date of 11/28/16 identified the following: * Sections/Items in D0500 and D0600 completed with a Z0400 date of 11/28/16. * Sections/Items in C0700, C1000, and C1310 completed with a Z0400 date of 11/27/16. - Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS with an ARD date of 12/14/16 identified the following: * Sections/Items in C0700-C1000, C1310, J0100, J0800, J1100-1550, and J1800 completed with a Z0400 date of 12/13/16. - Review of Resident #8's medical record occurred on all days of the survey. A quarterly MDS with an ARD date of 01/08/2017 identified the following: * Sections/Items D0500, D0600, Q0400 and Q0600 with a Z0400 date of 01/06/2017. - Review of Resident #9's medical record occurred on all days of the survey. An admission MDS with an ARD date of 11/07/2016 identified the following: * Section/Item C1310 with a Z0400 date of 11/07/2016. - Review of Resident #10's medical record occurred on all days of survey. An admission MDS with an ARD date of 10/30/16 identified the following: * Sections/Items in C1310, J0100, J1100, J1400, J1550, J1800, Q0400, and Q0600 with a Z0400	F 278	and Resident #8. These two residents are the only residents in the facility with belts in place when up in their wheelchairs for postural support that could also be looked at as a restraint. Please note that Resident #3 was inadvertently missed in the deficiency report and should have been noted. Resident #3's MDS dated 12/19/16 and Resident #8's MDS dated 01/08/17 had the belts scored as a trunk restraint as the residents are not able to open the belts. During the survey, surveyors visited with the RCC who completed the MDS for these two residents and with much discussion and the reviewing the definition of restraints in the RAI manual it was determined the belts are postural supports for both residents. A correction MDS was completed on Resident #3 and Resident # 8 on 01/26/17. 2.) All Residents who reside at MMHCC have the potential of having their MDS scored incorrectly and if they require a postural support, could that device be considered a restraint. To assure that these concerns are avoided the following interventions were put in place. A. Individual in-services were held with the nurses and the CNAs on 02/08/17 at which time the deficiency tag and concerns were reviewed. This was not discussed in depth as the tag pertains more so to the IDT that completes the MDS. B. The IDT did meet after the survey exit on 01/25/17 to discuss the concern noted with dating sections C, D, J, Q and the	

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F 278	Continued From page 8 date of 10/28/16. - Review of Resident #11's medical record occurred on 01/25/2017. A quarterly MDS with an ARD date of 11/21/2016 identified the following: * Section/Item C1310 with a Z0400 date of 11/16/2016. - Review of Resident #13's medical record occurred on January 24-25, 2017. A quarterly MDS with an ARD date of 12/06/16 identified the following: * Sections/Items in C1310, J0100-J0300, J1100-J1550, J1800, and J1900 with a Z0400 date of 12/01/16. HALLUCINATIONS The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2015, pages E-2 - E-3 stated, ". . . E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. *Check E0100A, hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch . . ." Review of Resident #13's medical record occurred on January 24-25, 2017. Diagnoses included Alzheimer's disease. The quarterly MDS, dated 12/07/16, identified hallucinations during the assessment period. The medical record lacked documentation to support the	F 278	accuracy of Z0400. The concerns with Section E and P were also discussed. Refer to #1. Section A for in depth information of that particular meeting. C. On 01/30/17 the IDT met for their weekly MDS meeting. Every Monday Morning the Administrator and the IDT meet to review what MDSs need to be completed for the upcoming week. Each resident who has an MDS that needs completion for the week, is briefly discussed in regards to any new concerns with the resident and the most recent CASPER report is reviewed to see what concerns are noted on the report for the resident etc.… At the meeting on 01/30/17 the findings from our survey the prior week (01/25/17) that involved the MDS reviews were discussed. In regards to the concerns with sections C, D, J, Q and Z0400: the IDT discussed as to who of the residents that have an MDS due for the week of 01/30/17 may require a staff interview to assure sections C, D, J and Q are dated correctly and that Z0400 is accurate. The DON instructed IDT members that when they are done with the sections C, D, J and Q they need to have another RCC/DON check that these sections and Z0400 is accurate before the MDS is saved as completed. IDT also discussed that the facility's software (American Data Electronic Charting System or ECS) was notified via phone 01/26/17 of our concern with Section Z0400. ECS informed us that ECS will only note that there were two different dates for the whole section. The	

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F 278	Continued From page 9 coding of Resident #13's hallucinations. During an interview on the morning of 01/25/17, an administrative staff member (#6) agreed Resident #13 did not experience hallucinations during the assessment period. RESTRAINTS The Long-Term Care facility RAI User's Manual, revised October 2016, Chapter 3, page P-3 states, " . . . observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use. . . . Remember, the decision about coding any manual method or physical or mechanical device, material, equipment as a restraint depends on the effect it has on the resident. . . ." Review of Resident #8's medical record occurred on all days of the survey. A quarterly MDS dated 01/08/2017 identified total assistance of two for transfer and bed mobility, and a trunk restraint used daily. The Velcro Belt-seat belt Monitoring form, dated 01/19/2017, stated, ". . . Is a postural support . . ." The physician orders state, "Restraint: Velcro belt . . . when up in wheelchair . . . to maintain posture . . ." Observations during all days of survey showed Resident #8 made no attempts to reposition or stand from the reclining wheelchair and the velcro belt secured loosely around the resident's waist.	F 278	ECS software is unable to note each individual section of a whole section such as Sections C, D, J and Q with the date completed and the name of who completed the section. The spokesperson for ECS informed us that they will look into but it may not be feasible at this time because if the change would be required that is a huge task with the software. The DON spoke via phone with the State RAI Coordinator J. C. on 02/10/17 and informed her of the concern with ECS & section Z0400. The State RAI Coordinator suggested to manually making note of the concerns on the Z0400 by writing in the individual sections of C, D, J and Q with the date completed and the staff member that completed the area to sign or initial the area. This is what the IDT members involved with those areas will do. In regards to Section E and Section P: The SW is to check all the residents (except for residents on the survey sample roster) most recent MDS completed and review Section E to assure that it was completed correctly. If an MDS is noted to be scored incorrectly for Section E then a Correction MDS needs to be completed and a copy of the corrected MDS is to be given to the DON for QA monitoring. The RCCs are to check all the residents (except for residents on the survey sample roster) most recent MDS completed and review Section P to assure that it was completed correctly. If an MDS is noted to be scored incorrectly for Section P then a Correction MDS needs to be completed and a copy	

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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 278	Continued From page 10 An interview with an administrative staff member (#8) on 01/24/2017 at 11:00 a.m., stated Resident #8's velcro belt is used as a postural support when she is restless and moves around in the chair. Staff member (#8) stated, "Resident (#8) does not try to get out of the reclining wheelchair."	F 278	of the corrected MDS is to be given to the DON for QA monitoring. In the future if a postural support is utilized for a resident that could also be looked at as a restraint, when that resident's MDS is due the RCCs and DON will discuss the situation, review the definition of restraint in the RAI manual (and if necessary consult the State RAI Coordinator) and then determine how to score Section P. The SW and RCCs were reminded (as discussed at the meeting on 01/25/17) that they need to have Section E and P checked by another RCC/DON if scored correctly before the MDS is saved. 3. With Quality Assurance (QA) monitoring the following will be conducted to assure the concerns with the tag are being addressed: With the weekly IDT meeting to discuss MDS reviews for the week and any other concerns that may require careplan changes, The DON will have a checklist that will address the survey concerns and that includes the following: 1. DON to remind the team that sections E, C, D, J, P, Q and Z0400Q are to be reviewed by another RCC/DON to assure all are accurate before saving the MDS. 2. For QA purposes: The RCCs are to bring copies of the Z0400 from the previous week of MDSs for review to assure the dates for sections, C, D, J and Q are noted correctly on the form and also bring copies of Section E & P for review to assure they were marked correctly. 3. In regards to Section E: With MDS's due for the upcoming week, is there any resident	

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F 278	Continued From page 11	F 278	who possibly would be noted to have hallucinations, if so the SW to make note and thoroughly review when doing the MDS if Hallucinations needs to marked. 4. In regards to Section P: With MDS's due for the upcoming week, have there been any postural supports placed for any of those resident's since their last MDS that would be considered a restraint? If the answer is yes, RCCs and DON are to review the RAI manual for section P and determine how to score section P for that resident's MDS. 5. Are there any new concerns or major changes noted with any resident the past week that needs to be addressed on the careplan and ADLs? 4.) Frequency of QA Monitoring: Weekly for four (4) weeks: 01/29/17 thru the week of 02/19/17 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2017) and then quarterly (August and November) with QA monitoring completed 11/30/17. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved staff by DON or Designee). The DON will submit a "report of the deficiency" along with the completed monitoring at the next QA meeting tentatively set for 04/24/17. Then at the quarterly meetings after 04/24/17 only the monitoring results will be reported to the QA committee through 11/30/17. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 03/01/17	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		3/1/17

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F 280	Continued From page 12 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		

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F 280	Continued From page 13 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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F 280	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 3 of 13 sampled residents (Resident #2, #3, and #8). Failure to revise the care plan limited staffs' ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of hemiplegia (inability to move one side of the body). An Occupational Therapy order, dated 12/15/16, stated, ". . . attempt to increase functional independence . . ." Review of the admission Minimum Data Set (MDS), dated 12/20/16, identified intact cognition. The current care plan stated, ". . . Siderails x (times) 2 when in bed per request of resident as an enabler and safety. . . ." Observation on all days of survey identified three side rails on Resident #2's bed: two at the upper parr of the bed and one at the lower part of the bed. During an interview on 01/22/17 at 2:45 p.m., Resident #2 stated she grabs the lower side rail to sit up on the edge of the bed. During an interview on 01/25/17 at 10:10 a.m., an administrative nurse (#3) confirmed the careplan	F 280	F280: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #2, #3 and #8 from the survey sample roster and all residents of MMHCC careplan is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review and also when changes occur between assessments. This tag has the following concerns with residents #2, #3 & #8: 1.) A. Resident #2 has two (2) very small siderails on her bed (one on either side) per her request for enablers and one at the foot end of the bed that is more like a transfer bar that resident uses to assist herself to sit at the edge of the bed and that particular siderail was not careplanned. The careplan was updated on 01/25/17. B. Resident #3's careplan was noted to have that no call light cords or bed controls were to be within his reach. A call light was noted at his side by surveyor. His mood status had improved to where it was safe to place the call light at his side but the careplan had not been updated stating that. The careplan was updated on 01/25/17. C. Resident #8 at times displays disruptive behavior in the dining room by hollering out. In order to avoid that, when resident is brought to the dining room, staff will get her meal right away and feed her, her meal. This intervention was not	

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F 280	Continued From page 15 failed to identify three side rails on Resident #2's bed. - Review of Resident #3's medical record occurred on all days of survey and identified diagnoses of depression and borderline personality disorder (unstable emotions). Review of the quarterly MDS, dated 12/19/16, identified feelings of being better off dead or wishes for death on several days. The current care plan stated, ". . . No call light cords or bed controls in reach, may have a bell . . ." Observation on all days of survey identified a call light placed in reach of Resident #3. During an interview on 01/24/17 at 10:30 a.m., an administrative nurse (#3) confirmed Resident #3's mood had improved and staff should have revised the care plan to include the use of a call light. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses include paranoia, anxiety, aggression, and dementia with Lewey bodies. Resident #8's care plan identified: "Problem . . . mood swings, verbal and physical aggression. Approach: . . . Attempt to seek out reason for negative behavior, assess if having pain, is she hungry, etc. Meet concerns if feasible. If her anger with cares persists, you may need to reapporach. . . ."	F 280	careplanned. The careplan was updated 01/25/17. 2. Every Monday Morning the Administrator and the Interdisciplinary team which consists of the activity and dietary supervisor, social worker (SW), RCCs, Occupational therapist (OT) and DON meet to review what MDSs need to be completed for the upcoming week. Each resident who has an MDS that needs completion for the week, is briefly discussed in the sense of are there any new concerns with the resident, what concerns are noted with the resident on the most recent CASPER report etc.… Any new concerns with any of the other residents in house are also discussed and what needs to be careplanned etc.… IDT members are reminded by the DON to make sure and update the careplan with any changes. At the end of the month we have always had a CNA that reviews all the residents current Activities of Daily Living (ADLs) to assure the ADLs are current and if changes are necessary the CNA will discuss that with the RCC, changes are then are made in the ECS ADL section and a new door card is printed. The ADL's are considered part of the careplan and a statement will be added to the residents' careplan that states "ADL's are part of the plan of care". 3. All Residents who reside at MMHCC have the potential of not having their careplan updated when changes occur between routine MDS assessment. To assure that care plans are updated in a timely manner the following interventions	

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F 280	Continued From page 16 Nurses notes, dated February 25, 2016-January 23, 2017, identified Resident #8 exhibited "noisy/loud behavior during meals" 11 times. During an interview on 01/24/217 at 2:30 p.m., an administrative staff member (#8) stated staff presently feed Resident #8 first and take her back to her room. The facility failed to revise Resident #8's care plan to address her behaviors at meals and interventions to be used.	F 280	were put in place. 4. Individual in-services were held with the nurses and the CNAs on 02/08/17 at which time the deficiency tag and concerns were reviewed. The DON did remind the nurses that if any changes occur with a resident to inform the RCC via ECS or voicemail so the care plan can be updated. The DON also informed the CNAs if there are changes in the resident's ADL's to inform the RCC as the ADLs are part of the resident's careplan and need to be up dated at that time when the change has occurred. 5. With Quality Assurance (QA) monitoring the following will be conducted to assure the concerns with the tag are being addressed: With the weekly IDT meeting to discuss MDS reviews for the week and any other concerns that may require careplan changes, the DON has a checklist with concerns that need to be addressed (those concerns are noted in F tag 278) and the following is an item on that checklist and is noted as #4. Are there any new concerns or major changes noted with any resident the past week that needs to be addressed on the careplan and ADLs? 6.) Frequency of QA Monitoring: Weekly for four (4) weeks: 01/29/17 thru the week of 02/19/17 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2017) and then quarterly (August and November) with QA monitoring completed 11/30/17. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved	

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F 280	Continued From page 17	F 280	staff by DON or Designee). The DON will submit a "report of the deficiency" along with the completed monitoring at the next QA meeting tentatively set for 04/24/17. Then at the quarterly meetings after 04/24/17 only the monitoring results will be reported to the QA committee through 11/30/17. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 03/01/17	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services	F 328		3/1/17

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F 328	Continued From page 18 to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure staff provided proper treatment and care to maintain good foot health for 1 of 1 diabetic resident (Resident #10) who sustained an injury during foot care. Failure to ensure foot care is provided by a qualified person	F 328	F 328: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Resident #10 and all residents of MMHCC receive proper treatment and care to maintain mobility and good foot health. This tag has the following concern with	

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F 328	Continued From page 19 may have contributed to a foot injury. Findings include: Review of the facility policy titled "PEDICURE" occurred on 01/24/17. This undated policy stated, ". . . Procedure . . . Trim nails carefully, straight across and not too short. . . . Particular care is required when trimming a diabetic's nails. . . . Bath aides are responsible for nail and foot care of diabetic residents under the direction of the charge nurse. . . ." Diana L. Durgan, "Successful Nursing Assistant Care", 2nd ed., Hartman Publishing, Inc., Albuquerque, page 213, stated, "Nail Care . . . Do not cut a resident's toenails. Problems with circulation can lead to a serious infection if skin is accidentally cut while caring for the nails. For a resident who has diabetes, an infection can lead to a severe wound or even amputation. . . ." Berman, Snyder, and Frandsen's "Kozier and Erb's Fundamentals of Nursing, Concepts, Process, and Practice", 10th ed., Pearson Education, Inc., New Jersey, page 688, stated, ". . . Often, podiatrists must be consulted for clients with diabetes, peripheral vascular disease, long-term steroid therapy, and anticoagulant therapy [blood thinner]. . . ." The facility's policy contradicted with the professional references related to who can perform nail/foot care for diabetic residents. Review of Resident #10's medical record occurred on January 24-25, 2017. Diagnoses included Type 2 diabetes mellitus (DM),	F 328	resident #10. 1.) Resident #10 is a diabetic and has necrotic large toes. It has been the facility's policy that the Bathing CNAs can trim the toenails of a diabetic resident under the direction of the charge nurse. With resident #10 the bathing CNAs were trimming toenails that had no concerns and the Provider would trim the toe nails of the toes that had concerns. Resident was also seen on a routine basis by a Podiatrist in Bismarck. CNAs are not to trim toenails on any of the residents, only finger nails can be trimmed by a CNA. On 01/24/17 with the end of the day review with the survey team leader this issue was discussed with the DON and the Administrator. A note was placed in the bath area that evening of 01/24/17 by the DON that stated "bath aides will no longer be clipping toenails on any residents effective immediately." A message was also sent out to the nurses 01/24/17 via ECS that the bath aides are no longer to cut any toenails only. 2.) A message was also placed in the Nursing Staff communication book the evening of 01/24/17. The facility's policy "Pedicure" has been updated and the following was added "Do note that pedicure/toenail trimming is to be done by a nurse, provider or podiatrist. CNAs/Bath aides DO NOT trim toenails." Bath aides have been informed to report to the wardclerk if a resident's toenails are in need of trimming and the wardclerk will add the resident's name to the list for the nurses that now do the toe nail	

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F 328	Continued From page 20 peripheral vascular disease (poor circulation), and dementia. Medications included warfarin (a blood thinner) daily and acetaminophen 1000 milligrams twice a day. Resident #10's quarterly Minimum Data Set (MDS), dated 01/15/17, identified infection of the foot, diabetic foot ulcer, an open lesion on the foot, and frequent pain rated at 9 (on a scale of 0 to 10, 0 meaning no pain and 10 meaning the worst pain). Resident #10's care plan stated, "PROBLEM: Potential for Alteration in skin integrity . . . (12/21/16) Manifested by necrotic large toes (01/01/17) Manifested by gangrenous toes . . . APPROACH: Nurse Aide - Inspect skin and feet with bathing . . . Report concerns to nurse . . . PROBLEM: Alteration in metabolic status RELATED TO: diabetes mellitus APPROACH: . . . Nurses/Nurse Aide - Bath water tepid, diligent pedicure and foot care weekly . . ." The admission nursing assessment, dated 10/20/16 identified Resident #10's feet as extremely dry and cracked with no open areas and his toenails as thick, fungal, and yellow. Review of Resident #10's progress notes identified no concerns related to his feet prior to 11/08/16. On 11/08/16, a progress notes stated, "During bath today, called by bath aide. Shown resident's toenail and fingernails - L [left] great toe loose and partially detached from nailbed. Some bleeding noted as they [bath aides] were clipping his nails. Note left for [physician's assistant (PA)] . . . to see resident."	F 328	trimming. 3.) All Residents who reside at MMHCC have the right to receive good foot health. To assure that good foot health is provided the following interventions were put in place. A. Individual in-services were held with the nurses and the CNAs on 02/08/17 at which time the deficiency tag and concerns were reviewed. B. Two charge nurses volunteered to do the toenail trimming. Prior to the survey, the facility signed a contract with a Podiatrist from Bismarck that will make his first visit on 02/17/17. One of the charge nurses that will be trimming toenails has been designated by the DON the rounds nurse for the Podiatrist. C. With Quality Assurance (QA) monitoring the following will be conducted to assure the concern with this tag is being addressed: DON will check the charting of the nurse(s) doing the toe nail trimming to assure that if concerns are noted that the Provider or Podiatrist have been made aware for possible further interventions. . 4.) Frequency of QA Monitoring: Weekly for four (4) weeks: 01/29/17 thru the week of 02/19/17 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2017) and then quarterly (August and November) with QA monitoring completed 11/30/17. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved staff by DON or Designee). The DON will	

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F 328	Continued From page 21 The PA visited with Resident #10 on 11/08/16 and stated, ". . . Thick ecchymosis [bruising] and dystrophic [inadequate nutrition] with pressure, no feeling r/t [related to] DM neuropathy [nerve damage]. R [right] great toe nail pressure ulcer from nail, debrieded [sic] [removed]. 1) Cleanse great toe nails with hibiclenz [antiseptic skin cleanser], rinse with NS [normal saline] then apply Bactoban [sic] ointment [antibacterial] to site daily til [sic] healed. Re-check 11/11/16. Rest of toenails debrieded [sic]." On 01/23/17 at 11:05 a.m., a nurse (#16) provided wound care to Resident #10 great toes. Observation showed his left great toe tan in color with some drainage. The nurse (#16) stated Resident #10's left toe, "looks much better." During an interview on 01/24/17 at 2:30 p.m., two administrative nurses (#3 and #8) stated it is the facility practice for the bath aides to trim resident's toenails, including diabetic residents. One nurse (#8) interviewed both bath aides who worked on 11/08/16 and the bath aides described Resident #10's left toenail as "hanging loose" and noted "it bleeding"while they trimmed his other toenails. The facility failed to ensure only qualified staff members provided nail care to residents. This failure may have contributed to Resident #10 toe injury.	F 328	submit a “report of the deficiency” along with the completed monitoring at the next QA meeting tentatively set for 04/24/17. Then at the quarterly meetings after 04/24/17 only the monitoring results will be reported to the QA committee through 11/30/17. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *completion date 03/01/17	
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when	F 329		3/1/17

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F 329	Continued From page 22 used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure each resident's drug regimen is free from unnecessary medications for 3 of 9 sampled residents (Resident #1, #4, and #6) receiving psychotropic medications. Failure to attempt a gradual dose reduction (GDR) or provide an explanation as to the benefit versus risk for continued use placed residents at risk of receiving medications in either excessive dose, excessive duration, or without adequate indications for use. Findings include: Review of the facility policy titled "GUIDELINES FOR PSYCHOACTIVE MEDICATION MONITORING/CHEMICAL RESTRAINTS" occurred on 01/25/17. This policy, dated 03/16/16, stated, "POLICY: . . . Each resident's	F 329	F329: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #1, #4 and #6 from the survey roster and all residents drug regimen is free from unnecessary drugs. 1. In regards to the Residents of concern from the survey roster: with the last pharmacy consult for these residents it was suggested that a Gradual Dose Reduction (GDR) be done with the residents' antipsychotic. The responsible party or resident requested no GDR with the medication and that request was passed on to the Doctor and the Doctor made no change in the med order per the request of responsibility party or resident. The Doctor did not personally visit with family/responsible party and/or resident about the benefits and risks of a GDR.	

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F 329	Continued From page 23 drug regimen is free from unnecessary drugs. Antipsychotic drugs are not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. 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. Resident's behavior will be reviewed with monthly provider visits or sooner if necessary. . . . BEHAVIOR MONITORING SHEET: 1. This monitoring is done via computer charting whenever an antipsychotic drug is ordered or a dosage change is ordered. 2. Nurses document whenever behaviors are noted. 3. Nurses monitor for adverse reactions to medication and document as these are noted. . . . 4. Any noted concerns or recommendations are communicated to the resident's physician and family as they arise for further orders or evaluation by a psychiatrist. 5. Additions are made to the care plan as necessary. . . . REQUEST FOR MEDICATION REVIEW AND GRADUAL DOSAGE REDUCTION 1. . . . 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 assistant] for review. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, paranoia, dementia, and hallucinations. Medications included Risperidone (an antipsychotic) 0.25 milligrams (mg) in the morning and at noon, and 0.5 mg in the evening (initiated 10/14/16). Both	F 329	1. A. Resident #1: DON visited with resident on 01/30/17 and again on 02/06/17 about the use of the antipsychotic Abilify. DON explained what the regulations are in regards to antipsychotic use and that GDR should be attempted as he has had not one in nearly 2 years. Resident is very aware of his rights and requests no change in the Abilify. Asked if he would visit with doctor about the med and GDR before his routine appointment in March (exact date not set by clinic yet) and he refused to do so. Note placed in Doctor's folder for his March visits to visit with resident about med use. Resident refuses to see psychiatry. B. Resident #4: Resident is unable to make decisions related to his Dx of Alzheimer's. Resident's spouse is his responsible party, is a retired nurse and very aware of regulations and the possible side effects of the antipsychotic Risperidone. In the past she has requested no changes in Risperidone dosage. Spouse has been visited with the RCC and the DON in regards to the benefits of the meds vs the risk and she has requested no change in the med dose. The Provider did visit with resident's spouse in November 2016 about resident's medication regimen but failed to review with the spouse the benefits of the Risperidone versus the risks. The Doctor needs to discuss the benefits vs the risks and Dr. L. did have that discussion with resident's spouse on 01/31/17 and spouse requested no	

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F 329	Continued From page 24 quarterly Minimum Data Set (MDS), dated 01/09/17, and the annual MDS, dated 10/06/16, identified no behaviors present during the assessment period. Observation throughout the survey showed Resident #4 either in the dining room for meals or sleeping in bed. No behaviors were noted during cares. Review of Resident #4's medical provider's notes identified the following: * 12/10/15 - ". . . A/P [assessment and plan] 1. Dementia: Alz [Alzheimer's] and Vascular. Continue Asa [aspirin]. Pt [patient] not on statins [cholesterol medications] and discussed with his wife and decided against in the past. . . . Has aggressive behaviors and are well controlled with Risperidone. . . . Spoke to Mrs. [name] over phone and we discussed treatment plan in detail, in the past." * 01/14/16 - ". . . A/P 1. Dementia: Alz and Vascular. Continue Asa. Pt not on statins and discussed with his wife and decided against in the past. . . . Has aggressive behaviors and are well controlled with Risperidone . . ." * 05/05/16 - ". . . A/P 1. Dementia: Alz and Vascular. Continue Asa. Pt not on statins and discussed with his wife and decided against in the past . . . Has aggressive behaviors and are well controlled with Risperidone . . ." * 09/01/16 - ". . . He has a long list of behaviors. . . . Review of Systems: Impossible to obtain from patient. The nurses had nothing to contribute in addition to the above. . . . Assessment: 1) Dementia of senile origin and vascular, continue aspirin. His wife does not want him started on any statins. . . . The patient has had aggressive	F 329	change in the Risperidone (Risperdal). Resident was seen in house by Psychiatry Dr. B on 01/23/17 and Dr. B. recommended no changes in med regimen. C. Resident #6: Resident is with advanced Alzheimer's and is unable to make decisions. Resident's son is her responsible party and has been visited with several times by the resident's RCC who has reviewed the benefits of the med vs the risks. Son has requested no changes in the med. The Doctor needs to discuss the benefits vs the risks and Dr. L. did have that discussion with resident's son on 01/31/17 and son requested no changes in the Risperidone (Risperdal). Resident was seen in house by Psychiatry Dr. B. on 01/23/17 and Dr. B. recommended no changes in med regimen 2. All residents who reside at MMHCC who are identified as having psychiatric concerns may have the potential to be affected by the use of unnecessary drugs. To assure residents who receive an antipsychotic med or any type of psychoactive med have a GDR if feasible the following interventions have been put in place. A. Individual in-services were held with the nurses and the CNAs on 02/08/17 at which time the deficiency tag and concerns were reviewed. With discussion about the tag with the nurses, the DON informed the nurses to make sure to document behaviors noted on residents and to utilize the NPI's for residents as	

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F 329	Continued From page 25 behaviors which are well controlled on Risperidone . . ." * 11/01/16 - ". . . vascular arteriosclerotic dementia and Alzheimer's dementia with visual and auditory hallucinations, psychosis, paranoia, and history of aggression with personality disorder, verbal abuse, and major depression. His wife does not want his anti-depressant or anti-psychotic medications changes, as he is stable with these. . . . We will continue with Risperdol [Risperidone] . . . For the hypertension . . . I visited with Mrs. [name] concerning this . . . Mrs. [name] does not want this [heart medication] increased any further . . . No other changes in medications will be done at this time. I telephoned Mrs. [name] to review labs as well as medications and/or treatments." The provider failed to discuss the benefits versus risks of the continued use of Risperdol with the resident's spouse. Review of the "Consultant Pharmacist Communication to Physician," dated 04/28/16, stated, "ANTIPSYCHOTIC GRADUAL DOSE REDUCTION- Risperidone . . ." An administrative nurse (#15) wrote a note on the communication form which stated, "[provider's names] Meds [medications] are effective in managing his paranoia, aud [auditory] & vis [visual] hallucinations, phy. [physical] aggression & verbal aggression. His spouse is a retired nurse & [and] requests no changes in med doses as she feels meds have been very effective in managing his behaviors & a dose reduction would cause an exacerbation of symptoms. Displays no adversities to med use. Do you feel benefits outweigh the risks?" The medical provider responded on 06/09/16 (six weeks later)	F 329	careplanned. Nurses were informed that the NPI's are not only for PRN psych med use but also for those residents on routine psych meds. If behavior charting is noted frequently, a routine psych med may be increased but if NPI's would have been utilized the behavior may have settled and the need to increase the med may not have been necessary. Nurses informed to review the NPI's that are located in their chart backs for these particular residents. At the CNA in-service, the DON stressed the importance of reporting behaviors to the charge nurse and also the importance of utilizing the NPI's for residents with behavior concerns and to refer to the NPI sheets in their ADL folder. B.) The DON did visit with the providers after the survey (01/30/17) and encouraged them to thoroughly review the psychoactive meds and to note the necessity of the meds in their progress notes and to always look at the possibility of a dose reduction. It was explained to Dr. L. the importance of visiting with the resident or responsible party in regards to benefits vs the risks if resident or responsible party refuse dose reductions and to make note of that conversation in his progress notes. C. Starting with the February Consulting Pharmacist reviews (drug reviews), residents that Dr. B. (psychiatry) sees Dr. L. requests that Dr. B. reviews the drug reviews if feasible. DR. L. was informed that can be arranged but when those drug reviews are completed, he as the	

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F 329	Continued From page 26 and stated, "(MPOA) [medical power of attorney] wife insists "no change in meds," Benefit out weigh risk." Review of the "Consultant Pharmacist Communication to Physician," dated 10/24/16, stated, "ANTIPSYCHOTIC GRADUAL DOSE REDUCTION- Risperidone . . . After the first year, a GDR must be attempted annually, unless clinically contraindicated." An administrative nurse (#15) wrote a note on the communication form which stated, "[provider's names] Meds [medications] are effective in managing his paranoia, auditory & visual hallucinations, physical aggression & verbal aggression. Spouse is a retired nurse, very aware of med regimen. She feels meds are in appropriate dose to manage his DXs [diagnoses]. If you feel a dose reduction would be appropriate to try now that its a year, please talk to her first for her input. If you feel no dose reduction is feasible, do you feel the benefits of the med outweigh the risks?" The medical provider responded "Yes" next to "benefits of the med outweigh the risk" on 12/12/16 (seven weeks later). Review of Resident #4's behavior notes, dated 02/28/16 through 01/24/17 (11 months), identified behaviors of confusion, self-transferring, restless, wanting to sleep, incontinence, one episode of hallucinations, and resistive with cares twice. Resident #4's medical record showed the provider failed respond to the pharmacist's recommedations in a timely manner, failed to identify if the provider reviewed the behavior notes, and failed to identify if he/she discussed the risks and benefits of a GDR related to	F 329	residents' provider will also need to sign the consult note. The DON will attempt to assure that the consult reviews (drug reviews) are done in a more timely manner by the providers and the goal is one (1) month after the DON receives the consult sheets from the consulting pharmacist the reviews should be returned or sooner if feasible. If Dr. B. is not in house for a visit (his visits alternate one month in house and one month via tele med/skype) the consult sheets will be either mailed or faxed to him for his review. B. With Quality Assurance (QA) monitoring the following will be conducted to assure the concern with the tag is being addressed: The DON reviews consult sheets before given to Provider to review and will make note of any information that will assist the provider in his decision making about a GDR e.g. attach behavior charting from previous quarter (or less if feasible), if a GDR was done in the past what were the results of that GDR, will make note if the Provider needs to talk to the resident or responsible party about GDR due to their refusal to a GDR in the past, reminder for provider of regulations etc... If a drug review was noted by the DON that provider needs to talk to resident or responsible party, the DON or Designee will review the Doctors Progress notes when available if the provider documented his conversation with resident or responsible party, if not the DON will inform the provider that the	

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F 329	Continued From page 27 Risperidone with resident's spouse. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. Medications included Risperidone 0.25 mg in the morning and 0.5 mg in the evening. The last dose reduction occurred on 12/23/15. Both the quarterly MDS, dated 12/14/16, and the annual MDS, dated 09/14/16, identified no behaviors present during the assessment period. Observation throughout the survey showed Resident #6 either in the dining room for meals or sleeping in bed. No behaviors were noted during cares. Resident #6's medical provider progress note, dated 10/11/16, stated, ". . . EKG [electrocardiogram] showed it dropped down to 50 beats per minute. I telephoned her son concerning the above. He wants no further interventions. . . . P [Plan]: I visited with her son concerning the above. No further interventions. He does not want to change any of her medications. . . . She will continue with medications . . . Risperdol [Risperidone] 0.25 mg in the morning, and 0.5 mg in the evening. We tried to decrease this in the past and behaviors exacerbated. . . ." The resident's record failed to show the facility attempted a dose reduction since 12/23/15. The above note failed to identify if the provider reviewed the behavior notes and and if the provider discussed Resident #6's Risperidone and the risks and benefits of a GDR with her son.	F 329	conversation needs to be done per regulations. 4.) Frequency of QA Monitoring: Pharmacist consults that address GDR are done on a monthly basis so for this Tag the QA will be done monthly beginning with the February reviews. February visit by consulting pharmacist is scheduled for 02/24/17. DON will also be receiving the copies of the Providers Progress notes from their routine visits and will note if any changes were made in residents med regimen that are pertinent to this tag as meds may be changed between consult reviews. The QA monitoring will be completed 11/30/17 unless it is deemed necessary to continue. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. visiting with providers about the regulations and documentation necessary if GDR is not feasible etc.…) The DON will submit a report of the deficiency along with the completed monitoring at the next QA meeting tentatively set for 04/24/17. Then at the quarterly meetings after 04/24/17 only the monitoring results will be reported to the QA committee through 11/30/17. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 03/01/17	

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A Consultant Pharmacist Communication note to Physician", dated 12/16/16, stated, ". . . ANTIPSYCHOTIC GRADUAL DOSE REDUCTION - Risperidone 0.25 mg Q [every] AM & 0.5 mg QPM . . . After the first year, a GDR must be attempted annually, unless clinically contraindicated. . . ." An administrative nurse (#15) wrote a note on the communication form which stated, "Dr. [name] & [name] . . . Resident may do fine with a dose reduction but family has voiced concerns about reducing med [medication] as she is comfortable & managed . . . behaviors with this dose. Dr. [name], psychiatrist [a new psychiatrist for the facility] will be reviewing her chart on 01/23/17. Do you feel the benefits outweigh the risks? . . . " The physician checked the box which stated, "An attempted GDR is likely to result in impairment of function or increased distressed behavior." On 01/23/17 (six weeks later), the physician stated, "Let's see what our psychiatrist says."

Resident #6's behavior notes, dated 03/25/16 through 01/24/17 (10 months), identified one behavior on 08/11/16 as "resistive with cares this am. Then settled on her own when dressed and in her w/c [wheelchair]."

Resident #6's medical record showed the provider failed respond to the pharmacist's recommedations in a timely manner, failed to identify if the provider reviewed the behavior notes, and failed to identify if he/she discussed the risks and benefits of a GDR related to Risperidone with the resident's son.

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- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included post traumatic stress disorder (PTSD) and anxiety. The MDS, dated 12/04/2016 and the quarterly MDS dated 10/23/16, identified the resident makes self understood and usually understands others, cognition intact, no behavioral problems and no hallucinations or delusions.

Resident #1's current medications included Abilify (antipsychotic) 10 mg daily for PTSD. The resident has been on this dose since 05/07/2015.

Review of Resident #1's medical provider notes identified the following:
* 07/14/2016: ". . . Monthly nursing home visit. . . . Neither the patient nor the nurses have anything in particular to discuss today. . . . Medications: . . . Abilify one tablet daily p.m. . . . Physical Exam: . . . General: He is alert, oriented times 3, and in no apparent acute distress. The patient has appropriate mood, affect, and judgement."
* 09/29/2016: ". . . monthly nursing home visit. . . . General: The patient is a pleasant, middle aged, Caucasian male. he appears to be somewhat older than his state age of 67. he is alert, oriented times 3 . . . The patient has appropriate mood, affect, and judgement."
* 11/04/2016: " . . . monthly nursing home visit. . . General: This is a pleasant, middle-aged . . . He is alert, oriented times 3 in no acute distress. The patient has appropriate mood, affect, and judgement. . . . "

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F 329	Continued From page 30 * 12/05/2016: " . . . General: This is a pleasant, middle aged, Caucasian male. He is alert, oriented times 3 . . . The patient has appropriate mood, affect, and judgement." Review of the "Consultant Pharmacist Communication to Physician", dated 02/19/16, stated, "Antipsychotic Diagnosis-Justification for Use-Abilify 10 mg daily. 1. An antipsychotic medication should be used only for the following conditions/diagnosis as documented in the record . . ." Check mark identified by 'Mood disorders'. 2. Since diagnosis alone do not warrant the use of antipsychotic medications, the clinical conditions must also meet at least one of the following criteria." Check mark identified by 'psychosis (such as: auditory, visual, or other hallucinations; delusions such as paranoia or grandiosity). . . . On 02/22/16, the medical provider stated, "No changes. Meds ordered/psych." Review of the "Consultant Pharmacist Communication to Physician", dated 04/28/16, stated, "Antipsychotic Gradual Dose Reduction - Aripiprazole [Abilify] 10 mg daily." A written note by the Director or Nursing (DON) states, "Resident has major depression order and chronic PTSD - Displays mood swings, unkept appearance at times. Is felt that with his diagnosis and symptom would worsen. He is to see a psychiatrist but refuses to do so and is unable to be redirected in the matter. Displays no adversities to med [medication] use. . . . Do you feel the benefits outweigh the risks?" On 06/07/16 (six weeks later), the medical provider stated, "no change. Absolutely needs med. Benefit outweighs risk."	F 329		

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F 329	Continued From page 31 Resident #1's medical record showed the provider failed respond to the pharmacist's recommedations in a timely manner, failed to identify if the provider reviewed the behavior notes, and failed to visit with the resident regarding the risks and benefits of the continued use of Abilify,	F 329		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		3/1/17

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	355036	A. BUILDING _____ B. WING _____	01/25/2017

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F 441	Continued From page 32 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 33 Based on observation, record review, policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 2 of 4 sampled residents (Resident #3 and #4) dependent on staff for perineal cares. Failure to remove gloves and perform hand hygiene before providing catheter care and after providing perineal cares may contribute to the spread of infection. Findings include: Review of the facility policy titled "HAND WASHING/HAND HYGIENE GUIDELINES & [and] PROCEDURE" occurred on 01/25/17. This policy, dated 02/03/15, stated, ". . . Objectives: . . . 2. To prevent the spread of disease from resident to resident or to self. . . . Some CDC [Centers for Disease Control] guidelines: . . . 2. Staff is required to wash their hands in accordance with accepted professional practice. Hand hygiene is to be done after completing any on hands cares with resident. 3. Hand washing/hand hygiene should always follow the removal of gloves, to remove bacteria, harboring moisture buildup. 4. Indications for hand washing after removal of gloves always include but are not limited to: . . . whenever hands are soiled; . . . after contact with resident . . . body secretions, . . . after handling items such as . . . catheters, . . . Situations that require hand washing with soap and water: 1. When hands are visibly soiled. . . ." Review of the facility policy titled "PERICARE WITH DISPOSABLE WASHCLOTH AND/OR PERIWASH WITH WASHCLOTH" occurred on 01/25/17. This undated policy stated, ". . . FEMALE PERINEAL CARE . . . 12. Remove	F 441	F441: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #3 and #6 from the survey sample roster and all residents of MMHCC have an Infection Control Program that provides a safe, sanitary and comfortable environment and helps prevent the development and transmission of disease and infection. This tag has the following two concerns: 1.) A. Failure to remove gloves after peri cares were completed and then continuing with other care tasks e.g. catheter care, applying lotions or crèmes to cleaned peri area with gloves on. B. Failure to do hand hygiene after removal of gloves and before exiting the resident's room. 2.) DON was made aware of the care concerns at the survey exit on 01/25/17 and a note was placed in the communication book 01/25/17 about the concerns and what our policies are in regards to these issues and stressing the importance of proper infection control practices. 3.) Residents who reside at MMHCC who require assistance with peri care and catheter care have the potential of not having a safe, sanitary and comfortable environment provided if policies from the Infection Control Program are not followed. To assure that the facilities policy for these two (2) concerns are followed and residents' environment is safe, sanitary and comfortable the following interventions were put in place.	

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F 441	Continued From page 34 gloves following pericare. Assure resident is safely positioned and then wash hands (soap and water or hand gel) before carrying out other duties. . . . MALE PERINEAL CARE . . . 10. Remove gloves following pericare. Assure resident is safely positioned and then wash hands (sic) soap and water or hand gel before carrying out other duties. . . . " Review of the facility policy titled "PERICARE FOR INDWELLING CATHETER" occurred on 01/25/17. This undated policy stated, "Objective: 1. To provide proper cleansing of indwelling catheter. 2. To prevent source of infection. . . . Procedure: . . . 12. Remove gloves following pericare. Assure resident is safely positioned and then wash hands (soap & water or hand gel) before carrying out other duties. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Observations of personal cares included the following: * 01/22/17 at 3:45 p.m. - Two certified nursing assistants (CNAs) (#9 and #10) provided incontinence cares for Resident #6, and the CNA (#9) applied a barrier cream to the resident's buttocks. After removing their gloves, one CNA (#9) failed to perform hand hygiene before leaving the room. * 01/22/17 at 4:40 p.m. - Two CNAs (#9 and #10)donned gloves and transferred Resident #6 from bed to a wheelchair, placed slippers on her feet, and offered her water. Both CNAs exited the room without performing hand hygiene. *01/23/17 at 9:35 a.m. - A CNA (#11) provided	F 441	A. Individual in-services were held with the nurses and the CNAs on 02/08/17 at which time the deficiency tag and concerns were reviewed and policies related to these F tag concerns were reviewed. Nurses were informed if they observe these concerns to remind the CNA of the policy and CNAs were also informed if they observe these concerns with a co-worker to remind that CNA of the policy. B. With Quality Assurance (QA) monitoring the following will be conducted to assure the concerns with the tag are being addressed: *The DON or Designee will randomly observe peri cares on residents #3 and #6 from the survey sample roster as well as other residents in the facility that are dependent/require supervision with cares to assure that peri care, removal of gloves, and hand washing/hand hygiene etc.… are being done properly.*The DON or Designee will observe catheter care on #3 as well as other residents in house that require catheter care. Concerns with these observations will be immediately addressed at the time of care by the DON or Designee with the CNA(s) involved. 4.) Frequency of QA Monitoring: Weekly for four (4) weeks: 01/29/17 thru the week of 02/19/17 (that is 4 full weeks). Monthly for three (3) months (March-April-May 2017) and then quarterly (August and November) with QA monitoring completed 11/30/17. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved	

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F 441	Continued From page 35 incontinence cares for Resident #6. Observation showed stool on the wipe, and with the same gloves, the CNA (#11) applied a barrier cream to the resident's buttocks. The CNA (#11) failed to remove her gloves, sanitizer her hands, and apply clean gloves after performing pericares and before applying the barrier cream. *01/23/17 at 3:35 p.m. - A CNA (#12) provided incontinence cares for Resident #6 as another CNA (#13) assisted in positioning the resident from side to side. With the same gloves, the CNA (#12) applied a barrier cream to the resident's buttocks. The CNA (#12) failed to remove her gloves, perform hand hygiene, and apply clean gloves after performing pericares and before applying the barrier cream. An interview occurred on the morning of 01/25/17 with two administrative staff members (#14 and #15). The staff member (#15) stated she expected facility staff to wash or sanitize their hand after pericares and before exiting a resident's room. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. The physician orders, dated 12/30/16, identified an indwelling foley catheter (tube placed into the bladder) set to continuous drainage. Review of the quarterly Minimum Data Set (MDS), dated 12/19/16, identified total assistance of two persons for toilet use. Observation of personal cares on 01/22/17 at 3:25 p.m. showed two CNA's (#4 and #5)	F 441	staff by DON or Designee). The DON will submit a report of the deficiency along with the completed monitoring at the next QA meeting tentatively set for 04/24/17. Then at the quarterly meetings after 04/24/17 only the monitoring results will be reported to the QA committee through 11/30/17. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. *Completion date 03/01/17	

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F 441	Continued From page 36 assisted Resident #3 with perineal cares after a bowel movement. With visibly soiled gloves, the CNA (#5) obtained a new wipe and cleaned the catheter tubing at the urethra (urinary opening). During an interview on 01/25/17 at 9:30 a.m., a nurse manager (#3) confirmed staff should not have completed catheter care with soiled gloves.	F 441		