| 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 _____ | 01/25/2024 |

| 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<br><br>The standard Medicare/Medicaid recertification survey started on 01/22/24 and concluded 01/25/24. | F 000 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; | F 623 | | 2/6/24 |

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

Electronically Signed | 02/12/2024

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.

| 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 _____ | 01/25/2024 |

| 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 623 | Continued From page 1<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the | F 623 | | |

| 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 _____ | 01/25/2024 |

| 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 623 | Continued From page 2<br>agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide the resident or the resident's representative a written notice of transfer for 1of 1 resident (Resident #22) reviewed for hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights.<br><br>Findings include:<br><br>Review of Resident #22's medical record occurred on all days of survey. A hospital transfer occurred on 12/21/23. The medical record lacked | F 623 | 0623 Corrective actions was taken on 01/26/2024 at 12:00 pm<br>The Transfer form was developed (or revised) and will be mailed to the responsible party with all hospital transfers and therapeutic leave.<br>Reviewed last 6 weeks of hospital transfers/therapeutic leave Found that 2 residents were hospitalized in December form was explained to and give to them.<br>Documentation will be done in the resident nurses notes as to what day and to whom the form was mailed to.<br>All documentation will be done in the | |

| 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 _____ | 01/25/2024 |

| 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 623 | Continued From page 3<br>documentation the facility provided the resident and/or representative with a written transfer notice.<br><br>During an interview on 01/24/24 at 4:45 p.m., an administrative staff member (#2) confirmed the facility failed to provide written notice of a transfer to the family/representative. | F 623 | residents chart under Discharge/Transfer/leave folder. Reported quarterly.<br>The business office or designee will monitor documentation for all residents hospital transfers or therapeutic leave tracking date sent, received, related to communication. The monthly monitoring will be performed and documented by a business office or designer, monitored by the Administrator, and reported quarterly to the quality assurance committee. Monitoring will not be discontinued until the facility completes four consecutive rounds of quarterly monitoring that demonstrate sustained compliance approved by the quality assurance committee.<br><br>Administrator went over transfer form policy and regulation with office manager who will be in charge on 1/31/24<br><br>Monitoring will be done with each transfer along with a QA done with each transfer, all will be reviewed at the quarterly QA meeting for 1 year. Ending 1/26/25<br><br>Corrective action will be completed by February 6, 2024. | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital | F 625 | | 2/6/24 |

| 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 _____ | 01/25/2024 |

| 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 625 | Continued From page 4<br>or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or resident's representative a written bed hold notice for 1 of 1 resident (Resident #22) reviewed for hospital transfer. Failure to provide a written copy of the bed hold notice and include the reserve bed amount does not allow the resident and/or their representative to make an informed decision regarding their rights.<br><br>Findings include: | F 625 | -625 Corrective action was taken on 01/26/2024 at 12:00 pm<br>A Bed Hold/Release notice has been developed. The form will include the reserved bed amount. It will be mailed along with the transfer form asking the responsible party to complete the form stating which they choose, either to hold the bed or release the bed in the self-addressed stamped envelope.<br><br>Documentation will be done in the | |

| 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 _____ | 01/25/2024 |

| 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 625 | Continued From page 5<br>Review of the facility policy "Bed Hold" occurred on 01/25/24. This undated policy, stated, "Before a resident is transferred to a hospital or goes on therapeutic leave, the facility will provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy. . . . The resident, or a person acting on behalf of the resident, must request that the bed be held and informed of the charges. . . ."<br><br>Review of Resident #22's medical record occurred on all days of survey. A hospital transfer occurred on 12/21/23. The medical record lacked documentation the facility provided the resident and/or their representative with a written bed hold notice or the reserve bed hold amount.<br><br>During an interview on 01/24/24 at 4:45 p.m., an administrative staff member (#2) confirmed the facility failed to provide a written bed hold notice or the reserve bed hold amount to the family/representative. | F 625 | resident□s nurses notes as to whose form was mailed to, date mailed, and date returned to facility.<br>Office manager will keep record of the date the form was received as ongoing QA, the returned form will be scanned into the resident.<br>If the form is not received in 2 weeks, a phone call will be made asking for the form to be completed returned.<br>The business office or designee will monitor documentation for all Bed hold/Release tracking date sent, received, related to communication. The monthly monitoring will be performed and documented by a business office or designer, monitored by the Administrator, and reported quarterly to the quality assurance committee. Monitoring will not be discontinued until the facility completes four consecutive rounds of quarterly monitoring that demonstrate sustained compliance approved by the quality assurance committee.<br>Ongoing QA will be done by the business office or designer starting 1/26/2024.<br><br>Administrator went over the facilities bed hold policy with office manager who will be in charge on 1/31/24.<br><br>Monitoring will be done by office manager with each Be Hold send with a QA being done with each Bed hold sent.<br><br>A Quarterly QA review will be done for 1 year ending 1/26/25 | |

| 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 _____ | 01/25/2024 |

| 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 625 | Continued From page 6 | F 625 | Corrective action will be completed by February 6, 2024. | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 7 residents (Resident #4 and #31) prescribed Aspirin. Failure to accurately complete the MDS for medications taken by the residents may affect the accurate development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, dated October 2023, pages N-1, and N-6 to N-8 stated, "Section N Medications . . . N0415: High-Risk Drug Classes . . . Coding Instructions: Code all high-risk medications according to their pharmacological classification, not how they are being used. . . . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., [for example] aspirin/extended release . . . ) was taken by the resident at any time during the 7-day observation period . . ."<br><br>- Review of Resident #4's medical record occurred on all days of survey. A physician's | F 641 | 1. It was brought to Director of Nursing□s attention by a surveyor during the second day of the survey (1/23) that Resident #4□s MDS dated 12/19/23 had an incorrect coding in section N (medications). DON then discussed this with the MDS coordinator and this MDS was corrected that same day. DON was unaware that a second resident□s MDS was also coded incorrectly until the exit interview. At that time, DON was not made aware of who this second resident was. Today (2/5/24) when DON received our Summary Statement of Deficiencies, she was able to determine which resident assessment was affected (Resident #31 dated 11/01/23). This MDS was corrected today with the accurate coding.<br>2. All Residents who reside at MMHCC have the potential of having their MDS scored incorrectly if the resident(s) are ordered an antiplatelet or anticoagulant medication □ specifically aspirin. To assure that this concern is avoided the following interventions were put in place:<br>3. An in-service was held by the DON with facility MDS coordinators on 2/6/24. The deficiency for tag F641 was | 2/9/24 |

| 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 _____ | 01/25/2024 |

| 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 641 | Continued From page 7<br>order, dated 12/19/23, stated, "Aspirin 325mg [milligram] EC [Enteric Coated] by mouth daily [antiplatelet medication] . . ."<br><br>The admission MDS, dated 12/26/23, showed staff failed to code Resident #4's use of an antiplatelet medication.<br><br>- Review of Resident #31's medical record occurred on all days of survey. A physician's original order, dated 2/19/23, state, "Aspirin 325mg EC tab 1 tab by mouth daily . . . "<br><br>The quarterly MDS, dated 11/01/23, showed staff failed to code Resident #31's use of an antiplatelet medication.<br><br>During an interview on 01/23/24 at 11:38 a.m., an administrative nurse (#4) identified the aspirin should have been coded as an antiplatelet medication. | F 641 | reviewed. Discussions and overview were held on Section N of the MDS □ reviewing the regulation as well as the RAI Manual (Oct 2023 Update in Section N coding). Explanations of the two resident assessment coding errors/corrections were discussed and reviewed. MDS coordinators all expressed understanding and any/all questions were answered. MDS coordinators will print out Section N on future MDS assessments for DON to monitor moving forward.<br>4. The Director of Nursing will be responsible to monitor the correct coding of Section N of the MDS Assessments. MDS coordinators were instructed to print out the Section N for each completed MDS assessment when completed to give to the DON. The DON will then assure the coding is correct. If the coding is incorrect, the MDS coordinator will correct the MDS. DON will monitor Section N by random selection of assessments according to the following schedule:<br>5. Frequency of QA Monitoring: Weekly for four (4) full weeks: 2/11/24 through 3/9/24. Monthly for three (3) months (April-May-June 2024) and then quarterly (September and December 2024) with QA monitoring completed 12/9/24. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved MDS Coordinator by DON or Designee and correction of MDS). The DON will submit a report of the deficiency along with the completed monitoring at the next | |

| 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 _____ | 01/25/2024 |

| 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 641 | Continued From page 8 | F 641 | QA/QAPI meeting tentatively set for 4/11/24. Then at the QA/QAPI quarterly meetings after 4/11/24, only the monitoring results will be reported to the committee through 12/9/24. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee. Completion date: 2/9/24 | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or | F 732 | | 2/9/24 |

| 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 _____ | 01/25/2024 |

| 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 732 | Continued From page 9<br>written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure posting of accurate and complete staffing information on 3 of 4 days of survey (January 22-24, 2024). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift.<br><br>Findings include:<br><br>Review of the facility's "Posting of Staff" policy occurred on 01/25/24. This undated policy stated, ". . . The charge nurse will be responsible to do the staffing report daily. The nurse with C by her name will fill out the form for the next shift . . ."<br><br>Observation of the daily staffing report occurred on January 22-24, 2024. The report failed to identify all categories of licensed and unlicensed nursing staff directly responsible for resident care per shift on the three days observed.<br><br>During an interview on 01/25/24 at 10:25 a.m., an administrative nurse (#2) agreed the posting of staff should have been updated at the beginning of every shift. | F 732 | 1. N/A<br>2. All Residents who reside at MMHCC have the potential of being affected if the staffing is inadequate. By posting the staffing on duty at any given time MMHCC is being proactive in assuring staff numbers are adequate for resident care.<br>3. The staffing report policy and completion procedures were reviewed on 2/6/24 and have been updated to reflect the current staffing needs of the facility. A previous miscommunication error was also corrected and the appropriate staff are now aware of what their part is in the completion of our staffing report.<br>4. The Director of Nursing will be responsible to monitor the staffing report to assure it is and remains filled in correctly. If found to be inaccurate, the DON will address this with the nurse or office personnel filling out that shift□s report.<br>5. Frequency of QA Monitoring: Weekly for four (4) full weeks: 2/11/24 through 3/9/24. Monthly for three (3) months (April-May-June 2024) and then quarterly | |

| 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 _____ | 01/25/2024 |

| 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 732 | Continued From page 10<br><br>The facility failed to ensure the posted staffing information was accurate and complete. | F 732 | (September and December 2024) with QA monitoring completed 12/9/24. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with involved personnel by DON or Designee and update to staffing report). The DON will submit a report of the deficiency along with the completed monitoring at the next QA/QAPI meeting tentatively set for 4/11/24. Then at the QA/QAPI quarterly meetings after 4/11/24, only the monitoring results will be reported to the committee through 12/9/24. In the absence of the DON if any monitoring needs to be completed that will be done by a Designee.<br>Completion date: 2/9/24 | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and | F 812 | | 2/16/24 |

| 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 _____ | 01/25/2024 |

| 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 812 | Continued From page 11<br>serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to prepare, store, and serve food in a sanitary manner in 1 of 1 kitchen. Failure to discard outdated food items and monitor the sanitizer concentration may result in unsafe food storage/preparation and foodborne illness.<br><br>Findings include:<br><br>OUTDATED FOOD ITEMS<br><br>Review of the facility policy titled "Food Safety Requirements" occurred on 01/25/24. This policy, revised January 2024, stated, ". . . Practices to maintain safe refrigerated storage include . . . Labeling, dating, and monitoring refrigerated food . . . so it is used by its use-by date, or . . . discarded . . ."<br><br>Observation of the kitchen on 01/22/24 at 11:00 a.m. and 01/24/24 at 11:18 a.m. showed six quart-sized cartons of buttermilk sitting on a shelf in the walk-in refrigerator. Each carton was dated 01/06/24 (19 days past the "use-by" date). A managerial dietary staff member (#3) confirmed she would discard the outdated buttermilk.<br><br>SANITIZER<br><br>Review of the facility policy titled "Sanitation Inspection" occurred on 01/25/24. This policy, revised January 2024, stated, ". . . The department shall establish a sanitation program | F 812 | 1. F812 - Corrective action was taken immediately following the dietary health survey observation on 1/24/2024. The Dietary Manager removed and discarded the dated buttermilk from the walk-in cooler which expired beyond the 7-day “best by date”.<br><br>Corrective action was taken immediately following the dietary health survey tour on 1/22/24. The Dietary Manager discarded a bucket of chlorinated sanitizer solution in the food prep area of the kitchen and replaced it with a pre-measured sink and surface sanitizer solution.<br><br>2. All residents, staff and visitors have the potential of receiving a foodborne illness due to improper procedures for sanitation, labeling, dating and the use of expired food items.<br><br>3. To take measures to prevent these recurrences, dietary staff will check the walk-in cooler and reach-in refrigerators every three days for outdated food and discard it. A date log will be implemented and initialed weekly. Staff will purchase low usage items such as buttermilk either in dry or smaller quantity from local grocery store. The dietary manager reviewed MMHCC policies “Date Marking | |

| 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 _____ | 01/25/2024 |

| 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 812 | Continued From page 12<br>for food services . . . The dietary manager shall develop and provide food service personnel with standard operating procedures for sanitation . . ."<br><br>Observation on 01/22/24 at 11:00 a.m. showed a bucket filled with a sanitizer solution in the food preparation area of the kitchen. A managerial dietary staff member (#3) indicated the sanitizer solution contained chlorine and asked a staff member to retrieve test strips from the other room. The dietary staff member (#5) returned with test strips, tested the solution, and obtained a reading of 170 ppm (parts-per-million), which is outside the acceptable 50-100 ppm range for a chlorine solution.<br><br>During an interview on 01/23/24 at 3:15 p.m., the managerial dietary staff member (#3) stated, "I think we used the wrong test strips yesterday. I think we used [brand name] test strips. I'm not sure what the chemical is. [Name of corporation] brings it." When asked how staff typically mix the sanitizer solution, the dietary staff member (#5) stated, "I usually do a quarter cup, like two ounces, like two lids full." When asked if they monitor the concentration of the solution, the managerial dietary staff member (#3) stated, "No, we don't have a log for this." | F 812 | for Food Safety" and "Food Safety Requirements" on 1/24/24 with dietary staff.<br><br>In addition, pre-marked red sanitation buckets with a test strip in them have been ordered. Staff will add pre-mixed Ecolab sink and surface sanitizer solution to the bucket. The proper ppm reading for sink and surface solution must be between 272-700. When the test strip shows sanitizing solution is soiled, it will be replaced with a fresh solution. Dietary will discontinue the chlorine and water solution. Staff will continue to test the bucket of sanitizer and will be recorded in a sanitation log. The dietary manager provided immediate training 1/22/24 to dietary staff about the importance of dispensing the right amount of sanitizing solution in the sanitizer bucket. The Dietary MMHCC policies "Sanitation Inspection "were updated and reviewed with staff on 1/24/24.<br><br>Post survey training/education will be provided to all dietary staff 2/14/24 and reviewed quarterly for a year.<br><br>The Policies were reviewed for "Date marking for food safety." and "Food Safety Requirements." The facility adheres to a date marking system to ensure the safety of ready to eat, time/ temperature control for food safety. The facility may refrigerate labeled and dated prepared items. If these food items are not consumed within 3 days, the facility | |

| 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 _____ | 01/25/2024 |

| 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 812 | Continued From page 13 | F 812 | staff will throw them away. Opened dairy products must be used within 3 days from opening. Unopened milk is good for 7 days after the “best by date.”<br><br>The Dietary Manager provided training with dietary staff 1/24/24 about the importance of dating and labeling opened food items in the walk-in cooler and reach-in refrigerators reminding staff to make sure to discard expired food after 3 days. The Dietary Manager reviewed the use of proper sanitizing procedures. Dietary personnel will continue to train at monthly in-services for any new policies or practices about labeling and dating food guidelines, documentation, sanitation and the prevention of foodborne illness.<br><br>4. QA monitoring will include a log kept in the kitchen for recording outdated foods/dairy products every week.<br><br>A sanitation log will be kept in the kitchen. Staff will initial and record ppm readings for the bucket of sanitizer solution. It will be tested daily to make sure proper ppm levels are maintained.<br><br>To ensure that proper procedure is followed, Dietary Manager will audit logs completed by dietary staff weekly for four full weeks (January 29th,2024 to February 19th) monthly for 3 months (February 19th to May 19th) and then quarterly (June to September) with Q/A monitoring completed by December 31st, | |

| 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 _____ | 01/25/2024 |

| 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 812 | Continued From page 14 | F 812 | 2024. If concerns are noted with the monitoring, immediate corrective actions will be taken (e.g., teaching with involved staff by Dietary Manager or Designee). The Dietary Manager will submit a report of deficiency along with the completed monitoring at the Q/A April 2024 meeting and at the quarterly meetings through January 2025. In the absence of the Dietary Manager, if any monitoring needs to be completed, that will be done by a designee.<br><br>5. Completion date 2/16/2024 | |
| F 921 SS=E | Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)<br><br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of the North Dakota Plumbing Code, and staff interview, the facility failed to provide an air gap for 1 of 1 two-compartment sink observed in the main kitchen. Failure to provide the required air gap for a two-compartment sink has the potential to allow contamination of the sink in the event of a sewer back up.<br><br>Findings include:<br><br>Review of the 2018 North Dakota Plumbing Code, Section 801.2 Air Gap or Air Break Required, stated, "Indirect waste piping shall discharge into the building drainage system | F 921 | □ On January 24, 2024, the maintenance staff corrected the issue by cutting the drainage line to provide the required air gap for the two-compartment sink in the main kitchen. As all residents could be impacted by this practice, all facility drainage lines for sinks were reviewed to ensure that the required air gap is present or backflow prevention hardware is in place. Housekeeping and maintenance staff are retrained regarding the proper length of drainage hoses and the risk of backflow into the water system. Future sink drainage installments will be reviewed to ensure that required air gap | 2/16/24 |

| 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 _____ | 01/25/2024 |

| 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 921 | Continued From page 15<br>through an air gap or air break as set forth in this code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood-level rim of the receptor shall be not less than 1 inch (25.4 mm)." Section 801.3.3 Food-Handling Fixtures, stated, "Food-preparation sinks, steam kettles, potato peelers, ice cream dipper wells, and similar equipment shall be indirectly connected to the drainage system by means of an air gap. Bins, sinks, and other equipment having drainage connections and used for the storage of unpackaged ice used for human ingestion or used in direct contact with ready-to-eat food, shall be indirectly connected to the drainage system by means of an air gap. Each indirect waste pipe from food-handling fixtures or equipment shall be separately piped to the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall be not less than the drain on the unit and in no case less than 1/2 of an inch (15 mm)."<br><br>Observations on 01/23/24 at 3:15 p.m. and 01/24/24 at 11:18 a.m. showed the end of a two-compartment sink drainpipe ending approximately three inches below the rim of a cut out in the tiled flooring that contained the grease trap/floor drain.<br><br>During an interview on 01/24/24 at 2:15 p.m., a maintenance staff member (#1) confirmed the two-compartment sink failed to have an air gap. | F 921 | is in place or backflow hardware installed. Current sinks with drainage hoses will be inspected for proper air gap placement or installed backflow hardware and documented monthly by housekeeping staff to ensure compliance, monitored by the administrator and reported to the quality assurance committee on a quarterly basis. Completion date is February 16th. | |