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 _____	02/25/2016

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 February 22, 2016 and completed on February 25, 2016 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 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure residents were free of physical restraints not required to treat medical symptoms for 4 of 6 sampled residents (Resident #1, #3, #8, and #13) identified with a restraint. Failure to assess physical restraints (hand mitts, one piece jumpsuit, emergency full belt, and Merry Walkers), obtain a physician's order, notify the resident's family/legal representative, and documentation of discontinuation of restraints (12 hour emergency full belt) placed the residents at risk of serious injury, loss of mobility, and/or death. Findings include:	F 221	Revised 3rd time 04/06/16 F221: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that residents #1, #3, #8 and #13 from the survey roster and all residents are free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident□s medical symptoms. To assure that all residents are free of unnecessary physical or chemical restraints the following was put in place. 1. A. In regards to Resident #1 of the Survey Roster: " A restraint assessment was completed 03.02.16 for the use of the back zipped jumpsuit and the body suit or	4/11/16

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

Electronically Signed | 03/24/2016

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F 221	Continued From page 1 Review of the facility policy titled "Restraints" occurred on 02/25/16. This undated policy stated, "Equipment: 1. Type of restraints (These are not restraints if resident is able to open - see restraint definitions). . . . b. waist safety belt, regular belt (hooks in back of chair), Velcro belt, seat belt, sentinel seat belt . . . f. Hand mitts. . . Procedure for determining need for restraint: (Completed by Resident Care Coordinators initially and quarterly. PT [physical therapy] and OT [occupational therapy] involved with initial assessment as necessary). 1. A "fall" assessment of the resident will be completed. Assess the environment. Perform a physical assessment of the resident. Does not apply to emergency use of restraint. 2. The resident and/or family and/or legal representative will be contacted. . . . 4. Selection of the least restrictive type of restraint or support will be made and suggested to the physician. The physical therapist and nurse will be consulted to make this suggestion prior to use of physical restraint. 5. A physician's order indicating the duration, type, and circumstances of the restraint will be obtained. . . . Once a restraint is used: (Resident Care Coordinators assess quarterly) 1. Continually reassess the resident's functional status to ensure: a. That the medical condition requiring restraint continues. b. That decline in functional status is related to medical condition, not restraint use. c. Negative effects are monitored and (1) No unanticipated negative effects are occurring. (2) Benefits continue to outweigh the risks. . . . 4. Residents in restraints are to be observed at least q [every] 15-30 minutes. . . .	F 221	onesies. These options were noted as alternate clothing on the order. " A physician□s order was obtained on 03.02.16 that stated May use alternate clothing restraint to deter harmful or undignified behaviors. " Family member was contacted in regards to the use of the alternate clothing restraint on 03.02.16 and was in agreement with the necessity of the alternate clothing. " The restraint assessment will be reviewed on a quarterly basis to determine if alternate clothing is still required for this resident. " In regards to the Seat belt alarm a restraint assessment had been completed for the seat belt alarm, a physician□s order was in place, family was aware of the need and do note that this item is also reviewed on a quarterly basis. B. In regards to Resident #3 of the Survey Roster: " A restraint assessment was completed on 02.29.16 for the use of the backed zipped jumpsuit. " A physician□s order was obtained on 02.29.16 that stated May use alternate clothing restraint to deter harmful or undignified behaviors. " As noted on the assessment, a family member had already been contacted on 09.21.15 to use the back zipped jumpsuit and was in agreement with the necessity of the alternate clothing at that time. " The restraint assessment will be reviewed on a quarterly basis to determine if alternate clothing is still	

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F 221	Continued From page 2 Procedure: . . . 8. Emergency Full Belt Restraint a. If restraint is used due to emergency (if harmful to self or others) it's to be used for only 12 hr [hours] and state in nurses notes why e.g. [such as] emergency full belt restraint used for 12 hrs when in w/c [wheelchair] due to displaying exhaustion related to constant pacing, high risk of falling due to extreme unsteady gait. As soon as possible the Dr. [doctor] is to be notified. If restraint is for more than the 12 hours a Dr.s (sic) order needs to be obtained, and responsible party or family consent is needed. b. Inform RCC's [resident care coordinators] that a restraint was necessary." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice, " 10th ed., Pearson Education, Inc., New Jersey, page 659, states, "Restraining Clients: . . . The decision to use a restraint must be based on a comprehensive, individualized client assessment. This assessment needs to determine whether the use of less restrictive measures is a greater risk than the risk of using a restraint . . . Restraints should not be considered a part of routine client care and should not be included in a fall prevention program. . . ." - Review of Resident #8's medical record occurred on all days of survey. Current diagnoses included dementia with psychosis, anxiety disorder, and Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 02/08/16, identified severely impaired cognition, sometimes made himself understood and sometimes understood others, and daily wandering. Resident #8's record identified, "Non Pharmacological Interventions: Walk out in patio,	F 221	required for this resident. C. In regards to Resident #8 and #13 of the Survey Roster: " No full belt restraints are used and the Merry Walker (MW) is no longer available. 2. All residents who reside at MMHCC have the potential to be affected by the use of restraints. Refer to number 3 for interventions and policies put in place. 3. A. A note was placed in the Nursing department communication book the evening of 02.24.16 by the Director of Nursing (DON) stating that if a restraint is necessary for any type of a situation a provider needs to be called and an order obtained for the restraint before placing the restraint. B. On 02.25.16 an updated restraint protocol was placed in the chart backs of each wing, the nightshift chart back and the protocol folder and a note was also sent to the nurses 02.25.16 through the electronic charting system (ECS) in regards to bringing their attention to the updated protocol being placed in the chart backs for them to review. C. The restraint protocol was also added to the restraint procedure. D. An In-service with the nurses was held on 03.16.16 at which time the restraint protocol was reviewed and a copy of the protocol was included in the in-service packet. E. In the nurse□s charting section in the ECS system, a folder was added entitled Restraint Assessment. If the RCC is not in house to do an initial Determination of Need for a Restraint assessment, the charge nurse can do an	

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F 221	Continued From page 3 1:1 [one-to-one] with staff, massage to back, neck and/or forehead, lavender lotion, reassurance, fold towels, offer picture magazines or books, Bible to hold, weighted blanket, lap activity apron, walk with him in halls." Review of Resident #8's nurses notes identified the following restraint use (12 hour emergency full belt and/or merry walker): *08/13/15 "01:05 AM . . . is agitated, is combative, resident continues to walk up and down the halls, angry with staff. Unable to get resident to go to room and bed. Staff continues 1:1 with him. He is unsteady on his feet . . . 03:21 AM continues with behavior. 12hr [hour] restraint placed for resident safety. Will continue to monitor. Resident was brought to nurse's station and placed in recliner with full gray belt . . . 03:33 AM is agitated, is combative, CONFUSED to place to time to person irritable resident assisted to toilet, refuses to go to bed. returned to recliner with full gray belt on." There is no documentation to identify when the 12 hour restraint was actually removed. *08/13/15 "07:05 PM out north door again both alarms are sounding. [Nurses name] decided to have him walk around the building and I (writer) met him at on [sic] the side walk by the main doors. Was cooperative with coming in. Time: 07:10 PM decided to try the merry walker to see how he would do. Placed in merry walker for only a little while because this did upset him. Time: 07:20 PM [Nurses name] noted that resident had gotten the buckle undone and had his foot on the strap that went between the legs. Nurses [names] tried to get him to put his leg back where it was suppose to go and tried to buckle the buckle back when resident got upset and hit	F 221	assessment of that resident prior to obtaining the order from the provider. Once this assessment is completed, the assessment is automatically sent to the RCC□s and the DON through ECS to alert them that an assessment and order was necessary for a resident. The RCC□s/DON can then review the situation for the possible need of further evaluation or assessment. 4. The following will be the Frequency of the Quality Assurance (QA) monitoring that the DON or designee will conduct to assure that Need of Restraint assessments and orders are completed. " Weekly for 4 weeks: 02.29.16 through the week of 03.21.16 (that is 4 full weeks). Monthly for 3 months (April-May-June2016) and then quarterly (September & December 2019) with QA monitoring completed December 30, 2016. If concerns are noted with the monitoring, immediate corrective action will be taken (e.g. teaching with nurses involved). The DON or designee will submit completed monitoring at the quarterly QA Committee meetings through December 30, 2016 at which time the QA committee will determine if further monitoring is necessary. The facility□s next quarterly QA meeting is tentatively set for April 28, 2016. Completion date 04.11.2016	

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F 221	Continued From page 4 nurse [name] in the arm. Nurse [name] tried to have resident stand up in the merry walker to see if he would walk but he got upset. I (writer) tried to get him to walk with the merry walker also but then he sat down and was going to open the buckle and put his foot over the leg straps. CNA [certified nursing assistant] [name] and I (writer) was trying to get him out of the merry walker because it was just agitating him more as we got the buckle undone from between the legs he started going under the main bar and [CNA name] and I (writer) had to lower him to the floor. We than (sic) stood him up and walked him back to his room. . . ." *09/11/15 "03:08 PM Resident has been very is [sic] agitated, and is combative,. [sic] He was trying to exit the west door and when staff attempted to redirect him he became aggressive. He attempted to hit one of the CNAs and stated 'I have never hit a woman but I have had enough of this.' I tried to give him his PRN [as needed] lorazepam PO [per oral] but resident was uncooperative. He tried pushing my hand away and ended up hitting the cup out of my hand. We did help him to sit in his wheelchair and applied a seat belt restraint. . . . 05:01 PM resident is much more calm and relaxed at this time. He is sitting quietly in his wheelchair. He does have a hand on the belt and has been trying to remove it." There is no documentation to identify when the 12 hour restraint was actually removed. *09/12/15 "09:07 AM Again trying to go out north exit. When redirected says 'I've never seen a christian place that invites you and then doesn't let you go. I've gotta go I have to get to my job.' When assisting to w/c [wheelchair] say [sic] 'What are you trying to do get in my pant [sic]?' Restraint placed at this time." There is no	F 221		

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F 221	Continued From page 5 documentation to identify when the 12 hour restraint was actually removed. *09/28/15 "10:28 PM has cont [continued] to pace, eyes are half open refuses to lie or sit, stumbles and leans way forward observed nearly tipping over numerous times, requires 1:1, 1:1, staff has read the bible with him, offered snack, assessed for pain, conversation, toileted, unchanged, looks exhausted, in w/c with emergency 12 hour restraint on for safety. 10:45 PM is already dozing in the w/c. There is no documentation to identify when the 12 hour restraint was actually removed. *09/29/15 "01:01 AM resident was able to roll w/c down the East wing hall and somehow able to get the restraint down around his knees and was sitting on back side of w/c. . . ." There is no documentation to identify when the 12 hour restraint was actually removed. *10/05/15 03:17 PM "Is agitated, restless, has attempted to exit via 3 different doors x 6 in past 40 mins [minutes] shuffling walk 1:1, music, conversation, offered snack, unchanged, does not want to sit and visit or listen to scriptures, tells me 'Darling, I am so tired that if I sit down I won't wake up until morning.' Intervention: Will utilize emergency restraint. 03:30 PM Is in his room in w/c watching The Waltons. 05:48 PM Emergency gray belt has been off since 5 pm, has not attempted to leave his room. . . ." *11/29/15 10:47 PM "Due to restlessness, poor gait due to being overly tired and cold outdoor temperatures, emergency grey belt utilized." There is no documentation to identify when the 12 hour restraint was actually removed. *01/22/16 04:15 AM "Assisted to bed and was up immediately walking, and nearly fell again if I had not been there to catch him. I will NOT give him	F 221		

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F 221	Continued From page 6 the Lorazepam as that will only increase the chance of him falling due to increased lethargy. Intervention: Will use a gray belt restraint as an emergency 12 hour standing order per Dr. [name] for his own safety. With a fall and near fall all with in a 10 minute period. I am doing this as a nursing measure to protect him from himself. . . . 05:33 AM Had a change of position for 10 minutes, was toileted, dressed and tried to assist back to bed, but would not stay so is back in his w/c with the grey belt on as is still extremely unsteady and is walking and then nearly jumps, then walks again. Very unsafe!" There is no documentation to identify when the 12 hour restraint was actually removed. During an interview on 02/24/16 at 1:45 p.m., an administrative nurse (#1) stated the facility utilized standing orders for the emergency restraint. She stated staff could use the standing order for the twelve hours and, if used longer than that, staff would complete an assessment and obtain a physician's order. The nurse (#1) returned at 2:31 p.m. and stated the facility had no standing orders for emergency restraints. She stated the nurse makes the decision and writes the order and the physician signs off the order the next day. During an interview on 02/25/16 at 12:45 p.m., an administrative nurse (#1) stated when staff use an emergency restraint they should notify the resident's family. When asked to provide documentation of family notification, she stated staff document the notifications in the nurses notes. Failure to assess and implement appropriate	F 221		

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interventions to manage Resident #8's behaviors resulted in recurrent use of emergency restraints (full belt and merry walker) to control his exit seeking behaviors and unsteadiness. The facility failed to complete a comprehensive assessment of the restraints utilized, failed to obtain physician orders at the time of the restraint use, failed to provide documentation of family notification. These failures resulted in an episode of entrapment and an increased risk of serious injury or death (Refer to F323).

- Review of Resident #1's record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, and anxiety. Resident #1's quarterly MDS, dated 12/09/15, identified long and short term memory problems and severe impairment in daily decisions. The record identified Resident #1 fell on 10/23/15 while self-transferring. The facility transferred Resident #1 to the emergency room after the fall. An x-ray showed a right hip fracture, however the orthopedic physician recommended no surgery at that time. Resident #1 returned to the facility the same day (10/23/15).

Nurses notes, dated 10/24/15, stated, "Attempting to self transfer many times. . . . New orders: . . . Emergency Full Gray belt when up in w/c [wheelchair] until seen by PAC [physician assistant - certified] on 10/26/15. . . . family notified . . . of order changes - was already aware of fracture."

Physician/physician assistant progress notes, dated 10/26/15, stated, "Due to her advanced dementia she has already been up and walking. . . . persistent pain in the right hip area especially

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with any type of transfer. . . . She is very likely to displace the fracture if she continues to walk on it and put weight on it. We utilized a gray belt in her chair to immobilize her. For her to be up and walking would be very detrimental for her. . . We will continue with bed and chair alarms. If we feel it is necessary a safety belt will be utilized. She cannot get up and walk around and displace this fracture further. I understand from staff that medical Power of Attorney agreed to the above. . . ."

Physician's orders dated 10/26/15, stated, "Full belt restraint in place when up in w/c for her safety due to her severe cognitive impairment - she does not comprehend to call for help. Safety belt buckle or Velcro belt will not be tried for residents safety due to her broken hip [and] it not being repaired."

The facility completed the "Initial Determination of Need for Restraint" on 11/03/15, 10 days after the initiation of the full belt restraint. The assessment stated, in part, ". . . Benefits outweigh the risks at this point. We will re-evaluate to change to less restrictive means as her weight bearing abilities improve. . . ."

On 11/09/15, the physician assistant ordered "Try to downgrade from full gray belt to sentinel belt x 5 days then RCC to assess if to continue."

An update on the "Initial Determination of Need for Restraint" form, dated 11/13/15 stated, "Seat belt alarm placed 11/9/15 [and] evaluated today. She has not attempted to open the belt in the past 5 days [and] is not able to open it even [with] instruction. Due to her confusion, she is unable to

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comprehend on a consistent basis how to remove any devise attached to her wheelchair such as a Velcro belt or a lap buddy. A saddle seat would likely not deter her from self transferring [and] due to her hip fracture is not an option. Verbal cues do not deter her or keep her safe or injury free. We will continue [with] the seat belt alarm [and] keep her in a visible area when possible."

The facility failed to complete an assessment on the use of the full gray belt restraint until 10 days after it was initiated and failed to identify and use the least restrictive method of restraint.

- Review of Resident #13's medical record occurred on February 24-25, 2016. Medical diagnoses included Alzheimer's disease, dementia, unspecified psychosis, and anxiety. The admission MDS, dated 06/21/15, and a quarterly MDS, dated 12/07/15, identified severe impairment in daily decisions and extensive assist of one for walking in room and corridors.

Review of Resident #13's nurses notes identified the following:
*07/24/15 - "7:00 AM is restless at this time . . . 7:30 AM . . . is requesting to lay down at this time but only lays down for about 5 minutes . . . [Resident #13] . . requesting to go to the bathroom . . . and again she requested to lay down. did lay her down but . . only stays in bed for about 5 minutes. Therapy has walked with her to keep her content . . . 8:00 AM . . . continues to try to stand and walk per self . . . 9:26 AM . . . Request to lay down but it is only for a short period of time and is up walking the halls. . . 10:30 AM . . . continues to try to get up from

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F 221	Continued From page 10 wheelchair to stand/walk. Will try merry walker this afternoon to see if this helps with her restlessness. . . . 11:47 AM resident has been very restless up and down from sitting in her w/c frequently setting off alarm and sometimes walking unsafely pulling the w/c behind herself as she walks. Order obtained to try using Merry walker when restless and wanting to walk per nurses discretion x 10 days then re-evaluate. Use PRN [as needed]. Release q 2 hr for 10 minutes for position change. . . . placed in merry walker due to restlessness and wanting to walk to "Mandan" . . . does really well walking with the merry walker - did note x 1 that she was trying to get her foot over the strap but was unable to do so. . . . does sit down when she gets tired. . . . Son Notified . . . about new orders and risk of falls/injuries with merry walker. . . is okay with idea of the merry walker. . . . 4:10 PM walking in the merry walker at the time. Resident repeatedly states 'I don't call this walking. Do you?' She also calls out 'Please, I can walk better by myself.' Also stated "Let me get out of this thing!' I informed her that she can walk alone using the merry walker or she can sit in her wheelchair but she is not allowed to walk on her own for her own safety. . . ." *07/25/15 " . . . 1:05 PM resident sat in merry walker for 15 minutes this am, did not walk; was restless and wanted to walk with her walker. . . . 8:50 PM Resident was very restless and agitated this afternoon and before supper . . . She refused to sit in merry walker. . . ." *07/26/15 "8:58 AM Resident restless this am. . . . wanted to lay down . . . then got out of bed x 4. Resident assisted into merry walker and she is now sitting in the hall. . . . Resident sat in merry walker for about 10 minutes. She became more	F 221		

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	355036	A. BUILDING _____ B. WING _____	02/25/2016

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F 221	Continued From page 11 agitated and was trying to get out of the chair. She was also hollering out. . . . She is now sitting at the table coloring. . . . 10:36 AM resident sat in merry walker for about 10 minutes. She was agitated and restless and kept trying to get out of the chair. . . 6:57 PM . . . resident refused to sit/walk in merry walker this evening. *07/27/15 - "10:38 AM . . . Repositions very often, up and down frequently from wheelchair - is unsteady, holds arm rests behind her while she's trying to stay standing. . . . Again trying to stand from wheelchair and nearly tripped on the front wheel. Placed in Merry Walker so she can be up and walking as she pleases. . . . again restless in Merry Walker - calling out, 'help me out of here!' . . . Will place back in wheelchair . . . 12:11 PM . . . Wants again to lie down, attempted to but again got right back up. Placed in Merry Walker . . . she is walking down the hall in it and is steady. 12:35 PM crying in Merry Walker - 'let me out of this thing! I just want out so I can walk like a normal person!' Taking her shoes off and lifting her leg over the side bar on the walker. . . . Assisted to bed . . . spent much of the shift going from bed to wheelchair and back again. . . . *07/28/15 10:38 AM . . . assisted into merry walker after toileting, is not content in merry walker with 'get me out of this [expletive] thing' . . . wants to lie down, assisted to bed. . . 4:01 PM . . . Did place in merry walker at this time so she is able to walk around per self. . . 4:22 PM Take me out of this [expletive] thing (merry walker) I didn't do anything to be placed in here.' Did try to explain to her that the merry walker is so she can walk around by herself and when she gets tired that she can sit down without getting hurt. She then stated 'I can't walk very well in this thing.' As I (writer) was about to tell her she does very well	F 221		

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F 221	Continued From page 12 in it she was up and walking . . . " *07/29/15 - ". . . 10:26 AM is restless at this time and is still in merry walker, [Resident #13] does try to take her leg out of the merry walker . . . 10:32 AM is hollering out that she wants out of this [expletive] thing (merry walker). 'Can someone please get me out of this [expletive] thing, I want to lay down!' . . . 5:31 PM . . . the res. [resident] was attempting to crawl out of her merrywalker. The res. was assisted to the floor . . . the res. landed on her bilateral knees [and] her right thigh in a modified sitting position on the floor. The res. was assisted off the floor with assist of 3 . . . gait belt [and] assisted back to her merrywalker. . . . instructed res. to ask for assistance if she wanted to transfer out of her merrywalker in the further. . . ." *07/31/15 - "5:03 PM Resident is in the Merry Walker . . ." *08/04/15 - "7:37 AM used the Merry Walker 4 x in the past 10 days. Will continue x 10 more days then re-evaluate use. . . ." *08/12/15 - "will DC [discontinue] merry walker. Res. did not do well with it and it was unsafe for her." The facility failed to identify and/or assess the use of the Merry Walker as a restraint and continued to use the device after the resident repeatedly asked to get out of the Merry Walker and on one occasion landed on her "bilateral knees [and] her right thigh." She required three staff to be assisted off the floor. Use of this restraint increased the resident's anxiety and risk for falls. - Review of Resident #3's medical record occurred on all days of survey. The current	F 221		

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F 221	Continued From page 13	F 221		

diagnoses included Alzheimer's disease, dementia with behavioral disturbance, anxiety, and delusional disorder. The resident's quarterly Minimum Data Set (MDS), dated 02/01/16, identified problems in short and long term memory and daily decision making severely impaired.

The activities of daily living (ADL) sheet identified, ". . . Has adult onesies to wear to prevent digging. Printed ones for day wear and solid colored ones for HS [hours of sleep]. . . ." The current care plan stated, "Alteration in thought process related to confusion . . . inappropriate behavior e.g. digging in brief, eating stool (corophagy). . . . Approach: . . . Dress in one piece clothing to deter her digging in stool behavior. . . ."

During a staff interview on the morning of 02/22/15, an administrative nurse (#3) stated that Resident #3 wears the one piece jumpsuit 24 hours a day to deter from accessing her soiled brief.

Observation on all days of survey showed Resident #3 in a one piece jumpsuit with the zipper in the back.

Review of Resident #3's nurses notes identified the following hand mitt restraint use:
*07/14/15 ". . . Incontinent of BM [bowel movement] in which she had both of her hands covered in BM and fingers in her mouth . . . white mitts placed on her hands by RCC [resident care coordinator] . . ."
*07/15/15 "Mitts placed to bilateral hands at HS."
*07/17/15 ". . . She quickly removes the hand

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mitts meant to keep her from scratching at herself and from ingesting her own feces. Intervention: teaching, reapplication."
*07/18/15 "Is uncooperative, with leaving her hand mitts . . . replaced numerous times on this shift."
*07/19/15 "Is uncooperative, with hand mitt . . ."
*07/23/15 ". . . works to get the mitts off her hands and is successful at times, does scratch vigorously at skin when they are not in place."
*07/29/15 ". . . Grabs firmly at brief during pericares. Mitts placed so she won't tear the brief . . ."
*09/06/15 "Resident inc. [incontinent] large amt. [amount] stool. Was able to get one mit [sic] off and had stool on hands and face. . . ."

Resident #3's record lacked evidence the facility identified the one piece jumpsuit or the hand mitts as a restraint and lacked a physician's order and restraint assessment for the use of the jumpsuit and/or mitts.

During an interview, on 02/24/16 at 02:07 p.m., an administrative nurse (#5) confirmed the facility did not identify the one piece jumpsuit or hand mitts as restraints. Facility staff failed to assess the one piece jumpsuit and hand mitts as restraints.

- Review of Resident #1's record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, and anxiety. Resident #1's quarterly MDS, dated 12/09/15, identified long and short term memory problems and severe impairment in daily decisions.

Resident #1's current care plan stated "Alteration

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F 221	Continued From page 15 in thought processes, related to: Alzheimer's/dementia, manifested by: increasing forgetfulness and confusion . . . undresses self in public . . . Approach: . . . Wears 1 piece jumpsuit when having episodes of public disrobing or one piece shirt or t-shirt." The ADL sheet identified " . . . Dress in the shirts or t-shirts that have the snaps at the crotch area due to frequent dis-robbing (sic) AM shift . . ." Observation on 02/22/16 showed Resident #1 in a one-piece jumpsuit with the zipper in the back. Observation on 02/23/16 showed Resident #1 with a shirt that snaps in the perineal area. Resident #1's nursing progress notes, dated 09/24/15, stated, "Social worker and myself visited with [name of resident]'s sister. . . via phone. Informed her that we ordered onsies [a one piece garment] for her dignity issues as she has been undressing in public. . . ." Resident #1's medical record lacked evidence the facility identified the one piece jumpsuit a restraint and lacked a physician's order and a restraint assessment.	F 221		
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to	F 222	F222: It is the policy of Marian Manor	4/11/16

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F 222	Continued From page 16 ensure 1 of 8 sampled residents (Resident #8) with as needed antianxiety medications remained free of chemical restraints imposed for the purposes of staff convenience. Failure to assess and implement behavioral interventions to manage Resident #8's exit seeking behaviors resulted in the frequent utilization of psychotropic medication for the purpose of staff convenience. Findings include: - Review of Resident #8's medical record occurred on all days of survey. Current diagnoses included dementia with psychosis, anxiety disorder, and Alzheimer's disease. The quarterly MDS (Minimum Data Set), dated 02/08/16, identified the resident's cognition as severely impaired, sometimes made himself understood and sometimes understood others, and daily wandering. The non drug interventions listed on Resident #8's chart stated, "Non Pharmacological Interventions: Walk out in patio, 1:1 with staff, massage to back, neck and/or forehead, lavender lotion, reassurance, fold towels, offer picture magazines or books, Bible to hold, weighted blanket, lap activity apron, walk with him in halls." Resident #8's physician orders included the following psychoactive medications: *09/01/15 Lorazepam (antianxiety) 0.5 mg [milligrams] tab 1 tab by mouth at bedtime. *09/10/15 Lorazepam 0.5 mg to 1 mg by mouth as needed q4h [every 4 hours] (anxiety). *09/11/15 Lorazepam 1 mg intramuscular q4h as needed (severe anxiety) *02/09/16 Risperidone (antipsychotic) 2 mg po (per oral) daily 11:00 AM.	F 222	HealthCare Center (MMHCC) to assure that resident #8 from the survey roster and all residents are free from chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident□s medical symptoms. 1. In regards to resident #8 of the survey roster: A. The chemical restraint concern: " On 03.16.16 at the Nurses□ In-service it was discussed in great detail the importance of utilizing the Non-Pharmacological Interventions (NPI□S) and noting the times. Was also stressed to look at the individual NPI sheet for this resident for suggestions of NPI□s to try. B. Resident□s exiting-elopement behavior concern: this is a twofold concern and this concern is addressed in F323. 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 chemical restraints and those residents who have a diagnosis of Alzheimer□s or Dementia may have a risk of elopement. Refer to number 3 for interventions and policies put in place. 3. A. An In-service with the nurses was held on 03.16.16 at which time the importance of utilizing NPI□s with residents who have behavior or other psychiatric concerns was discussed in depth. It was stressed to look at the individual NPI sheets for all of our behavior residents (such as Resident #8)	

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F 222	Continued From page 17 Resident #8's Nursing progress notes included the following behavior episodes, interventions, and administration of PRN lorazepam: *09/12/15 08:56 AM "[Resident name] has been awake and walking this am. Started out slow but now has been moving very quickly. Has gone out south exit 2x. And has attempted to go out west exit 1x. Is looking for money. Does not accept redirection well. Tries to hit at staff with his bible. Does not lay down for a nap. Only sits for a very short time in recliner then is up walking toward exit. Tried toileting and giving coffee and cookie." Lorazepam 1mg intramuscular (IM) at 08:56 AM. *09/23/15 11:58 AM "11:55 AM out north door returns willingly w/staff [with staff], w/'I [sic] thought I could go outside for awhile'! [sic] Intervention: taken to living area to watch television." Lorazepam 0.5-1 mg PO at 12:15 PM (dose not specified on medication administration record (MAR)). *10/05/15 2:54 PM "12:00 PM resident has been wandering up and down the wings. Did attempt to go out the west doors. Staff was already by the doors and redirected resident back to his room. 12:15 PM Alarm sounding at the 300 wing doors. Staff was alarmed and resident redirected to return to room. Resident did sit down in his recliner for a short time as he stated 'I am tired.' 12:30 PM Both alarms sound at the south door, resident is already walking towards the garages. Does get upset with writer and CNA [Certified Nursing Assistant] [name] as resident think he is late for his appointment and then states 'My appointment was changed for tomorrow at 2 o'clock' Resident did return back to building. Offered the bathroom and resident stated he did not need to go, water given, food offered but	F 222	that are in their chart back at their nurse□s station to use for reference for suggestions as to what NPI to try. DON reminded the nurses to pay attention to the pop up message in ECS: in ECS when the nurses click on a PRN Psychotropic to give, it will pull up the behavior charting folder and a reminder will pop up that states Chart non-pharmacological interventions and times attempted. 4. The following will be the QA Monitoring that the DON or designee will conduct to assure unnecessary drug concerns are being addressed. Note that the monitoring for F329 and this tag F222 in regards to medication use are combined as one monitoring sheet as both tags have the same concerns. " The DON will randomly review Resident #8 and other residents for PRN psychotropic med use, were the NPI□s utilized to the fullest prior to giving the PRN psychotropic med etc... Any concerns will be noted & reviewed with the nurses involved in the situation and RCC for that particular resident and report concerns to the provider if necessary. " With monitoring the PRN psychotropic med use, the DON will also monitor if follow-up documentation was done (e.g. was the med effective in managing the behavior concerns). " Frequency of QA monitoring: Weekly for 4 weeks: 02/29/16 through the week of 03/21/16 (that is 4 full weeks). Monthly for 3 months (April-May-June2016) and then quarterly (September & December 2019)	

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F 222	Continued From page 18 refused. 12:30 PM Resident is now going out north doors, alarms sounding, is cooperative with redirection. Did sit up at the aviary for a short while but than [sic] headed down. 01:15 PM PRN Ativan (Lorazepam) given as non pharmacological interventions are not helpful." Lorazepam 0.5-1 mg PO at 01:10 PM (dose not specified on MAR). *11/13/15 03:05 PM "02:20 PM alarm sounded at west door, is between doors wanting to go out but is brought back inside facility with assist of one. Intervention: taken to church service. Outcome: would not settle for service, assisted back to his room, is soon back up and out of room wandering in hallways." Lorazepam 0.5-1mg PO at 03:09 PM (dose not specified on MAR). *11/22/15 11:43 AM "11:00 AM went out the 300 wing door, alarm sounding and alerted staff, resident is cooperative to return into building. Lavender lotion applied to bilateral neck, and hands. After lotion applied resident is taken back to the dining room to see if he will finish eating as he left the dining room earlier. 11:20 AM alarm sounding by the 300 wing door resident did go out the door was cooperative with returning. Will not stay in the dining room to eat. Brought back and had resident go to his room where music was played but only lasted a few minutes as he was up and wandering down the 300 wing hall. Does sit at the aviary but only last for a few minutes as he is up and going. 11:35 AM heading out the west doors at this time, alarm sounding and alerting staff. Does not need the bathroom. Cookies and coffee given. PRN Ativan given. As soon as resident is done eating his cookie he is up and wandering and heading towards one of the doors." Lorazepam 0.5-1 mg PO at 11:37 AM	F 222	with QA monitoring completed December 30, 2016. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with staff involved: nurses, RCC and SS). The DON or designee will submit completed monitoring at the quarterly QA Committee meetings through December 30, 2016 at which time the QA committee will determine if further monitoring is necessary. The facility□s next quarterly QA meeting is tentatively set for April 28, 2016. " The Elopement QA monitoring for this tag F222 and F323 are combined as one monitoring sheet as both tags had the same concern. Completion date 04.11.16	

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(dose not specified on MAR).
*12/11/15 Lorazepam 0.5-1 mg PO at 11:59 AM (dose not specified on MAR). 12:14 PM "Did let me lay him down on his bed, stayed for only about 3 minutes. Up and about again."
*12/12/15 Lorazepam 0.5-1 mg PO at 12:56 PM (dose not specified on MAR). 01:30 PM "Res [resident] napped most of morning in chair at nurses station. Woke when his family got here approximately 10:30. He has been awake the res [sic] of the day and pacing near constant. He has attempted to leave the building 3 more times since PRN Lorazepam was given. . . ."
*12/23/15 01:08 PM "Attempted to leave the building x 5 so far today. Mildly resistive with staff intervention." Lorazepam 0.5-1 mg PO at 1:21 PM (dose not specified on MAR).
*12/28/15 Lorazepam 0.5-1 mg PO at 09:46 PM (dose not specified on MAR). 09:48 PM "Resident has been wandering about the facility throughout the shift. Within the past hour he has become increasingly restless and has been trying to exit the facility. He did exit the south door once and he hit staff as they were trying to assist him back into the facility."
*01/17/16 Lorazepam 0.5-1 mg PO at 05:57 PM (dose not specified on MAR). 06:00 PM "Becoming increasingly angry with redirection, is insistent that his car is 'in the parking lot' tells me he has 'to make the turn off.' Intervention: PRN medication."
*01/19/16 04:21 PM "For the last 45 minutes resident has been wandering the hallways. He continually tries to go outside stating he is looking for 'a green car to put some stuff in.' Intervention: 1:1, conversation, redirected." Lorazepam 0.5-1 mg PO at 04:21 PM (dose not specified on MAR).

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F 222	Continued From page 20 *01/20/16 12:06 AM "Again was headed outside, intercepted as he opened the outside door. Intervention: brought back to NS [nurses' station] and heads right back to the exit. For his own protection will need to medicate so he relaxes and can rest." Lorazepam 0.5-1mg PO at 12:07 AM (dose not specified on MAR). *02/05/16 02:22 PM "Has been out the west door 3 x in the past 10 minutes. Each time staff tries to talk to him/extend their hand to him he slaps it away. Says 'leave me be!' Wont answer what is bothering him or where he is going. Has no interest in toileting, snacks that we offer, fluids, activity room, etc. Pacing quickly and unsteadily- is very determined to get outside." Lorazepam 0.5-1 mg PO at 02:23 PM (dose not specified on MAR). *02/09/16 01:30 PM "Tried exiting south door, became combative with CNA hitting out and cursing, is now hollering at another CNA about exiting the North door. Will continue to observe." Lorazepam 0.5-1 mg PO at 01:49 PM (dose not specified on MAR). Failure of the facility to appropriately assess and implement behavioral interventions to manage Resident #8's behaviors (multiple elopements) resulted in the frequent utilization of lorazepam to control his exit seeking behaviors for staffs' convenience.	F 222		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		4/7/16

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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 250	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide medically-related social services for 1 of 1 sampled resident (Resident #9) who, prior to admission, had expressed suicidal behaviors. Failure to address the psychosocial needs of Resident #9 and develop and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect the resident's overall level of functioning. Findings include: Review of the facility policy titled "Suicidal Thoughts/Threats" occurred on 02/25/2016. This policy, undated, stated, "Policy: Every attempt is made to identify residents with suicidal ideation or attempt and to provide guidelines to care for the suicidal resident. . . . Procedure: . . 5. It will be the responsibility of the Charge Nurse and Social Services to assess residents expressing suicidal thoughts or exhibiting suicidal behavior . . . f. the Charge Nurse and Social Services will update the care plan the following: [sic] 1. be alert for suicidal ideations/gestures. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included anxiety disorder, Post-traumatic stress disorder (PTSD), and major depressive disorder. An admission Minimum Data Set (MDS), dated 07/27/2015, and a quarterly MDS, dated 02/08/2016, identified intact cognition.	F 250	F250: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that resident #9 from the survey roster and all residents receive medically-related social services in order to attain or maintain their highest practicable physical, mental, and psychosocial well-being. 1. In regards to Resident #9 from the survey roster: • On 02.25.16 after the survey team exit, the DON, RCC who did Resident #9's admission and the Social Worker (SW) had a conference and reviewed the facility's Policy titled Suicidal thoughts/threats. DON did point out that it is the responsibility of the nurse and SW to assess suicidal thoughts and care plan even if there is a history of suicidal thoughts or attempts. On 02.25.16 after our conference the suicidal concern was added to the care plan and as of 03.31.16 the care plan is still current. • If reported by charge nurse that Resident is experiencing increased depression or is making comments of harming himself: the resident's provider will be notified and the SW or designee and RCC or charge nurse will assess further his plan and put interventions in place according to policy. • With Resident's scheduled Minimum Data Set (MDS) reviews Section D of the MDS titled Mood there is the question that	

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F 250	Continued From page 22 A discharge summary from the hospital, dated before Resident #9's admission to the nursing home, identified the chief complaint for the admission as suicide attempt. The report stated, ". . . [he/she] was having bad thoughts and missing [spouse] and so decided to take 'some extra sleeping pills' so that [he/she] could die and be with [spouse] . . . denies feeling suicidal now and says that it was a stupid idea. . . . Assessment and Plan: 1. Depression with suicide attempt by overdose. The patient does seem willing to speak with a psychiatrist here while [he/she] is here . . . and in fact does have a psychologist . . . and would like to continue with that psychologist . . . feels significantly improved and denies any suicidality. . . ." A MDS Care Area Assessment (CAA) note, dated 07/28/15, stated, ". . . took an overdose of medications with a suicide attempt and ended up in the hospital . . . had a psych [psychiatric] consult in the hospital and they felt [he/she] was no longer suicidal and in fact regretted action. . . ." Resident #9's medical record identified information regarding the hospitalization in the CAA, the CAA notes and the nurse's admission note. The resident's care plan lacked an approach and/or interventions to monitor for changes in behaviors and/or suicidal ideation. During an interview at 10:15 a.m. on 02/25/16 a social service staff member (#6) indicated not being aware of Resident #9's suicide attempt. During an interview at 11:00 a.m. on 02/25/16 an	F 250	is asked by the SW or designee: do you have thoughts that you would be better off dead, or of hurting yourself in some way. If concerns are noted the SW or designee will assess further if resident has a plan, will notify provider of concerns put interventions in place as noted in the facility's policy. 2. All residents who reside at MMHCC and have a diagnosis of Depression or other psych diagnoses may have a potential for suicidal thoughts. Refer to number 3 for interventions and policies put in place 3. A. An In-service with the nurses was held on 03.16.16 and the teaching was provided by the DON that if any resident voices suicidal thoughts, the facility's policy addressing suicidal threats needs to be followed and concerns reported to resident's provider and to the SW or designee and RCC. B. Teaching by DON to SW and RCC's who do admissions to make sure that all read thoroughly the new resident's discharge papers for any indication of possible suicidal thoughts or attempts and to address concerns on the care plan and or put in place any interventions if deemed necessary on admission day. They are also to review hospital discharge papers on residents who have returned from a hospital stay if there are any concerns noted about suicidal thoughts as sometimes a resident may voice those thoughts in another care setting. 4. The following will be the Quality Assurance (QA) monitoring that the DON	

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F 250	Continued From page 23 administrative nurse (#5) reported knowing about the incident that occurred before Resident #9's admission and acknowledged she did not identify it as an area on the care plan. The facility staff failed to communicate and develop an interdisciplinary approach at the time of Resident #9's admission which included interventions and monitoring for suicidal ideation.	F 250	or designee will conduct to assure that residents with suicidal ideation is addressed and careplanned. • With new admissions and/or hospital returns were the progress/discharge notes from a hospital or clinical history etc.… reviewed by the SW and/or RCC/admitting nurse? • If suicidal ideation was noted or suicide ever attempted, does the care plan address the concern? If not was the concern addressed & teaching done with the RCC and/or SW by the DON? • Frequency of QA monitoring: Weekly for 4 weeks: 02.29.16 through the week of 03.21.16 (that is 4 full weeks). Monthly for 3 months (April-May-June2016) and then quarterly (September & December 2019) with QA monitoring completed December 30, 2016. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with staff involved: nurses, RCC and SS). The DON or designee will submit completed monitoring at the quarterly QA Committee meetings through December 30, 2016 at which time the QA committee will determine if further monitoring is necessary. The facility's next quarterly QA meeting is tentatively set for April 28, 2016. Completion date 04.07.16	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		4/11/16

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F 323	Continued From page 24 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: FALLS 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision to prevent accidents for 2 of 2 sampled residents (Resident #8 and #13) who experienced a fall while using a Merry Walker (an enclosed framed wheeled walker) and 1 of 2 sampled residents (Resident #8) who experienced entrapment in a full belt restraint. Failure to complete an adequate assessment to ensure resident safety when utilizing a Merry Walker and full belt restraint resulted in Resident #8 and #13 experiencing avoidable falls as well as Resident #8 becoming entangled in the full belt restraint, which has the potential to cause serious injury. Findings Include: Review of the facility policy titled "Restraints" occurred on 02/25/16. This undated policy stated, "Equipment: 1. Type of restraints (These are not restraints if resident is able to open - see restraint definitions). . . . b. waist safety belt, regular belt (hooks in back of chair), Velcro belt, seat belt, sentinel seat belt . . . Procedure for determining need for restraint: (Completed by Resident Care coordinators initially and quarterly. PT [physical therapy] and	F 323	F323: It is the policy of MMHCC to assure that Resident #8 and Resident #13 are and all residents have an environment that remains as free as of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. A. In regards to Resident #13 from the survey roster: " With the use of the Merry Walker (MW) for this resident, this concern was addressed in F221 Section C. Please refer to that tag for further information. With the MW no longer being an option a plan of correction (POC) is not necessary for MW use as it is no longer utilized or available. B. In regards to Resident #8 from the survey roster: " With the use of the Merry Walker (MW) for this resident, this concern was addressed in F221 Section C. Please refer to that tag for further information. With the MW no longer being an option a plan of correction (POC) is not necessary for MW use as it is no longer utilized or available. " In regards to the exiting/elopement concerns for this resident: a) Resident	

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F 323	Continued From page 25 OT [occupational therapy] involved with initial assessment as necessary). . . . 2. The resident and/or family and/or legal representative will be contacted. . . . Once a restraint is used: (Resident Care Coordinators assess quarterly) 1. Continually reassess the resident's functional status to ensure: a. That the medical condition requiring restraint continues. b. That decline in functional status is related to medical condition, not restraint use. c. Negative effects are monitored and (1) No unanticipated negative effects are occurring. (2) Benefits continue to outweigh the risks. . . . 4. Residents in restraints are to be observed at least q [every] 15-30 minutes. . . . Procedure: . . . 8. Emergency Full Belt Restraint a. If restraint is used due to emergency (if harmful to self or others) it's to be used for only 12 hr [hours] and state in nurses notes why e.g. [such as] emergency full belt restraint used for 12 hrs when in w/c [wheelchair] due to displaying exhaustion related to constant pacing, high risk of falling due to extreme unsteady gait. As soon as possible the Dr. [doctor] is to be notified. If restraint is for more than the 12 hours a Dr.s (sic) order needs to be obtained, and responsible party or family consent is needed. b. Inform RCC's [resident care coordinators] that a restraint was necessary." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia with psychosis, anxiety disorder, and Alzheimer's disease. The ADL (activities of daily living) care sheet identified, ". . . Mobility: per self . . . with extensive assist of one depending on his day. . . ."	F 323	wears a code alert alarm bracelet on his right wrist. The wrist code alert is noted on resident□s Activities of Daily Living (ADL□S) sheet to be checked each shift by the Certified Nurses□ Aides (CNAS) for placement. b.) The Code alert alarm bracelet that resident wears and the code alert alarms on these exits are tested weekly for proper functioning by the Housekeeping supervisor. c.) Resident□s family was contacted and visited with by Social Services (SS) in regards to placement at a facility with a locked unit and family felt if that was necessary they may consider that. SS called several facilities in the area with a locked unit and no one had openings and all had a waiting list. SS will continue to contact these facilities two times a month to check for availability. d.) Resident□s elopement assessments have been completed and Careplan addresses the elopement concern. e.) Staff from all departments takes part in watching resident #8 for possible exiting behavior. This was stressed by the DON at the All Staff meeting on 03.16.16 explaining the importance of it being every employee□s duty to answer exit alarms. Each department talked about the issue at their separate in-services also held on 03.16.16. f.) Staff encouraged to take resident outside (if resident allows it) when noted at one of the exits. Often resident refuses to go outside when offered. g.) If resident allows when pacing, staff encouraged to take resident to the fenced in backyard if weather	

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F 323	Continued From page 26 Resident #8's nurses' notes, dated 08/13/15, stated, "09:00 PM: Behavior: Time: 07:05 PM out north door again both alarms are sounding. [Nurses name] decided to have him walk around the building and I (writer) met him at on [sic] the side walk by the main doors. Was cooperative with coming in. Time: 07:10 PM decided to try the merry walker to see how he would do. Placed in merry walker for only a little while because this did upset him. Time: 07:20 PM [Nurses name] noted that resident had gotten the buckle undone and had his foot on the strap that went between the legs. Nurses [names] tried to get him to put his leg back where it was suppose to go and tried to buckle the buckle back when resident got upset and hit nurse [name] in the arm. Nurse [name] tried to have resident stand up in the merry walker to see if he would walk but he got upset. I (writer) tried to get him to walk with the merry walker also but then he sat down and was going to open the buckle and put his foot over the leg straps. CNA (certified nursing assistant) [name] and I (writer) was trying to get him out of the merry walker because it was just agitating him more as we got the buckle undone from between the legs he started going under the main bar and [CNA name] and I (writer) had to lower him to the floor. We than (sic) stood him up and walked him back to his room. . . ." A fall incident report dated 08/13/15, stated, ". . . Mental state: restrained agitated. . . . Equip. [equipment] involved: merry walker. . . . Transfer belt used: yes when getting resident off the floor. . . . Possible cause: removed restraint slid down under the bar of the merry walker restraint use not effective. . . ."	F 323	permits, and allow him to walk around. Often resident will holler no when taken to the backyard exit door and turns around and goes back into the facility. When resident does go into the backyard resident immediately goes to the fence and shakes the locked gates and when he realizes he cannot go out the gate he then wants back in the facility. 2. All residents who reside at MMHCC who are identified as a high fall risk and have poor comprehension of requiring assistance with transfers and/or are unable to maintain proper positioning in their wheelchair even with other postural support devices being utilized may require the use of a seat belt or full belt in their chair for their safety. Those residents who have a diagnosis of Alzheimer□s or Dementia may have a risk of elopement. Refer to number 3 for interventions and policies put in place. 3. A. In regards to use of restraints please refer to F 221 # 3 as to what has been put in place to manage restraint use and provide a safe environment for all residents. B. For those residents, after assessed for need of full belt placement, proper placement of the belt will be monitored to assure there is no risk of entanglement if resident would attempt to self-transfer from their wheelchair. C. In regards to the elopement concerns: residents newly admitted to facility who are at risk of elopement will have an elopement assessment completed by the RCC or designee. Those residents who have been assessed as possible elopers	

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F 323	Continued From page 27 Resident #8's nurse's notes included the following behavior episodes and interventions: * 09/28/15, 10:28 p.m. - "Behavior: has cont (continued) to pace, eyes are half open refuses to lie or sit, stumbles and leans way forward observed nearly tipping over numerous times. requires 1:1 [one-to-one], Intervention: 1:1, staff has read the bible with him, offered snack, assessed for pain, conversation, toileted, Outcome: unchanged, looks exhausted, Intervention: in w/c (wheelchair) with emergency 12 hour restraint on for safety." The notes failed to identify what an "emergency 12 hour restraint" meant. * 09/28/15, 10:45 p.m. - "Behavior: is already dozing in the w/c" * 09/29/15, 01:01 a.m. - "Behavior: resident was able to roll w/c down the East wing hall and somehow able to get the restraint down around his knees and was sitting on back side of w/c. no evidence of a fall, very combative. assisted resident to room and to toilet . . ." The facility's failure to complete an assessment to determine Resident #8's safety when utilizing a Merry Walker resulted in an avoidable fall. Failure to assess the Merry Walker as a restraint for Resident #8 increased the potential for serious injury (Refer to F221). The facility failed to monitor Resident #8 in the full belt restraint, which resulted in the resident becoming entangled in the belt. This placed Resident #8 at risk for serious injury. - Review of Resident #13's medical record occurred on February 24-25, 2016. Medical diagnoses included Alzheimer's disease,	F 323	will be assessed on a quarterly basis or sooner if deemed necessary. If a resident is a constant or dangerous eloper, there family or responsible party will be contacted by Social Services or designee and visited with about the possible placement of resident in a facility with a locked unit. Those residents who wear code alert bracelets will continue to be checked daily by CNAS for placement and the bracelet will checked weekly for proper function. Exit alarms that have a code alert or a tabbed alarm in place will also be monitored weekly for proper function and that monitoring is completed by the Housekeeping supervisor or designee. D. Education was provided by the DON at the All staff meeting on 03.16.16 that ALL staff from all departments takes part in watching any wandering residents for possible exiting behavior. It was stressed by the DON the importance of it being every employee□s duty to answer exit alarms. On 03.16.16 each department also addressed the elopement issue at their separate in-services held prior to the All Staff meeting. 4. The DON or designee will conduct the following QA Monitoring to assure all residents have an environment that remains as free as of accident hazards as is possible. Frequency of QA monitoring: Weekly for 4 weeks: 02/29/16 through the week of 03/21/16 (that is 4 full weeks). Monthly for 3 months (April-May-June2016) and then quarterly (September & December 2019) with QA	

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F 323	Continued From page 28 dementia, unspecified psychosis, and anxiety. The admission Minimum Data Set (MDS), dated 06/21/15, and quarterly MDS, dated 12/07/15, identified Resident #13 as severely impaired in daily decisions and required extensive assist of one person for transfers and locomotion on and off the unit. Review of Resident #13's nurse's notes identified the following: *07/24/15 - "7:00 AM is restless at this time . . . 7:30 AM . . . is requesting to lay down at this time but only lays down for about 5 minutes . . . [Resident #13] . . requesting to go to the bathroom . . . and again she requested to lay down. Did lay her down but . . only stays in bed for about 5 minutes. Therapy has walked with her to keep her content . . . Order obtained to try using Merry walker when restless and wanting to walk per nurses discretion x [times] 10 days then re-evaluate. Use PRN [as needed]. Release q 2 hr [hours] for 10 minutes for position change. . . . placed in merry walker due to restlessness and wanting to walk to "Mandan" . . . does really well walking with the merry walker - did note x 1 that she was trying to get her foot over the strap but was unable to do so. . . . does sit down when she gets tired. . . . 4:10 PM walking in the merry walker at the time. Resident repeatedly states 'I don't call this walking. Do you?' She also calls out 'Please, I can walk better by myself' . . . I informed her that she can walk alone using the merry walker or she can sit in her wheelchair but she is not allowed to walk on her own for her own safety. . . ." *07/26/15 - "8:58 AM . . . Resident sat in merry walker for about 10 minutes. She became more agitated and was trying to get out of the chair. . . .	F 323	monitoring completed December 30, 2016. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with staff involved: nurses, RCC and SS). The DON or designee will submit completed monitoring at the quarterly QA Committee meetings through December 30, 2016 at which time the QA committee will determine if further monitoring is necessary. The facility□s next quarterly QA meeting is tentatively set for April 28, 2016. Completion date 04.11.16	

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F 323	Continued From page 29 10:36 AM resident sat in merry walker for about 10 minutes. She was agitated and restless and kept trying to get out of the chair. . . ." *07/27/15 - "10:38 AM . . . Again trying to stand from wheelchair and nearly tripped on the front wheel. Placed in Merry Walker so she can be up and walking as she pleases. . . . again restless in Merry Walker . . . 12:35 PM crying in Merry Walker - 'let me out of this thing! I just want out so I can walk like a normal person!' Taking her shoes off and lifting her leg over the side bar on the walker. . . ." *07/29/15 - ". . . 10:26 AM is restless at this time and is still in merry walker, [Resident #13] does try to take her leg out of the merry walker . . . 10:32 AM is hollering out that she wants out of this [expletive] thing (merry walker). 'Can someone please get me out of this [expletive] thing, I want to lay down!' . . . 5:31 PM . . . the res. [resident] was attempting to crawl out of her merrywalker. The res. was assisted to the floor . . . the res. landed on her bilateral knees [and] her right thigh in a modified sitting position on the floor. The res. was assisted off the floor with assist of 3 . . . gait belt [and] assisted back to her merrywalker. . . . instructed res. to ask for assistance if she wanted to transfer out of her merrywalker in the further. . . ." *08/12/15 - "06:53 PM will DC [discontinue] merry walker. Res. did not do well with it and it was unsafe for her." An incident report, completed after Resident #13's fall on 07/29/15 identified the resident had a history of previous falls and was at risk for additional falls. Facility staff assisted Resident #13 back into the Merry Walker immediately after the fall.	F 323		

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F 323	Continued From page 30	F 323		

Facility staff failed to assess and identify the fall risk of the Merry Walker for Resident #13, after the resident's repeated attempts to lift her leg over the side bar and eventually fell while attempting to crawl out of the Merry Walker. The facility did not discontinue use of the Merry Walker until 14 days after the resident's fall.

ELOPEMENT

2. Based on record review, and staff interview, the facility failed to ensure the safety of 1 of 3 sampled residents (Resident #8) who wandered and exited the facility. Failure to ensure and maintain resident safety by providing adequate supervision, implementing effective interventions, and monitoring and re-evaluating the interventions resulted in Resident #8 eloping from the facility on multiple occasions.

Findings include:

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia with psychosis, anxiety disorder, Alzheimer's disease and a history of elopement from the facility. The ADL care sheet identified, ". . . Mobility: per self to with extensive assist of one depending on his day. . . ." The current MDS dated, 02/08/16, identified severely impaired cognition and wandering behaviors occurred daily. The current care plan stated, ". . . Alteration in safety due to wandering into others rooms or out of facility. Exits with alarms on. Code alert on. Monitor res [resident] location with visual checks at least q hour or less. . . . Diversional door decals on 200 & 400 wing doors

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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

(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 323	Continued From page 31	F 323		

to outside. See non drug interventions." The non drug interventions stated, "Non Pharmacological Interventions: Walk out in patio, 1:1 with staff, massage to back, neck and/or forehead, lavender lotion, reassurance, fold towels, offer picture magazines or books, Bible to hold, weighted blanket, lap activity apron, walk with him in halls."

During an interview on the morning of 02/22/16, an administrative nurse (#2) identified Resident #8 had daily exit seeking behaviors.

Nurses' notes identified the following:
*08/02/15 10:48 a.m.: "Behavior: . . . He did exit the facility via the main door at 09:30 AM. . ."
*08/02/15 8:49 p.m.: "Behavior: did exit to outdoors via the wing door despite the mural, alarm alerted staff. . . "
*08/03/15 5:59 p.m.: "Behavior: Went out the west door at this time, alarm alerted staff, assisted back into the facility. . . ."
*08/06/15 8:40 p.m.: "Behavior: Alarm sounded, res. quickly out North door exit. Already outside before staff could respond. Didn't want to come back in. . . ."
*08/08/15 8:42 p.m.: "Behavior: 08:30 PM went out East door, alarm alerted staff. . ."
*08/13/15 6:53 p.m.: "Behavior: 06:51 PM out the North door at this time both box alarm that is on the main door and the door alarm sounding. Resident was going down the slope by the time I (writer) got to him. . . ."
*08/19/15 8:53 p.m.: "Behavior: 7:15 PM thru [sic] 8:05 PM - checking and exiting various doors numerous times (north x 3/ west x 1/ south x 2), looking for his car. Did actually walk through west door and made his way to the staff parking lot, I

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followed him as he tried to enter a car. . . ."
*08/22/15 1:42 p.m.: "Behavior: Went out the North door, alarm alerted staff. . ."
*08/23/15 6:22 p.m.: "Behavior: resident is restless, went out the North door x 2- alarm alerts staff and they bring resident back into the facility. . ."
*08/24/15 7:03 p.m.: "Behavior: . . . resident went out the North door -alarms alerted staff, resident had his coat and cap on and was on the street by the time staff got to resident. . . "
*09/03/15 2:07 p.m.: "Behavior: exited building from north door on east wing, alarm sounded to alert staff. . . ."
*09/04/15 2:29 p.m.: "Behavior: . . . 01:00 PM alarm sounding on the south door (400 wing) by the time staff was able to get to resident he already was out the door. . . ."
*09/05/15 11:12 a.m.: "Behavior: 09:30 AM out South door exit before staff could respond to alarm. . . .10:30 AM exited South door before staff could respond to alarm. . . ."
*09/06/15 12:15 p.m.: "Behavior: 12:10 PM exited South door again and by garbage dumpsters before could respond to alarm. . . ."
*09/07/15 8:53 p.m. : "Behavior: 02:45 PM did go out 300 wing door, door alarm sounding to alert staff. . . ."
*09/08/15 8:12 a.m.: "Behavior: exited the building x2 via south door. . ."
*09/08/15 10:18 a.m.: "Behavior: Did exit the south door again. . ."
*09/08/15 1:04 p.m.: "Behavior: Did exit the west door at this time. . ."
*09/12/15 8:56 a.m.: "Behavior: . . .Has gone out south exit 2x . . ."
*09/21/15 12:21 p.m.: "Behavior: Did exit south door 1x this shift."

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F 323	Continued From page 33 *09/21/15 5:15 p.m.: "Behavior: . . . attempted to exit the south entrance, and needed ii (two) assist to bring resident back inside. . ." *09/23/15 11:58 a.m.: "Behavior: 11:55 AM out north door. . ." *09/26/15 10:35 a.m.: "Behavior: . . .Out west exit x1. . . ." *09/30/15 10:09 a.m.: "Behavior: . . . did exit out west door 1x this evening at 8:15 PM . . ." *10/01/15 10:51 p.m.: "Behavior: 7 PM went out 2 East door 1x . . ." *10/05/15 2:54 p.m.: "Behavior: . . . 12:30 PM both alarms sound at the south door, resident is already walking towards the garages. . . .12:30 PM Resident is now going out north doors, alarms sounding . . . " *10/08/15 4:49 p.m.: "Behavior: . . . Out south exit x2." *10/26/15 11:44 a.m.: "Behavior: . . . Out south exit 4x, 2 East 1x, North 1x. . . ." *10/29/15 9:47 a.m.: "Behavior: exited north door . . ." *11/01/15 10:04 a.m.: "Behavior: Went out North door and out the door down on East. . . ." *11/07/15 10:12 p.m.: "Behavior: . . . attempted to exit x4, did make it out the doors and outside x1. . . ." *11/08/15 1:40 p.m.: "Behavior: . . . did go out first set of doors on west end. Code alert wasn't sounding . . ." *11/08/15 2:12 p.m.: "Behavior: exited the building now through the north door. . . ." *11/11/15 7:30 a.m.: "Behavior: 07:28 AM going out the east doors . . ." *11/13/15 2:03 p.m.: "Behavior: . . . has gone to North, West, Laundry exits alarms sound and is brought back into facility . . ." *11/13/15 3:43 p.m.: "Behavior: out the south exit	F 323		

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F 323	Continued From page 34 door. . . ." *11/13/15 4:02 p.m.: "Behavior: out the 200 East door. . . ." *11/13/15 4:12 p.m.: "Behavior: out the 400 wing exit door . . ." *11/20/15 11:33 a.m.: "Behavior: was out the doors this am three times before staff could stop him. . . ." *11/20/15 4:48 p.m.: "Behavior: 3 PM out north door 1x . . ." *11/21/15 11:34 a.m.: "Behavior: . . .10:00 AM north door alarm sounding and alerted staff, resident already down the ramp by the time staff reached him. . . ." *11/22/15 10:55 a.m.: "Behavior: 10:30 AM went out the west door . . . was about to go around the building before staff could get to him . . ." *11/22/15 11:43 a.m.: "Behavior: 11:00 AM went out the 300 wing door . . . 11:35 AM heading out the west doors at this time . . ." *11/23/15 1:30 p.m.: "Behavior: did open 1st door x3, 2x south 1x north . . . did assist resident back inside facility. . . ." *11/29/15 10:44 p.m.: "Behavior: 10:30 PM exited through 200 W exit door . . ." *11/29/15 10:47 p.m.: "Behavior: 10:40 PM exited NH (nursing home) via 400 wing exit door . . ." *12/09/15 1:39 p.m.: "Behavior: . . . Exited north door x1. . . ." *12/18/15 10:27 a.m.: "Behavior: . . . Res. already out both glass doors and on sidewalk. . . ." *12/19/15 3:49 p.m.: "Behavior: . . . exited both sets of glass doors causing alarms to sound and was moving very quickly down the ramp. . . ." *12/21/15 10:19 p.m.: "Behavior: . . . He did exit the south door x1 . . ." *12/28/15 9:48 p.m.: "Behavior: . . . He did exit	F 323		

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F 323	Continued From page 35 the south door once . . ." *12/29/15 10:58 a.m.: "Behavior: . . . He did exit the north door, to the outdoors, at approximately 10 AM. . . ." *01/02/16 10:36 a.m.: "Behavior: restless, has been out the south door x2 . . ." *01/03/16 9:19 p.m.: "Behavior: . . . Did exit out the north doors x1 and was walking down the ramp. . . ." *01/17/16 12:17 p.m.: "Behavior: 12:05 PM out south door . . ." *01/21/16 9:54 p.m.: "Behavior: . . . Resident eloped from building x 2 this shift. . . ." *01/31/16 1:41 p.m.: "Behavior: did now attempt to exit via south doors . . . was cooperative with redirection back into building." *02/01/16 2:02 p.m.: "Behavior: Has gone out patio door x2 and south door x1 . . ." *02/04/16 7:36 p.m.: "Behavior: . . . did exit facility by north door . . ." *02/05/16 2:08 p.m.: "Behavior: . . .Did exit the door . . . (is 32 degrees out today). . . . walked with him through the parking lot . . . Is looking at all the cars in the parking lot . . ." *02/05/15 2:22 PM: "Behavior: has been out the west door 3 x in the past 10 minutes. . . ." *02/05/15 3:40 p.m.: "Behavior: Resident exited west door . . . Staff ran and resident was in parking lot. . . ." *02/06/16 1:39 p.m.: "Behavior: . . . After noon meal did go through the south door . . ." *02/09/16 1:59 p.m.: "Behavior: Exited west door . . ." *02/10/16 5:42 a.m.: "Behavior: . . . exited out of 400 wing door . . ." *02/14/16 3:38 p.m.: "Behavior: exited out the south door . . ." *02/15/16 2:25 p.m.: "Behavior: Resident went	F 323		

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F 323	Continued From page 36 out south door . . ." *02/15/15 4:26 p.m.: "Behavior: Resident exited out the North door . . ." Review of Resident #8's medical record failed to identify the interdisciplinary team had discussed the possibility of an alternative placement such as a secure unit. During an interview on 02/25/16 at 9:40 a.m., an administrative staff member (#7) answered questions about the current door alarm system. The staff member walked with the surveyors to various doors and indicated which ones alarmed when opened and/or alarmed related to a resident wearing a code alert. This staff member also reviewed the door alarm panel which indicates the location of the door alarming and identified the patio area is enclosed by a fence. During this interview, the staff member (#7) stated, about 2 weeks ago the facility moved the code alert monitor into the hallway rather than next to the exit door (which already was alarmed) so that staff could be alerted before Resident #8 got close to the exit door. During an interview on the afternoon of 02/25/16 two administrative staff members (#1 and #3) identified there had been measures put into place for elopements, for example tabs on the top of the doors, and code alerts placed on doors that did not have them. During this interview, the staff members present confirmed staff had not considered placement in a secure unit for Resident #8. The facility failed to provide adequate supervision and effective interventions to prevent Resident	F 323		

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F 323	Continued From page 37 #8's multiple elopements from the facility.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/29/15. Based on record review, review of facility policies, and staff interview, the facility failed to ensure 2 of 8 sampled residents (Resident #8	F 329	F329: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that Residents #8 and #11 from the survey roster and all residents drug regimen is free from unnecessary drugs. 1. In regards to the Residents of	4/7/16

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F 329	Continued From page 38 and #11) receiving as needed (prn) antianxiety medication did not receive unnecessary medication. Failure to ensure adequate indications before using an antianxiety medication (Lorazepam) placed Resident #8 and #11 at risk of receiving unnecessary medication. Findings include: Review of the facility policy titled "Guidelines for Psychoactive Medication Monitoring" occurred on 02/25/16. This policy, updated 02/24/15, stated, ". . . 6. Prior to PRN medication for behavior concerns, staff is to try non-pharmacological interventions unless it is an emergency situation (e.g. behavior is unmanageable and could cause immediate danger to resident and/or staff). . . ." Review of the facility policy titled "PRN Medications" occurred on 02/25/16. This undated policy stated, ". . . Prior to giving PRN psychoactive medications, non-pharmacological interventions need to be attempted unless it is an emergency situation. . . ." - Review of Resident #8's medical record occurred on all days of survey. Current diagnoses included dementia with psychosis, anxiety disorder, and Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 02/08/16, identified severely impaired cognition, sometimes made himself understood and sometimes understood others, and daily wandering. The non drug interventions listed on Resident #8's chart stated, "Non Pharmacological Interventions: Walk out in patio, 1:1 with staff, massage to back, neck and/or forehead, lavender lotion, reassurance, fold	F 329	concern from the survey roster: A. Resident #8: This concern with this resident was thoroughly addressed in F 222 #1 Section A; please refer to that tag for more information. B. Resident #11: • NPI's are utilized with resident at times of agitation or restlessness and at times are short lived but mostly settling for resident. • Noted that if resident is out of his room and the noise level is high at his location (e.g. living room or activity room) that may cause his agitation or restlessness. If resident becomes restless and anxious in these public areas of the facility and is unable to be redirected, staff will then take resident back to his room, resides in a private room, and his behavior will settle. Later on staff will then bring him back out to these areas when there is less activity. 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. Refer to number 3 for interventions and policies put in place. 3. A. An In-service with the nurses was held on 03.16.16 at which time the importance of utilizing NPI's in order to avoid use of unnecessary drugs with residents who have behavior or other psychiatric concerns was discussed in depth. It was also stressed to look at the individual NPI sheets for all of our behavior residents (such as Resident #8 and #11) that are in their chart back at	

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F 329	Continued From page 39 towels, offer picture magazines or books, Bible to hold, weighted blanket, lap activity apron, walk with him in halls." Resident #8's physician orders included the following psychoactive medications: *09/01/15 Lorazepam (antianxiety) 0.5 mg [milligrams] tab 1 tab by mouth at bedtime. *09/10/15 Lorazepam 0.5 mg to 1 mg by mouth as needed q4h [every 4 hours] (anxiety). *09/11/15 Lorazepam 1 mg intramuscular q4h as needed (severe anxiety) *02/09/16 Risperidone (antipsychotic) 2 mg po (per oral) daily 11:00 AM. Resident #8's Nursing progress notes included the following behavior episodes, intervention, and administration of PRN lorazepam: *09/12/15 08:56 AM "[Resident name] has been awake and walking this am. Started out slow but now has been moving very quickly. Has gone out south exit 2x. And has attempted to go out west exit 1x. Is looking for money. Does not accept redirection well. Tries to hit at staff with his bible. Does not lay down for a nap. Only sits for a very short time in recliner then is up walking toward exit. Tried toileting and giving coffee and cookie." Lorazepam 1mg intramuscular (IM) at 8:56 AM. There is no documentation that other non-pharmacological interventions identified on his care plan were attempted prior to administering the IM Lorazepam. *09/23/15 11:58 AM "11:55 AM out north door returns willingly w/staff [with staff], w/'I [sic] thought I could go outside for awhile'! [sic] Intervention: taken to living area to watch television." Lorazepam 0.5-1 mg PO at 12:15 PM (dose not specified on the Medication	F 329	their nurse's station to use for reference for suggestions as to what NPI to try. B. With the QA monitoring: The DON or designee will randomly review Residents #8. & #11 from the survey roster as well as other residents for PRN psychotropic med use and will note any concerns & review those concerns with the resident's charge nurses and RCC for that particular resident and report necessary concerns to the provider. With monitoring the PRN psychotropic med use, the DON or designee will also monitor if follow-up documentation is being done (e.g. was med effective in managing the behavior concerns). If it was feasible, were non-pharmacological interventions tried before PRN pain med given. 4. The following will be the Quality Assurance (QA) Monitoring that the DON or designee will conduct to assure unnecessary drug concerns are being addressed (note the monitoring for F222 and this tag F329 are combined as one monitoring sheet as both tags have the same issues): • Frequency of QA monitoring: Weekly for 4 weeks: 02.29.16 through the week of 03.21.16 (that is 4 full weeks). Monthly for 3 months (April-May-June2016) and then quarterly (September & December 2019) with QA monitoring completed December 30, 2016. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with RCC and SW). The DON will submit a report of the deficiency at the next QA meeting only along with completed monitoring and then	

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F 329	Continued From page 40 Administration Record (MAR)). There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam. *10/05/15 2:54 PM "12:00 PM resident has been wandering up and down the wings. Did attempt to go out the west doors. Staff was already by the doors and redirected resident back to his room. 12:15 PM Alarm sounding at the 300 wing doors. Staff was alarmed and resident redirected to return to room. Resident did sit down in his recliner for a short time as he stated 'I am tired.' 12:30 PM Both alarms sound at the south door, resident is already walking towards the garages. Does get upset with writer and CNA [certified nursing assistant] [name] as residents think he is late for his appointment and then states 'My appointment was changed for tomorrow at 2 o'clock' Resident did return back to building. Offered the bathroom and resident stated he did not need to go, water given, food offered but refused. 12:30 PM Resident is now going out north doors, alarms sounding, is cooperative with redirection. Did sit up at the aviary for a short while but than [sic] headed down. 01:15 PM PRN Ativan (Lorazepam) given as non pharmacological interventions are not helpful." Lorazepam 0.5-1 mg PO at 01:10 p.m. (dose not specified on the MAR). *11/13/15 03:05 PM "02:20 PM alarm sounded at west door, is between doors wanting to go out but is brought back inside facility with assist of one. Intervention: taken to church service. Outcome: would not settle for service, assisted back to his room, is soon back up and out of room wandering in hallways." Lorazepam 0.5-1mg PO at 03:09 PM (dose not specified on the MAR).	F 329	at the following QA meetings only the monitoring results will be reported to the QA Committee at each scheduled quarterly meeting through November 30, 2016 (Next quarterly QA meeting is tentatively set for April 28, 2016). In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. • Completion date 04.07.16	

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F 329	Continued From page 41 *11/22/15 11:43 AM "11:00 AM went out the 300 wing door, alarm sounding and alerted staff, resident is cooperative to return into building. Lavender lotion applied to bilateral neck, and hands. After lotion applied resident is taken back to the dining room to see if he will finish eating as he left the dining room earlier. 11:20 AM alarms sounding by the 300 wing door resident did go out the door was cooperative with returning. Will not stay in the dining room to eat. Brought back and had resident go to his room where music was played but only lasted a few minutes as he was up and wandering down the 300 wing hall. Does sit at the aviary but only last for a few minutes as he is up and going. 11:35 AM heading out the west doors at this time, alarm sounding and alerting staff. Does not need the bathroom. Cookies and coffee given. PRN Ativan given. As soon as resident is done eating his cookie he is up and wandering and heading towards one of the doors." Lorazepam 0.5-1 mg PO at 11:37 AM (dose not specified on the MAR). *11/29/15 10:23 PM "cont [continues] to pace constantly, refuses to sit, tells each staff 'The Lord your God is coming! We must be prepared, not by going to church but in your heart.' Intervention: 1:1. Outcome: unchanged. Intervention: prn medication." Lorazepam 0.5-1 mg PO at 10:25 PM (dose not specified on MAR). There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam. *12/11/15 Lorazepam 0.5-1 mg PO at 11:59 PM (dose not specified on the MAR). 12:14 PM "Did let me lay him down on his bed, stayed for only about 3 minutes. Up and about again." There is no documentation that the non-pharmacological	F 329		

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	355036	A. BUILDING _____ B. WING _____	02/25/2016

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F 329	Continued From page 42 interventions identified on his care plan were attempted prior to administering the Lorazepam. *12/12/15 Lorazepam 0.5-1 mg PO at 12:56 PM (dose not specified on the MAR). 01:30 PM "Res [resident] napped most of morning in chair at nurses station. Woke when his family got here approximately 10:30. He has been awake the res [sic] of the day and pacing near constant. He has attempted to leave the building 3 more times since PRN Lorazepam was given. . . ." Thee is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam. *12/18/15 Lorazepam 0.5-1 mg PO (dose not specified on the (MAR) at 05:00 PM. No behaviors documented to justify the need for the medication. *12/19/15 Lorazepam 0.5-1 mg PO (dose not specified on the MAR) at 09:25 AM. No behaviors documented to justify the need for the medication. *12/23/15 01:08 PM "Attempted to leave the building x 5 so far today. Mildly resistive with staff intervention." Lorazepam 0.5-1 mg PO at 1:21 PM (dose not specified on the MAR). There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam. *12/28/15 Lorazepam 0.5-1 mg PO at 09:46 PM (dose not specified on the MAR). 09:48 PM "Resident has been wandering about the facility throughout the shift. Within the past hour he has become increasingly restless and has been trying to exit the facility. He did exit the south door once and he hit staff as they were trying to assist him back into the facility." There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to	F 329		

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F 329	Continued From page 43	F 329		

administering the Lorazepam.
*01/17/16 Lorazepam 0.5-1 mg PO at 05:57 PM (dose not specified on the MAR). 06:00 PM "Becoming increasingly angry with redirection, is insistent that his car is 'in the parking lot' tells me he has 'to make the turn off.' Intervention: PRN medication." There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam.
*01/19/16 04:21 PM "For the last 45 minutes resident has been wandering the hallways. He continually tries to go outside stating he is looking for 'a green car to put some stuff in.' Intervention: 1:1, conversation, redirected." Lorazepam 0.5-1 mg PO at 04:21 PM (dose not specified on the MAR).
*01/20/16 12:06 AM "Again was headed outside, intercepted as he opened the outside door. Intervention: brought back to NS [nurses' station] and heads right back to the exit. For his own protection will need to medicate so he relaxes and can rest." Lorazepam 0.5-1mg PO at 12:07 AM (dose not specified on the MAR). There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam.
*01/21/16 Lorazepam 0.5-1mg PO at 01:58 PM (dose not specified on the MAR). No behaviors documented to justify the need for the medication.
*01/31/16 Lorazepam 0.5-1 mg PO at 03:17 PM (dose not specified on the MAR). 03:28 PM "Already up and pacing, CNA offered toileting, he refused, did sit for only 5 seconds or so, then up and pacing again, follows other residents and their company." There is no documentation that the non-pharmacological interventions identified

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F 329	Continued From page 44 on his care plan were attempted prior to administering the Lorazepam. *02/01/16 Lorazepam 0.5-1 mg PO at 03:02 PM (dose not specified on the MAR). 03:09 PM "Resident has been pacing the facility since I came on shift. He does walk briskly and tries to exit the facility. He states that he wants to go out to the farm." *02/05/16 02:22 PM "Has been out the west door 3 x in the past 10 minutes. Each time staff tries to talk to him/extend their hand to him he slaps it away. Says 'leave me be!' Won't answer what is bothering him or where he is going. Has no interest in toileting, snacks that we offer, fluids, activity room, etc. Pacing quickly and unsteadily - is very determined to get outside." Lorazepam 0.5-1 mg PO at 02:23 PM (dose not specified on the MAR). *02/09/16 01:30 PM "Tried exiting south door, became combative with CNA hitting out and cursing, is now hollering at another CNA about exiting the North door. Will continue to observe." Lorazepam 0.5-1 mg PO at 01:49 PM. - Review of Resident #11's medical record occurred on all days of survey. Current diagnoses included dementia with behavioral disturbance restlessness and agitation, a history of frequent falls, and anxiety disorder. The quarterly MDS, dated 02/04/16, identified severely impaired cognition, and sometimes made himself understood and sometimes understood others. The non pharmacological interventions listed in Resident #11's chart identified, "Non-Drug Interventions: [Resident name] has a card table and some of the following in his room to help divert him when he is restless. Sorting legos and blocks. Paper and markers for	F 329		

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F 329	Continued From page 45 writing, drawing, coloring. Loves to look at picture books, has some of his own in his room, likes animal books. Tic tac toe. Horses. Apron with buttons, zippers, etc. Also watches some TV." Resident #11's physician orders included the following psychoactive medications: *12/24/15 Lorazepam 0.5-1 mg by mouth or intramuscular q6h as needed (anxiety) (aggression). *02/05/16 Quatiapine (antipsychotic) 100 mg tab by mouth b.i.d [twice a day] 07:00 AM and 05:00 PM. *02/10/16 Quetiapine 200 mg 1 tab by mouth daily 11:00 AM. Resident #11's nursing progress notes included the following behavior episodes, intervention, and administration of PRN lorazepam: *12/25/15 08:39 AM "PRN med given: Lorazepam given. Dose: 1mg po given [sic] for agitation anxiety restlessness. Non-Pharm interventions: fluids bathrooming repositioning 1:1 TV [television] on backrub. Response to non-pharm. interv [intervention]: behavior remains unsettled." Lorazepam 1 mg PO at 08:39 AM. *01/01/16 06:13 PM "05:30 PM is agitated, resistive and aggressive towards staff-hollering and self transferring from the w/c [wheelchair] in the dining room, grabs onto staff and pulls their arms and squeezes their hands- says to me when I intervene, 'I've been hounding them to take me home!' I did offer to give him a ride to his room which he accepted and then I brought his supper tray to his room- he ate well, but made a mess of his tray, spilling liquids into his plate and onto the floor, etc. Was content for about 20	F 329		

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F 329	Continued From page 46 minutes then self transfers again and is resistive with staff when they intervene - hollars [sic] loudly at them, saying, 'I just want to got there!' Does not tell me where 'there' is, but is cooperative to sit back in w/c and sit in his doorway to his room - I parked my med cart across the hallway from him, and he has been content to sit and visit with me for the time being. Intervention: 1:1, refused offer of toileting x 2, conversation, Outcome: improved." Lorazepam 1 mg PO at 06:09 PM. The antianxiety medication was given even though the interventions attempted improved his behavior. *01/13/16 09:01 PM "Resident appears slightly agitated at this time. He is sitting in the living room area and was looking through books and magazines and ripping pages out. When staff approached resident and removed items he yelled 'Got dammit!' He has also been standing from his wheelchair and ringing the bell. Intervention: conversation, left alone and reapproached." Lorazepam 1 mg PO at 09:36 PM. There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam. *02/24/16 12:40 AM "Lorazepam given Dose: 1/2 tab (2) given for agitation restlessness anxiety. Non-pharm interventions: lunch fluids bathrooming 1:1 resident up in wheelchair, refuses any cares on evening shift. CNA reports he has been very agitated, told her to get out when she approached him for hs [hours of sleep] cares. This writer entered room and resident was tapping feet on floor rapidly, attempting to plug cord into razor but unable to connect it. Refused help and loudly told writer 'You have to wait on that.' Re-approached and took medication and	F 329		

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F 329	Continued From page 47 fluids with snack." Lorazepam 1 mg PO at 12:35 AM. There is no documentation that the non-pharmacological interventions identified on his care plan were attempted prior to administering the Lorazepam. An incident report, dated 01/13/16 at 11:17 PM, identified Resident #11 experienced a fall sustaining an injury to the back of the head. The incident report stated, "Was called to resident's room by CNA [name]. Upon entering room resident was lying on floor with his head in the door way and his feet towards the sink. CNA [name] reports that he had just finished using the bathroom and they were beginning to walk out and to bed. At this time resident began turning to go back towards the toilet. While CNA [name] was trying to redirect him resident lost his footing. She said when he fell he did hit his head on the tiled wall underneath the towel bar. Resident did c/o [complain of] pain to back of head but no lump or open area noted." Resident #11 had received 1 mg of lorazepam at 09:37 PM. The facility failed to ensure adequate indications for the use of antianxiety medication, and to attempt non-pharmacological interventions prior to administering an antianxiety medication which placed Resident #8 and #11 at risk of receiving unnecessary medications.	F 329		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		4/7/16

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F 465	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain safe and sanitary conditions for 1 of 5 medication carts with staff food items stored inside. Failure to keep staff food items separate from medical supplies increases the risk for contamination of supplies. Findings include: - Observation of medication carts with a staff nurse (#4) occurred on 02/25/16 at 2:40 p.m. The medication cart, identified as the "night nurse cart," had numerous unlabeled food items including a package of Oreos, crackers, nuts, candy, and a coffee mug in the bottom drawer along with oxygen tubing, an open box of lancets (small needles for checking blood sugars) and other miscellaneous medical supplies. When asked, the nurse (#4) stated she was unaware of who the food items belonged to and since it was unlabeled, it would not belong to a resident. During a staff interview with an administrative nurse (#1) on 02/25/16 at 3:25 p.m., when informed of the food items in the medication cart she stated, "that can't be in there." The facility failed to maintain safe and sanitary conditions for all residents and placed residents at risk for contaminated medical supplies.	F 465	F465: It is the policy of Marian Manor HealthCare Center (MMHCC) to assure all residents, staff and public are provided a safe, functional, sanitary, and comfortable environment. 1. All residents who reside at MMHCC have the potential to be affected of possible failure by the staff to maintain safe and sanitary conditions. 2. A. On 02.25.16 the nightshift cart was cleaned out and any of the nurses' personal food items and/or dishes were removed. B. The DON did create a "Medication Carts" policy which #9 of the policy states: Nurse's personal food items are not to be stored in a medication cart. The policy was reviewed by the DON at the Nurses' In-service held on 03.16.16. C. With monthly cleaning of med carts there is a check list of what needs to be looked at and the following was added to that check list as #19: No employee personal items or food were found in the carts. If a concern with this is noted, the nurses that are doing the cleaning were instructed by the DON to remove the items and place them in the DON's office with the name of the nurse who the items belong to and the DON will visit with that nurse. 3. The following will be the Quality Assurance (QA) monitoring and frequency of the QA monitoring that the DON or designee will conduct to assure that all residents are provided a safe and	

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F 465	Continued From page 49	F 465	sanitary environment. • Will check all carts weekly for 4 weeks: 02.29.16 through the 03.21.16 (that is 4 full weeks). Then permanent monitoring of the issue will be conducted monthly with the monthly cart cleaning which for the month of March will be done the night of 03/22/16. It has always been protocol to report the monthly Med cart cleaning at the quarterly Pharmacy committee meeting. This concern will be included in the quarterly QA meeting set tentatively for April 28, 2016. After the April 2016 QA meeting the Med Cart cleaning reporting will go back to the quarterly Pharmacy Committee Meeting (which is always held the same day as the QA meeting). Completion date 04.07.16	