

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

PRINTED: 11/24/2009  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355036</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                                  |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/24/2009</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MARIAN MANOR HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>604 ASH AVE E<br/>GLEN ULLIN, ND 58631</b>                                   |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| K 000                                                                     | <p><b>INITIAL COMMENTS</b></p> <p>This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70(a) and NDAC 33-07-04.2-09(1)(c).</p> <p>This facility was located in a single story building with a partial basement. The building was of Type II (000) construction protected with a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems and smoke detection throughout the corridor system.</p> <p>Observation and records review determined the facility to be in compliance with the minimum requirements of the 2000 Life Safety Code.</p> | K 000                                                                      |                                                                                                                          |  |                                                        |

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.