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	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marian Manor Healthcare Center	604 Ash Ave E Glen Ullin, ND 58631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1.Based on observation, record review, review of the facility investigation, review of facility policy, review of professional reference, and resident, resident representative, and staff interviews, the facility failed to provide appropriate supervision for 1 of 1 sampled resident (Resident #3) who experienced a choking episode. Failure of staff to remove snack items not on Resident #3's ordered diet from the resident's room and ensure all foods served follow the resident's mechanically altered diet order resulted in Resident #3 experiencing a choking episode and hospitalization and placed all residents on mechanically altered diets at risk for injury. During the standard survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 02/17/26 at 11:30 a.m. The IJ resulted when the staff failed to remove snack items not consistent with Resident #3's mechanically altered diet order from the resident's room which resulted in Resident #3 experiencing a choking episode and hospitalization.*05/26/26 at 7:20 p.m., the survey team notified the Administrator and Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested the facility's removal plan for the IJ. *05/27/26 at 4:00 p.m., the SSA reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following:*All care plans/certified nurse aide (CNA) door cards of residents with mechanically altered diets were reviewed and updated per current orders. *Electronic meal charting screens in the electronic medical record (EMR) were reviewed and updated so all residents' diet orders are visible for staff.*Educational reference posters regarding altered diet levels (International Dysphagia Diet Standardisation Initiative) (IDDSI) placed in all nurses' stations and central station for staff to refer to. *CNAs and nurses were sent a memo via EMR informing them of the above information. *Office manager sent an electronic memo to all resident representatives/power of attorneys (POA) stating the following: Please be aware of your loved one's diet orders when bringing snacks and foods from home. This includes consistency of liquids and texture of foods that could potentially cause an increased risk of choking. Please notify your family members of this. *A form was added to the admission packet to notify representatives/POAs.*Dietary Supervisor obtained a food chopper to assure bite sized pieces are cut prior to serving residents. *Education provided to dietary personnel to assure any meal for any resident with mechanically altered diet is prepared according to their specific diet before leaving the serving window. *Dietary Supervisor contacted both the Speech Therapist and Dietician about a training possibility for nursing and dietary staff to be held at a future date. *Tray cards implemented for all residents for all meals. *05/27/26 at 6:00 p.m., the survey team verified the implementation of the removal plan. The deficient practice remained at a G scope and severity following the removal of the IJ.Findings include:Review of the facility policy titled Dietary Services occurred on 05/28/26. This undated policy stated, . The food and nutritional needs of residents will be met in accordance with the physician's orders . Therapeutic diets will be prepared and served as prescribed by the physician . Meals are planned, prepared, and supervised by knowledgeable persons . Food is prepared . in forms to meet individual needs, such as cutting, grinding, chopping, and pureeing, etc.Review of the Complete IDDSI Framework accessed at iddsi.org, (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated April 2026, stated, . describe texture modified foods . used for individuals with dysphagia [difficulty swallowing] . level 6 soft & [and] bite - sized . 'Bite-sized' pieces . Adults . 1.5 cm [centimeters] pieces (no larger than) . Food Textures That [NAME] A Choking Risk . Chewy textures are a choking risk because they are sticky and can become stuck on the roof of the mouth, the teeth or cheeks and fall into the airway. Examples of chewy textures: . marshmallows .Review of Resident #3's medical record occurred on all days of survey and identified intact cognition. Diagnoses included dementia, cleft palate (opening or split in the roof of the mouth), and dysphagia. A speech therapy SNF [skilled nursing facility] Daily Note, dated 09/24/25, stated, . long history of dysphagia and recurrent hospitalizations. recommend an IDDSI Level 6 diet (Soft and Bite-Sized) . This was discussed with dietary staff and nursing who verbalized understanding. The care plan stated, . I have a dx [diagnosis] of Dysphagia . I am at risk of aspiration [breathing food, liquid, saliva, or vomit into airway and lungs] and choking . Mechanically altered consistency . Level 6 soft and bite sized Original Order Date: 09/24/2025 .A nurse's note, dated, 02/17/26 at 12:54 p.m., stated, . Date of fall: 02/17/2026 Time of of fall: 11:30 AM . Possible Cause: found down face down; picking up marshmallows and possibly choked on marshmallow . CNA was just by the door of the nurses station and this writer was just at nurses station when we heard a loud thump on the floor, upon checking in less than a minute [Resident #3] was facing down with blood all over on the floor and his color from his head to upper limbs was all purple. Write called the provider right away then checked on [Resident #3] again . oxygen and pulse and breathing, non detected initially. Provider checked for pulse apically [directly over the heart using a stethoscope], it took few minutes before it became detectable. Marshmallows are coming out from . mouth and nose, suctioning done. Unsure if choked then . fell or . was picking up marshmallows on the floor.A hospital Discharge summary, dated [DATE] at 3:01 p.m., stated, . admitted on [DATE] after a syncopal episode [passing out] and fall . Patient was eating marshmallows when . became pulseless, apneic [temporary cessation of breathing], and was noted to be cyanotic [purple discoloration of the skin, indicating lack of oxygen] for about 2 to 3 minutes. was then transferred to the emergency room. Patient was started on treatment for aspiration pneumonia . was requiring additional oxygen .A cardiology consult note, dated 02/19/26 at 2:05 p.m., stated, . Dx [diagnoses]: Troponin elevation-secondary to stress cardiomyopathy [a sudden, temporary weakening of the heart muscle triggered by intense emotional or physical stress] . [question mark] PEA [pulseless electrical activity] arrest [type of cardiac arrest where the heart the heart muscle is either not pumping or too weak to produce a detectable pulse] secondary to choking/hypoxia . Plan: Patient states . choked on the food and had difficulty breathing and apparently turned blue and passed out. Coronary CTA yesterday demonstrated nonobstructive CAD [coronary artery disease] pattern [no artery blockages].Review of the facility investigation report occurred 05/26/26. This report, completed after the incident on 02/17/26, stated, . [Resident #3's initials] had been eating . noon meal and CNA [CNA #4 initials] came to remove his tray when he finished. He was alert, oriented and wheeling around in his room. He had a bag of marshmallows on his over the bed table which he had been snacking on prior to lunch.During an interview on 05/26/26 at 4:10 p.m., two administrative nurses (#1 and #2) stated the marshmallows were not bite-sized. The CNA (#4) told them the resident's sister brought the marshmallows in the night before and Resident #3 snacked on them prior to lunch. During an interview on 05/26/26 at 4:30 p.m., an administrative nurse (#1) stated staff are not really educated on mechanically altered diets/IDDSI levels and what food items are allowed foods and not allowed.During an interview on 05/27/27 at 9:44 a.m., when asked how she would know what a resident can/can't have based on the ordered diet, the CNA (#4) stated, The nurse is in charge of that. Observation on 05/27/26 at 11:15 a.m. showed a CNA (#3) delivered a meal tray to Resident #3. The meal consisted of Salisbury steak (a whole patty), mashed potatoes, and baked apples cut in approximately 1 inch pieces topped with whipped cream. The CNA removed the cover, failed to cut the Salisbury steak patty, and exited the room. Resident #3 used a spoon to cut bites from the patty. During an interview on 05/27/26 at 11:34 a.m., a dietary supervisor (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(#6) stated kitchen staff do not cut food into bite-sized pieces prior to the meal leaving the kitchen. She confirmed Salisbury steak as soft. During interviews on 05/26/26 at 1:30 p.m. and 05/27/26 at 1:10 p.m., Resident #3 stated he fell because he passed out. When asked about his food restrictions, Resident #3 stated, Peas, steak, and nuts. When asked specifically about marshmallows, the resident stated, Marshmallows are a dirty word and The last time I took a bite of a marshmallow I passed out. During a telephone interview on 05/27/26 at 1:20 p.m., Resident #3's representative identified awareness of the resident's diet order for soft and bite sized food but the facility had not provided her with a list of restricted foods. She stated the facility informed her about the marshmallows brought in by the sister after the 02/17/26 incident. The representative verified the sister's current awareness of the marshmallow restriction.During a telephone interview on 05/27/26 at 2:31 p.m., a dietician (#7) confirmed she expected facility staff to cut the Salisbury steak into bite-sized pieces before delivery to residents with an order for soft and bite-sized food. During a telephone interview on 05/28/26 at 11:05 a.m., a speech language pathologist (#8) confirmed marshmallows are not appropriate for an ordered IDDSI level 6 soft and bite-sized diet, and she expected staff to cut meat patties into bite sized pieces for a resident with an order for IDDSI level 6 soft and bite-sized food. The facility failed to ensure the resident, resident representative, and staff understood appropriate food choices for Resident #3's ordered diet, and staff followed Resident #3's ordered diet.2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices for 1 of 4 sampled residents (Resident #3) observed during a transfer. Failure to use a gait belt and the appropriate number of staff during transfers placed all residents at risk for accidents, falls, or injuries.Findings include:Review of the facility policy titled Transferring Resident with Transfer (Gait) Belt occurred on 05/28/26. This policy, dated March 2025, stated, . It is the policy of this facility to use a gait/transfer belt to guide and support residents who: . May require assistance with a transfer due to the resident being unsteady and having the potential to fall . Place the transfer/gait belt around resident's waist . Refer to ADLs [activities of daily living] and use one or two staff members with transfer as careplanned [sic] for safety of resident and staff.Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dizziness, weakness, syncope, and orthostatic hypotension (sudden drop in blood pressure when moving from lying/sitting to standing). The current care plan stated, . I have a Potential for Trauma-Falls . ADL door card is part of the care plan . provide assistance with ambulation, transfers, and assistive devices as per current ADL's . The ADL door card stated, . Transfers . recommend partial/moderate assist to pivot x2 [times two staff] with gait belt .Observation on 05/27/26 at 11:03 a.m. showed Resident #3 resting in bed. A certified nurse aide (CNA) (#3) entered the resident's room and assisted Resident #3 to stand and pivot to the wheelchair. The CNA failed to apply the gait belt and utilize a second staff member for the transfer.Observation on 05/28/26 at 9:35 a.m. showed Resident #3 seated in a shower chair with a gait belt around the waist. The resident held onto the assist bar on the wall and stood. A CNA (#5) placed the wheelchair behind the resident and the resident sat in the wheelchair. When asked if the CNA assisted the resident to transfer from the bed to the wheelchair alone prior to the bath, the CNA stated, Yes [Resident #3] is a one-person transfer.During an interview on 05/28/26 at 10:14 a.m. an administrative nurse (#1) confirmed Resident #3's care plan identified assist of two staff for transfers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of facility policy, and staff interview, the facility failed to ensure proper labeling and storage of medications for 2 of 9 observations of medication preparation and administration. Failure to date an insulin pen with the open and discard date and failure to ensure medications are administered promptly after preparation may result in an ineffective dose of insulin and medication errors. Findings include:Review of the facility policy titled Medication Disposal occurred on 05/28/26. This undated policy stated, . Insulins are disposed of 28 days from the date opened unless otherwise specified by the manufacturer. These will be labeled with open and discard dates.Review of the facility policy titled Administration of Drugs occurred on 05/28/26. This undated policy stated, . Drugs are to be administered as soon as possible after doses are prepared. Medications should not be pre-dished for future medication passes.-Observation on 05/26/2026 at 5:05 p.m. showed a staff nurse (#9) prepared Resident #25's Humalog insulin pen for administration. The nurse obtained the pen from a plastic bag labeled with the resident's name. The pen lacked an open and discard date. -Observation on 05/26/26 at 5:25 p.m. showed three medication cups containing oral medication, labeled with resident first names, on top of the medication cart. A nurse (#9) prepared a fourth medication cup and labeled it with the resident's first name. When asked about pre-dishing the medications, the nurse (#9) stated she prepared the supper medications for a few residents so she could help feed residents in the dining room and would administer the medications to those four residents at that time. During an interview on 05/28/2026 at 10:59 a.m., an administrative nurse (#1) confirmed staff should label insulin pens with an open and discard date and confirmed staff should not pre-dish medications.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on survey findings, review of facility policy, professional reference, and staff interview, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to develop a Performance Improvement Project (PIP) to decrease or prevent the likelihood of problems or occurrences of adverse events, and ensure compliance with federal requirements related to a resident choking incident. Findings include:Review of the facility Quality Assurance and Performance Improvement Plan occurred on 05/28/26. The undated policy stated, . Scope . we provide comprehensive clinical care to residents . all care is resident-centered and focuses on choice and Individualized plans of care . Implementation . will be carried out by the Quality Assurance and Performance Improvement Plan Committee (QA), which . assures that the monitoring activities selected effectively cover all types of services and categories of care rendered . The facility conducts PIPs to examine and improve care and/or services in specifically identified areas. PIPs are chosen based on their importance and meaningfulness in relation to the scope of services provided by the facility.Review of the Complete IDDSI (International Dysphagia Diet Standardisation Framework accessed at iddsi.org, dated April 2026, stated, . describe texture modified foods . used for individuals with dysphagia [difficulty swallowing] . level 6 soft & [and] bite - sized . 'Bite-sized' pieces . Adults . 1.5 cm [centimeters] pieces (no larger than) . Food Textures That [NAME] A Choking Risk . Chewy textures are a choking risk because they are sticky and can become stuck on the roof of the mouth, the teeth or cheeks and fall into the airway. Examples of chewy textures: . marshmallows .Review of the facility investigation report completed after the incident on 02/17/26, stated . [Resident #3's initials] had been eating . noon meal and CNA [Certified Nurse Aide #4 initials] came to remove his tray when he finished. He was alert, oriented and wheeling around in his room. He had a bag of marshmallows on his over the bed table which he had been snacking on prior to lunch. they heard a loud crash coming from [Resident #3's initials] room. They responded immediately and found him prone on the floor next to his wheelchair . Suctioning was done due to excess secretions, and noted small white pieces of material that looked like marshmallow were removed. Review of Resident #3's current care plan stated, . I have a dx [diagnosis] of Dysphagia . I am at risk of aspiration [breathing food, liquid, saliva, or vomit into airway and lungs] and choking . Mechanically altered consistency . Level 6 soft and bite sized . During the survey team's investigation, interview on 05/26/26 at 4:10 p.m. two administrative nurses (#1 and #2). confirmed Resident #3 ate regular sized marshmallows (not miniature sized) on the day of the choking incident.After reviewing Resident #3's choking incident, the survey team consulted with the State Survey Agency (SSA) and it was determined an immediate jeopardy (IJ) situation existed on 02/17/26 at 11:30 a.m. The IJ resulted when staff failed to remove snack items not consistent with Resident #3's mechanically altered diet order from the resident's room which resulted in Resident #3 experiencing a choking episode and hospitalization.During an interview on 05/28/26 at 11:10 a.m., an administrative nurse (#2) stated in the past, QAPI monitored food temperatures, but not the accuracy of diets served to residents. During an interview on 05/28/26 at 11:48 a.m., a dietary supervisor (#6) confirmed the dietary QAPI process did not include diet accuracy.Refer to F689.