STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on October 14, 2014 and completed on October 16, 2014, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop and implement an individualized activity program for 6 of 6 sampled residents (Resident #2, #3, #4, #6, #7, and #10) dependent on staff for activities. Failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their physical, cognitive, and emotional health. Findings include: Review of the facility's activity calendars from August to October 15, 2014 identified the following monthly activities: * Coffee Hour - every day of the month at 2:30	F 248	**F-248:** Maryhill Manor is committed to the development of an activity program that is designed to meet the residents' needs and interest. 1. Actions for the residents identified: a. The care plans for these six residents were reviewed and updated to include individualized activities of interest for each one. These interests were also added to the Kardex for the information of the Resident Assistants (C.N.A.s). The Resident Assistants were educated on this new section of the Kardex at a meeting on Nov. 13th. In addition, the individual needs of these residents were reviewed with activity/social service staff. 2. All residents who are cognitively and/or physically dependent on staff members to assist them in attending or carrying out activities have the potential to be affected by this practice. Continued on next page	11-20-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Tomlom | TITLE: CEO/Administrator | (X6) DATE: 11/19/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 1 p.m. except Sundays * Bingo - Monday, Wednesday, and Friday at 2:00 p.m. * Movie/Card Games every Saturday (no specific time) * Sing a long and Exercise every Thursday at 10:45 (except October 10) * TV Mass/Lutheran Service every Sunday at 10:30 a.m. and 11:00 a.m. * Mass - every Thursday at 10:30 a.m. * Church - every Tuesday at 2:00 p.m. Other special events included: * Birthday Bash once a month * Resident's Council once a month * Special music or activity - 5 times in August and September and once in October. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anoxic brain damage, anxiety, and depression. A significant change Minimum Data Set (MDS), dated 08/12/14, identified long and short term memory problems and extensive assistance for transfers and locomotion. The significant change MDS identified music, news, groups, favorite activities, and outside activities were very important and reading materials, animals, and religious activities were somewhat important to the resident. Review of the 08/12/14 psychosocial well-being care area assessment (CAA) stated, ". . . It is the goal that res [resident] mood/behaviors will improve and that res will become more involved again and start to do his crafts and arts that he enjoys. . . ." Resident #6's current care plan stated, ". . . Focus: Psychsocial [sic]: I am Lutheran and a member of [name of church] . . . I am a retired farmer. I am married and enjoy visits from my	F 248	3. To enhance our activity programming, the following changes are being made: a. An "Activity" section will be added to the Kardex to communicate individual resident interests to the Resident Assistants (C.N.A.'s). b. A new "Activity" task is being added to the Point of Care electronic charting record to document activity participation. c. The activity section in the care plans of all residents will be reviewed as they become due for their quarterly MDS and individual interests will be added to the Activity section of the Kardex. 4. A Quality Assurance check will be completed by nursing, social services and activities staff under the direction of the Nursing Services Coordinator and Resident Care Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: i. Are residents offered activities that meet their individual interests according to the care plan. ii. Is documentation completed to reflect activity participation or refusal.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 2	F 248		

family. . . . Goals: I will be happy and satisfied as evidenced by smiling and participation in activities of my choice. I will attend activities of my choice 2 to 3 times per week. I will enjoy watching TV in my room. . . . Interventions: . . . Staff will encourage activities of personal interest and offer to escort to activities. . . . Focus: Psychotropic Medication Use . . . Goals: I will attend activities of my choice and I will participate with my cares and treatments and I enjoy visiting with my family and staff. . . . Interventions: . . . I enjoy when staff visit with me and allow me to express my feelings. I enjoy working on my 'round barn' and showing it to visitors and staff. . . ."

Review of Resident #6's activity participation logs from August through October 15, 2014 (76 days) showed the following:
* 65 brief greetings/short visits (a staff member [#6] explained this as saying hello in the hallway and visiting during meals)
* 17 coffee hours
* 27 - 1:1 assistance with meals
* 4 assistance with meals
* 2 supervision with meals
* 4 family/company visits
* 3 outdoors
* 2 sing-a-long
* 2 bingo
* 2 special events
* 2 1:1
* 1 church service
* 1 Island Drum
* 1 happy hour
* 1 birthday bash
* 1 cowboy poet
* 1 horse therapy

Observations during the survey showed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 3 #6 propelling himself down the hallway in his wheelchair or lying in bed. Resident #6 participated in an off-site activity on 10/14/14. The facility failed to develop and implement a meaningful and individualized activity program for Resident #6 specific to his interests and preferences. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and depression. An annual MDS, dated 07/03/14, identified long and short term memory problems, extensive assistance with transfers, and total assistance with locomotion. The annual MDS identified reading materials and animals as very important and music, news, favorite activities, outside activities, and religious activities as somewhat important to the resident. Resident #7's current care plan stated, ". . . Focus: Psychosocial: I am Methodist. I will be happy with the cat in my room. . . . Goals: I will attend church services. I will attend 2 or 3 activities per week. . . . Interventions: Staff puts me close to the TV between meals, & [and] I watch some programs. I will be encouraged to attend church. I will be encouraged to attend activities of my choice. I like music programs. . . ." Review of Resident #7's activity participation logs for August through October 15, 2014 (76 days) showed the following: * 63 brief greetings/short visits * 59 - 1:1 assistance with meals * 4 assistance with meals * 4 sing-a-longs * 3 coffee hours * 3 special events	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 4 * 2 TV * 1 totem pole painting * 1 Island Drum * 1 company visit * 1 special music * 1 game * 1 haircut Observations during the survey showed Resident #7 sitting in her wheelchair in the family room with the television on and magazines in front of her or lying in bed. The facility failed to develop and implement a meaningful and individualized activity program for Resident #7 specific to her interests and preferences. During an interview on 10/16/14 at 9:05 a.m., a staff member (#6) stated when staff assist residents during meals their conversations with the residents are treated like a one to one. The staff member (#6) stated staff are expected to document what the one to one visit included. Resident #6 and #7's activity participation logs failed to include one to one documentation. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia. The annual MDS, dated 08/05/14, identified both long and short term memory difficulties and extensive assistance required for transfers and locomotion. The MDS identified the activities most important to Resident #2 were: family/friends, music, animals, outdoors, and religion. Resident #2's current care plan stated, "Focus: Psychosocial: I am a member of Trinity Lutheran Church. I enjoy visits from my family. My wife comes almost daily . . . Interventions: I will be	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 5 encouraged to attend activities of my choice. I sometimes have difficulties staying on task and being able to participate in a complete activity." Review of Resident #2's activity participation logs from August to October 15, 2014 (76 days) identified the following: * 73 brief greetings/short visits (a staff member (#6) explained this as saying hello in the hallway and visiting during meals) * 45 coffee hours * 47 visits from his wife * 7 family/company visits * 2 church services * 3 outdoors * 3 special events * 2 monthly birthday bash * 1 popcorn * 1 cowboy poet event * 1 - 1:1 assistance with breakfast * 1 special music and birthday cake (Resident #2's birthday) Observations on 10/15/14 at 2:10 p.m. showed Resident #2 seated in the dining room during Bingo. All other observations during survey showed him seated in his wheelchair and self propelling in the halls (except during meals and naps). The facility failed to develop and implement a meaningful and individualized activity program for Resident #2 specific to his interests and preferences. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia. The admission MDS, dated 09/18/14, identified both long and short term	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 6 memory problems and extensive assistance required for transfers and locomotion. Resident #3 identified the activities most important to her were: animals and outside as very important, and music, news, groups, and religion as somewhat important. Resident #3's care plan stated, "Focus: Psychosocial: . . . I was an active outdoors person. I enjoy TV (game shows, Judge Judy etc), going outside when it is nice, visits from family and enjoyed gambling. I am Catholic . . . Interventions: . . . I will be encouraged to participate in activities of my personal choice. Please ask me if I want to go to Mass. My family would like me to attend Mass if I am awake and able." Review of Resident #3's activity participation logs from September 12 to October 15, 2014 (34 days) showed the following: * 28 brief greetings/short visits * 11 coffee hours * 17 - 1:1 assistance with meals * 2 Bingo * 2 special events * 1 haircut * 1 TV * 1 special music * 6 family visits * 4 sitting by the nurse's station * 1 out to appointment with daughter The facility failed to develop and implement a meaningful and individualized activity program for Resident #3 specific to her interests and preferences. - Review of Resident #10's medical record	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 7 occurred on 10/16/14. Diagnoses included Alzheimer's disease. The significant change MDS, dated 08/07/14 identified both long and short term memory problems. The MDS identified the activities important to Resident #10 were: music, animals, groups, religion, and outdoors. Resident #10 care plan stated, "Focus: Psychosocial: I am Catholic . . . I have always been a person to keep to myself and never cared to social [sic]a lot (res [resident] family reports). I enjoy walking and spend a lot of time walking up and down the halls by my room . . . Interventions: I will be encouraged to attend activities of my choice . . ." Review of Resident #10's activity participation logs from August to October 15, 2014 (76 days) identified the following: * 69 brief greetings/visits * 13 coffee hours * 2 religious activities/church * 30 walking in the halls * 4 daughter or family visits * 1 TV * 1 Island Drums (musical activity) * 2 birthday bash * 4 resting in room The facility failed to develop and implement a meaningful and individualized activity program for Resident #10 specific to her interests and preferences. - Review of Resident #4's medical record occurred on all days of survey . Diagnoses included dementia. The quarterly MDS, dated 08/23/14, identified severely impaired cognition.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 248	Continued From page 8 Resident #4's current care plan stated, "Focus: Psychosocial/Activities. I make my own activity choices. I attend religious activities as I wish, which is rare. I like to sit in the recliners by the care station. . . . Interventions: Please visit one on one daily, assess for increased interest, and needs. Offer to assist. Please invite and remind me of upcoming activities, especially Church, special music, events and Bingo. Offer to escort as needed." Review of Resident #4's activity participation logs from August to October 15, 2014 (76 days) identified the following: * 70 brief greetings/short visits * 36 coffee hour * 7 bingo * 1 special event * 2 popcorn * 46 sitting by nurses station * 6 resting in afternoon Observations on 10/14/14 at 3:22 p.m., and on 10/15/14 at 8:40 a.m., 9:30 a.m., 10:10 a.m., 11:30 a.m., 12:30 p.m., showed Resident #4 seated in a recliner by the nurses station. During the survey, observations showed staff interacted with Resident #4 eight times. During these interactions staff failed to suggest or inform the resident of other activities going on in the facility. During an interview on 10/16/14 at noon, a staff member (#6) stated when staff offer other activities Resident #4 turns them down. The facility failed to develop and implement a meaningful and individualized activity program for Resident #4 specific to his interests and preferences.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 1 of 1 sampled resident (Resident #6) coded	F 278	**F-278:** Maryhill Manor is committed to the accurate completion of all assessments. 1. Actions for the residents identified: A corrected MDS was submitted for each of the two residents identified. 2. MDS's are completed for all residents, therefore they have the potential to be affected by this practice. 3. a. The definitions for delusions and pressure ulcers were reviewed with the MDS nurses by the Nursing Services Coordinator. b. A review of the definitions took place at the nurses meeting on 11/7/14. 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a. Is "delusional" coded? b. Is there supporting documentation stating that the delusion was contrary to evidence and the residents belief persisted? c. Does the resident have a pressure ulcer? d. Was it coded in MDS? e. Was there supporting documentation in record to support coding? f. Are smoking assessments in place for residents who smoke? g. Are care plans up to date for residents who smoke? h. Are the risks reviewed and consent signed if resident assessment identifies resident as being appropriate to smoke.?	11-20-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 278	Continued From page 10	F 278		

with delusions and 1 of 1 sampled resident (Resident #11) coded with a pressure ulcer. Failure to code portions of the MDS correctly does not reflect the resident's current status and may affect the accuracy of the care plan and the level of care provided to the resident.

Findings include:

The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages E-2 - E-3 stated, ". . . E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion. . . ." Page M-8 stated, ". . . Steps for Assessment . . . 4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site. . . . DEFINITIONS: STAGE 1 PRESSURE ULCER An observable, pressure-related alteration of intact skin, whose indicators as compared to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 278	Continued From page 11 adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. . . ." Page M-39 stated, ". . . M1200E Pressure Ulcer Care: Pressure ulcer care includes any intervention for treating pressure ulcers coded in . . . M0300A-G. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anoxic brain damage, depression, and anxiety. The significant change MDS, dated 08/12/14, identified delusions. The resident's medical record lacked evidence to support the coding of delusions during the 7-day assessment period. - Review of Resident #11's medical record occurred on 10/16/14. Diagnoses included dementia. Review of the skin assessment completed upon admission on 09/25/14 identified redness to the left and right inner buttock. The admission MDS, dated 10/01/14, identified two Stage 1 pressure ulcers. The current care plan stated, ". . . Focus: I have a potential for skin breakdown r/t [related to] Immobility Hx [history] of redness to my coccyx area. . . ." Review of the progress notes failed to identify two Stage 1 pressure ulcers. Resident #11's medical record lacked evidence to support the coding of two Stage 1 pressure ulcers.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 280	Continued From page 12 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 3 of 11 sampled residents (Resident #7, #8, and #11). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included generalized pain. Medications included a	F 280	**F-280:** Maryhill Manor is committed to the development and implementation of a comprehensive plan of care that reflects the residents' ever-changing needs. To that end, Maryhill Manor will do the following to enhance our services: 1. Actions for the resident identified: Resident #7 – specifics related to this resident's pain were reviewed and updated. Resident #11's care plan was reviewed and the activities section updated. Resident #8's care plan was reviewed and the smoking plan was updated. 2. Care plans are completed for all residents, so all residents are affected by this process. 3. Education to nurses related to the expectation that care plans be updated with changes in residents' care needs, i.e. new orders, significant changes in condition, dietary/nutritional changes occurred at a nurses meeting on November 7th. Medication aides and C.N.A.'s were educated on the importance of their role to update the nurse with any changes observed at their meetings on Nov. 7th and Nov. 13th respectively. A guideline was also developed for new orders to update the care plan updates with each new order. Continued on next page	11/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 280	Continued From page 13 Fentanyl patch for generalized pain. Resident #7's current care plan failed to address the resident's pain, an achievable goal, and interventions. - Review of Resident #11's medical record occurred on 10/16/14. Diagnoses included dementia and anxiety. The admission Minimum Data Set (MDS), dated 10/01/14, identified music, animals, outside, and religious activities as very important and reading materials, news, and group activities as somewhat important to the resident. The current care plan stated, ". . . Focus: Psychosocial: I am new to my surroundings and will need assistance to adjust and feel comfortable at Maryhill Manor. [Resident #11] is Lutheran and a member of [name of church]. He enjoys watching TV in his bedroom. . . . Goal: [Resident #11] will enjoy watching TV in his room and occasionally come out for activities of his choice. . . . Interventions: [Resident #11] will be encouraged to participate in daily care and decision/goal making. [Resident #11] will be encouraged to attend activities of his personal choice. Which may include watching TV in his room or coming out for activities. . . ." The care plan failed to address an individualized activity program for Resident #11 specific to his interests and preferences. - Review of Resident #8's medical record occurred on 10/16/14. Diagnoses included nondependent tobacco use disorder, and hemiplegia affecting dominant side. A quarterly MDS, dated 08/15/14, identified the resident's cognitive ability as moderately impaired. The current care plan stated, "Focus: I smoke	F 280	Continued 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a. Were pain interventions and management goals added to the care plan at the time the problem was noted? b. Do residents activities care plans reflect current activity preferences? c. Do pain care plans reflect current problem plan and preferences?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 280	Continued From page 14 cigarettes. 2-16-14 Returned from hosp. [hospital] et [and] order states that res. [resident] is not to smoke. . . . Encourage res. not to smoke. Staff will assist me to exit the building at around 1 pm and 6 pm to a safe spot off Maryhill grounds. I will let them know when to come and get me to go back into the building. This is for my safety. . . ." During an interview, on 10/16/14 at 11:00 a.m., Resident #8 identified he no longer smokes twice a day, and does not go out in bad weather to smoke. The resident stated he might not smoke every day even in good weather. During an interview, on 10/16/14 at 11:20 a.m., a staff nurse (#7) identified the resident will go outside with smoking staff members to have a cigarette. When Resident #8 does go out alone, the staff member whom he tells he is going outside, or the staff who lets him outside, keeps an eye on him. The facility does not provide a means for Resident #8 to communicate with staff while out smoking. This staff member confirmed Resident #8 did not go out to smoke last winter. The current care plan failed to accurately address the frequency of Resident #8's smoking, failed to identify how staff monitor the resident when he goes off the property to smoke and how the resident would communicate with staff when out smoking.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	**F-309:** Maryhill Manor is committed to providing services to help residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. To that end, we will do the following to enhance the services we provide: Continued on next page	11/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 15 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: PAIN 1. Based on record review and review of facility policy, the facility failed to provide the necessary care and services to promote the optimal well-being for 1 of 1 closed record resident (Resident #12) who experienced uncontrolled pain secondary to a femur fracture (which went undiagnosed for 13 days). Failure to properly manage Resident #12's pain and provide adequate pain control measures resulted in continued unresolved pain for 24 days. Findings include: Review of the facility policy titled "PAIN MANAGEMENT" occurred on 10/16/14. This policy, revised 09/13, stated, ". . . 6. Administer prn [as needed] pain medications and document observations in the nurses notes. . . . 9. A Pain Assessment will be done on admission and readmission. Residents will be reassessed monthly, with each MDS [minimum data set] assessment, and as necessary. 10. Assessment and intervention should continue until pain is resolved or at the acceptable level for the resident. 11. The PRN Pain Med and Laxative form will be completed monthly by the night nurse. It will alert staff to contact the physician for scheduled pain medication for pain management. This form tracks use of 6 or more PRN pain meds [medications] in a 30 day period."	F 309	Continued 1. Resident #12 died on 9/11/14. For resident #3, a reminder was added to eMar to attempt non-pharmacological interventions prior to administering PRN Ativan and education was provided to staff administering the medication. Resident #10's PRN Haldol was discontinued due to non-use of the medication. 2. All residents receiving PRN pain medications or PRN antipsychotic and antianxiety medications may be affected by this practice. 3. Staff administering medications will be educated on the importance of documenting non-pharmacological interventions used prior to administering a psychotropic medication on a PRN basis. Reminders will be added to the electronic medication record for PRN psychotropic medication to document non-pharmacological interventions. 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a.Did resident receive prn psychotropic medication? b. Was there a note in the progress note reflecting non-pharmacological approaches attempted? c. Was there a reminder in the direction section of the eMar to attempt non-pharmacological interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 16 Review of Resident #12's medical record occurred on 10/16/14. Diagnoses included a right femur fracture. The annual MDS, dated 03/13/14, identified long and short term memory problems, experienced pain daily, and used PRN pain medication and non-medication interventions for the following pain indicators: non-verbal, vocal, expression, and body/posture. The current care plan stated, ". . . Focus: I was diagnosed with a right femur fracture on 3-4-14. 3-18-14 pain of R [right] leg. . . . Interventions: . . . 3-18-14 I am started on duragesic patch for pain . . ." A progress note, dated 02/23/14 at 1:29 a.m., stated, "2310 [11:10 p.m.] 2/22/14 Main nurses station lounge. . . . [Resident #12] started yelling out again and attempting to get out of the recliner chair and PM CNA [certified nurse assistant] . . . was sitting in the main nurses station lounge and [Resident #12's] chair alarm sounded and [name of CNA] turned and stated she witnessed [Resident #12] slide out of the recliner chair onto the carpeted floor when the legrests [sic] were in upright position and the back of the chair was reclined. . . . didn't bump his head . . . No new reddened areas and no new bruising observed. Passive range of motion to all extremities within normal limits with no gestures of pain. No verbalizations of pain when inquiries made by writer. . . . Will fax [name of physician]. . . ." Resident #12's progress notes stated the following: * 02/25/14 at 9:03 p.m., ". . . Said his leg hurt when using the lift to take him to the bathroom." * 02/26/14 at 3:08 p.m., "When laying [Resident #12] down in his bed, nursing noted a bruise on the right outer thigh. Approximately 6 cm	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 17 [centimeters] diameter. Also noted that the right leg is almost 2 times the size of the left leg from ankle to upper thigh. Given Tylenol . . . for discomfort and faxed [physician assistant] with our assessment and concern. Will continue meds for discomfort and wait for orders from PA [physician assistant]." * 02/27/14 at 10:47 a.m., "Order: Ultrasound to rule out DVT [deep vein thrombosis] . . . Pain to right leg, swelling, bruise." * 02/27/14 at 1:52 p.m., "Resident out for . . . ultrasound of right leg. . . ." * 02/28/14 at 12:17 a.m., ". . . PAL lift [sit to stand mechanical lift] used to get up to te [sic] bathroom and States leg hurts. . . ." * 02/28/14 at 7:38 a.m., ". . . Right leg from upper thigh to mid-shin area remains swollen. no reddened areas. leg and foot are. warm to touch. Resident is calling out loudly. c/o [complaining of] leg hurting with no apparent relief from Tylenol. . . . pa [physician assistant] faxed about increased pain. . . ." * 02/28/14 at 2:29 p.m., "Ultrasound report. Received report, no right lower extremity deep vein thrombosis." * 03/02/14 at 2:29 p.m., ". . . Leg continues to be swollen and upper thigh is bruised from outside to inside going behind leg. Does move leg but minimally. . . . Continue to use PAL lift for transfers and use Tylenol for pain. After resident has Tylenol he quiets down and appears to be more comfortable." Facility staff continued to use a sit to stand mechanical lift contributing to additional pain and potentially causing additional trauma to the fractured femur. * 03/02/14 at 9:20 p.m., ". . . Tylenol is Effective for approx [approximately] 2 hours before resident starts yelling ow ow ow again."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 18 * 03/03/14 at 5:00 p.m., "Received [sic] f/u [follow up] call from [physician assistant] regarding res cont [continue] to have pain to his Rt leg/thigh. Res has been receiving [sic] PRN tylenol routinely due to discomfort and medication is not helping much. . . . Hydrocodone 5/325 mg . . . Q [every] 6hrs [hours] PRN moderate pain. . . . Ordered XRAYS for Rt Tib [tibia], fib [fibula], Femur, and RT hip for tomorrow AM. . . ." * 03/04/14 at 10:00 a.m., ". . . Resident had xray done . . . that indicates a right femur fracture. . . . needs to get an orthopedic consult. . . ." * 03/17/14 at 1:38 p.m., "Nursing is requesting that resident have something more scheduled for pain control. Resident has occasional [sic] break through discomfort especially if the prn doses are not given every 6 hours. Faxed a request to [physician assistant] . . ." * 03/18/14 at 11:01 a.m., "Fentanyl Patch 25mcg/hr [microgram per hour], change every three days. . . . Pain from right leg fx [fracture]." Resident #12's medication administration record and progress notes identified Resident #12 received prn Tylenol 23 times in nine days (February 23, 2014 - March 3, 2014) and prn Hydrocodone/Acetaminophen 41 times in 16 days (March 3 - 18, 2014) before receiving adequate pain control from a Fentanyl patch. Facility staff failed to thoroughly assess Resident #12's complaints of right leg pain and provide adequate relief. As a result, Resident #12 experienced unresolved pain for a period of 24 days. 2. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms of	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 19	F 309		

dementia for 2 of 2 sampled residents (Resident #3 and #10) identified with behaviors and on psychopharmacological medications. Failure to thoroughly assess the residents' behaviors and attempt non-pharmacological interventions prior to administering psychopharmacological medications may result in decreased physical, mental, and psychosocial well-being and negatively impact these residents' quality of life.

Findings include:

- Review of Resident #3's medical record occurred on all days of survey and identified an admission date of 09/12/14. Diagnoses included dementia and anxiety. Medications included Risperdal (an antipsychotic medication) twice daily and lorazepam (an antianxiety medication) PRN.

Resident #3's admission Minimum Data Set (MDS), dated 09/18/14, identified long and short term memory problems. The current care plan stated, "FOCUS: . . . anxiety GOALS: I will be comfortable et [and] free of restlessness INTERVENTIONS: I will receive meds [medications] per drs. [doctors] orders. I have toys that I like to have in my lap to help keep my hands busy, family brings me toys."

Review of Resident #3's nurses' notes and medication administration record (MAR) from September 12 through October 15, 2014 identified facility staff administered lorazepam twice, October 03 and October 09, and failed to attempt non-pharmacological interventions prior to the administration of the lorazepam.

- Review of Resident #10's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 20 occurred on October 16, 2014. Diagnoses included Alzheimer's disease. Medications included Zyprexa (an antipsychotic mediation) daily and Haldol (an antipsychotic medication) PRN. Resident #10's quarterly MDS, dated 08/20/14, identified long and short term memory problems and no behavioral signs or symptoms during the seven day assessment period. The current care plan stated, "FOCUS: . . . I use antipsychotic medications dx [diagnoses] of anxiety/hx [history] of psychotic behaviors/depression . . . I have a hx of wandering into residents rooms/and other behavioral issues but that has improved greatly. I enjoy to walk up and down the halls by my room . . . INTERVENTIONS: Administer medications as ordered. Monitor/document for side effects and effectiveness . . . Monitor/record occurrence of behavior symptoms (Specify: pacing, wandering, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document . . . I love cats and love to talk about my cats . . . Please use these interventions to calm me: . . . Sit and visit with me; get me something to eat or drink; walk with me, try toileting me. Please document the effectiveness of these interventions . . ." Review of the nurses' notes and (MAR) from April 01 through October 15, 2014 identified Resident #10 received Haldol seven times. Three of the seven times facility staff failed to attempt non-pharmacological interventions prior to the administration of the Haldol. During an interview of the afternoon of 10/16/14, an administrative nurse (#11) stated she expected facility staff to attempt	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 309	Continued From page 21 non-pharmacological interventions before administering psychopharmacological medications.	F 309	F-323: Maryhill Manor is committed to providing an environment that is as free of accidents and hazards as possible. Maryhill Manor is a smoke- and tobacco-free facility that does not allow smoking in the facility or on the grounds.	11/20/14
F 323 SS=D	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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to adequately assess 1 of 1 sampled resident (Resident #8) for ability to safely smoke without supervision. Failure to provide a safe environment by ensuring residents who smoke can do so safely based on a consistent assessment process; reassessment with changes in resident status, and documentation of the assessment results, places residents who smoke at risk for burns or other injuries. Findings include: - Review of Resident #8's medical record occurred on 10/16/14. Diagnosis included nondependent tobacco use disorder, and hemiplegia affecting dominant side. A quarterly Minimum Data Set (MDS), dated 08/15/14, identified the resident's cognitive ability as moderately impaired. The medical record lacked	F 323	1. Resident #8 will be assessed for the ability to smoke and to leave the grounds safely. 2. There are no other residents who smoke at this time. If a smoker is admitted, they will be informed of the no-smoking policy and, if they want to smoke off grounds, they will be assessed for the ability to do so safely. 3. a. A "Resident Smoking Assessment" was developed which includes an assessment of the residents' physical and cognitive abilities to smoke safely. b. The facility Smoking Policy for Residents and Guests was updated to include the need for an assessment prior to smoking off grounds. c. Any resident who smokes off grounds will be assessed upon admission, quarterly, and with a significant change in condition. 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator. The QA will check: a. Was a smoking assessment in place? b. Was the care plan up to date? c. Was the policy reviewed with the resident and risk consent signed on the back of the policy?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 22 an assessment of Resident #8's capabilities and deficits to determine whether the resident required supervision while smoking. The current care plan stated, "Focus: I smoke cigarettes. 2-16-14 Returned from hosp. [hospital] et [and] order states that res. [resident] is not to smoke. . . . Encourage res. not to smoke. Staff will assist me to exit the building at around 1 pm and 6 pm to a safe spot off Maryhill grounds. I will let them know when to come and get me to go back into the building. This is for my safety. . . ." During an interview, on 10/16/14 at 11:00 a.m., with Resident #8, he demonstrated he carried his cigarettes and two lighters with him, pulling them from a pouch on the side of his electric wheelchair. The resident identified he goes outside behind a building to smoke. During an interview, on 10/16/14 at 11:20 a.m., a staff nurse (#7) identified the resident will go outside with smoking staff members to have a cigarette. When Resident #8 does go out alone, the staff member whom he tells he is going outside, or the staff member who assists him outside, watches out for the resident. The facility failed to assess the frequency of Resident #8's smoking, identify how staff monitor the resident when he leaves Maryhill grounds, and provide a method for the resident to communicate with staff should a need arise. Observation of the smoking area used by Resident #8, occurred on 10/16/14 at 11:25 a.m. The smoking area is to the far side of an out building at the back of the facility. This area is not visible from the facility.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 23 During an interview, on 10/16/14 at 2:10 p.m., an administrative staff member (#10) stated, "We don't do an assessment for a cognitively intact resident" when asked for an assessment. Resident #8's most current MDS, dated 08/15/14 identified the residents cognitive ability as moderately impaired. During an interview, on 10/16/14 at 2:30 p.m., an administrative nurse (#11) identified the facility did not have a smoking assessment for Resident #8. This nurse identified the facility as a no smoking facility and if a resident wants to smoke, they need to be off the facility property. The facility failed to ensure Resident #8 received the care and services necessary to attain the highest degree of safety possible while smoking. They failed to assess Resident #8's abilities and/or deficits, to ensure Resident #8's safety in the designated smoking area, including protecting him from weather conditions, and failed to identify how Resident #8 would contact staff for assistance once he had left the facility to smoke.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and facility policy review, the facility failed to offer fluids to 4 of 6 sampled residents (Resident #2, #3, #6, and #7) dependent on staff for fluid intake. Failure to	F 327	F-327 Maryhill Manor is committed to providing care that keeps a resident well hydrated. To that end, Maryhill will do the following to enhance our system of monitoring medication use: Continued on next page	11/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 327	Continued From page 24 offer fluids during cares increased the residents' risk of dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "FLUID INTAKE MONITORING" occurred on 10/16/14. This undated policy stated, "PURPOSE: Residents will be adequately hydrated . . . 8. The 24 hour fluid intake total will be calculated by the night resident assistants. If the resident does not accept greater than 750 cc's [cubic centimeters] x [for] 2 days, he/she will be put on alert fluid encouragement. 9. The resident on "fluid alert" will be offered fluids every 1-2 hours when awake, and the intake accepted will be documented on the 24 hour fluid alert log . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anoxic brain damage, constipation, diabetes, and dysphagia. The significant change Minimum Data Set (MDS), dated 08/12/14, identified long and short term memory problems and limited assistance for eating. The current care plan stated, ". . . Focus: I have a potential for alteration in nutrition and hydration R/T [related to] DM [diabetes mellitus], Gerd [gastroesophageal reflux disease], Hx [history] of anxoic [sic] episode secondary to Hypoglycemia. Hx of constipation. DM type 1. Flucating [sic] blood glucose. Dysphagia. . . . Interventions: . . . regular diet, thin liquids . . . Focus: I have, an ADL [activities of daily living] Self Care Performance Deficit . . . Interventions: . . . EATING: I am able to eat independently, I make my own choices. I do need assistance at times with eating to complete the task. . . ."	F 327	Continued 1. Education to nursing and C.N.A. staff occurred immediately on the importance of offering residents #2, #3, #6, and #7 fluids with cares at shift-to-shift reports. 2. All residents dependent on staff members for their hydration may be affected by this practice. 3. a. The policy for hydration was reviewed and updated. b. The updated policy and the importance of offering dependent residents fluids was reviewed with nurses at a meeting on 11/7/14 and with Resident Assistants (C.N.A's) on 11/13/14. 4. A Quality Assurance check will be completed by a nurse under the direction of the Nursing Services Coordinator monthly for the next three months, and quarterly for a minimum of one year. The QA check will monitor the following: a. Was the resident offered fluids with cares or shortly after cares were provided (i.e. out in dining room or living room).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 327	Continued From page 25 Review of the fluid intake records from September 15 through October 15, 2014 showed Resident #6 consumed 750 cc's or less of fluids on eight days. The record failed to identify Resident #6 as a "fluid alert" per policy. An observation on 10/14/14 at 3:35 p.m. showed two certified nurse assistants (CNAs) (#1 and #2) toileted Resident #6. The CNAs failed to offer/encourage fluids. Observations on 10/15/14 at 9:00 a.m., 11:07 a.m., and 12:45 p.m. showed two CNAs (#3 and #4) checked and changed Resident #6's incontinence product. The CNAs failed to offer/encourage fluids. An observation on 10/15/14 at 4:25 p.m. showed two CNAs (#1 and #5) checked and changed Resident #6's incontinence product. The CNAs failed to offer/encourage fluids. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia, constipation, and dysphagia. The annual MDS, dated 07/03/14, identified long and short term memory problems and extensive assistance for eating. The current care plan stated, ". . . Focus: I have occassional [sic] troubles with constipation. . . . Interventions: . . . Encourage fluids. . . . Focus: Alteration in nutrition and hydration. hx weight loss, hx pressure areas, difficulty chewing, dementia, constipation . . . Interventions: Soft diet as tolerated. with thin liquids. Assist of 1 . . . Focus: I have an ADL Self Care Performance Deficit r/t Dementia . . . Interventions: . . . EATING: I need extensive assistance of 1 for the task of eating. . . ."	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 327	Continued From page 26 Review of the fluid intake records from September 15 through October 15, 2014 showed Resident #7 consumed 750 cc's or less of fluids on six days. The record failed to identify Resident #6 as a "fluid alert" per policy. An observation on 10/14/14 at 4:06 p.m. showed two CNAs (#1 and #2) checked and changed Resident #7's incontinence product. The CNAs failed to offer/encourage fluids. An observation on 10/15/14 at 12:34 p.m. showed two CNAs (#3 and #4) checked and changed Resident #7's incontinence product. The CNAs failed to offer/encourage fluids. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia and constipation. Medications to aid in bowel elimination included Colace twice a day, bisacodyl tablets as needed (PRN), and a bisacodyl suppository PRN. Resident #3's admission MDS, dated 09/18/14, identified long and short term memory problems, extensive assistance for eating (drinking), and constipation during the seven day assessment period. The current care plan stated, "Focus: I have constipation . . . Whole grain bread, prunes, prune juice . . . Focus: I have an ADL Self Care Performance Deficit r/t [related to] Stroke . . . EATING: I require, assistance at times with meals and am able to be independent at times . . ." Review of the PRN medication administration records [MARs] from September 15 through October 15, 2014 showed Resident #3 received either a bisacodyl suppository or bisacodyl oral	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 327	Continued From page 27 tablets six times in September and eight times on October. Resident #3's dietary progress note, dated 09/13/14, stated, ". . . Dx [diagnoses] constipation. Offer prunes, prune juice PRN, whole grain bread offer with meals . . . Monitor meal and fluid intake . . ." The fluid intake records from September 15 through October 15, 2014 showed Resident #3 consumed 750 cc's or less of fluid daily 21 of 31 days. The record failed to identify Resident #3 as a "fluid alert" per policy. Observation of cares occurred on 10/14/14 at 3:30 p.m. and 4:25 p.m.; 10/15/14 at 9:20 a.m., 11:45 a.m., and 4:15 p.m. and showed staff failed to offer/assist Resident #3 with fluids. Meal observations showed Resident #3 consumed the following fluids: * 10/15/14 at 8:35 a.m. - 120 cc of cranberry juice. No other fluids were offered. * 10/15/14 at 1:15 p.m. - 90 cc of cranberry juice. No other fluids were offered. * 10/15/14 at 5:25 p.m. - 120 cc of cranberry juice and 240 cc of cola. No other fluids were offered. * 10/16/14 at 9:40 a.m. - 120 cc of cranberry juice. No other fluids were offered. The facility failed to offer/assist Resident #3 with fluid consumption during cares and failed to provide additional fluids during meals. This failure may have contributed to the frequent administration of medications to promote bowel elimination. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 327	Continued From page 28 included dementia and constipation. Medications to aid in bowel elimination included Colace twice a day, Senokot daily, Bisacodyl tablets PRN, and a bisacodyl suppository PRN. Resident #2's annual MDS, dated 08/05/14, identified both long and short term memory problems, limited assistance required for eating (drinking), and constipation during the seven day assessment period. The current care plan stated, "FOCUS: I have chronic urinary retention . . . Hx [history] of UTIs . . . Encourage fluids during the day to promote prompted voiding responses . . . FOCUS: I have constipation . . . Whole grain bread, prunes/juice as desires . . ." Review of the PRN MARs from September 01 through October 15, 2014 showed Resident #2 received either a bisacodyl suppository or bisacodyl oral tablets nine times in September and twice in October. Review of the fluid intake records from September 30 through October 15, 2014 showed Resident #2 consumed 750 cc's or less of fluids daily 12 of 31 days. The record failed to identify Resident #2 as a "fluid alert" per policy. Observation of cares occurred on 10/14/14 at 4:45 p.m. and 10/15/14 at 11:00 a.m. and showed staff failed to offer/assist Resident #2 with fluids. The facility failed to offer/assist Resident #2 with fluid consumption during cares. This failure may have contributed to the frequent administration of medications to promote bowel elimination, and has the potential for the resident to experience UTIs.	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 327	Continued From page 29 During an interview on the afternoon of 10/16/14, two administrative staff members (#10 and #11) stated facility staff are expected to offer residents fluids during the day.	F 327		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F-441 Maryhill Manor is committed to providing a safe, sanitary and comfortable environment to help prevent the development and transmission of disease or infection. 1. Nursing staff was reminded of the importance of proper hand washing and glove usage through report for a week beginning on 10/22/14 involving resident #6, #7, and #15. Resident #6, #7, and #15 will be included in the QA sample to be watched with cares and/or blood glucose monitoring to ensure proper hand washing and glove usage takes place. 2. All residents have the potential to be affected by this practice. 3. a. Proper hand washing and glove usage was reviewed at an all-staff meeting on October 22nd. b. Proper hand washing and glove usage was reviewed with nurses at a meeting on Nov. 7th. c. Proper hand washing and glove usage will be reviewed with C.N.A.staff at a meeting on Nov. 13th. Continued on next page	11-20-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 441	Continued From page 30 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to follow standard infection control practices for 2 of 11 sampled residents (Resident #6 and #7) observed during personal cares and/or medication pass and 1 of 3 supplemental residents (Resident #15) observed during medication pass. Failure to follow infection control practices related to handling of medical equipment (medication cart and tray), glove usage, and hand hygiene has the potential to spread infection within the facility. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 694, stated, "STANDARD PRECAUTIONS . . . 1. Perform proper hand hygiene after contact with blood, body fluids, secretions, excretions, and contaminated objects whether or not gloves are worn. a. Perform proper hand hygiene immediately after removing gloves. . . . a. Make sure reusable equipment is cleaned and reprocessed correctly. . . ." Review of the facility policy titled "INFECTION PREVENTION AND CONTROL PROGRAM" occurred on 10/16/14. This policy, revised 09/10, stated, ". . . Hand Hygiene . . . 6. Because ABHR	F 441	Continued 4. Quality Assurance will be completed by the Nursing Services Coordinator or their designee once a month for three months and quarterly for one year as follows: The QA will monitor the following: a. Did the nurse or medication aide sanitize hands appropriately when doing accu-check? b. Did the nurse or med aide wash their hands after removing gloves? c. Was Accucheck procedure done appropriately? (i.e. cotton ball/lancet placed in sharps and machine and other surfaces wiped off right away.) d. Did the RA sanitize her/his hands appropriately after peri-cares? e. Did the RA sanitize her/his hands after removing gloves? f. Were peri-cares done appropriately? (i.e. wash front to back) g. Did the RA assist or cue the resident to sanitize his/her hands after using the restroom or prior to leaving the room to eat a meal? Did the RA sanitize his/her hands after assisting with personal cares and prior to leaving the room or continuing with other personal cares for the resident?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 441	Continued From page 31 [alcohol based hand rubs] do not kill spores, the following situations require washing hands with soap and water: . . . Before and after assisting a resident with toileting . . . 7. Except for situations where hand washing is specifically required, anti-microbial agents such as ABHR are also appropriate for cleaning hands and can be used for direct resident care: . . . Before and after assisting a resident with personal care . . . Glove Hygiene . . . Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other residents. . . ." - During an observation on 10/14/14 at 3:35 p.m., two certified nurse assistants (CNAs) (#1 and #2) transferred Resident #6 from his wheelchair to the bed. The CNA (#2) applied gloves and completed perineal cares for Resident #6 who was incontinent of urine. The CNA (#2) then placed the toileting sling under the resident, connected the sling to the full body mechanical lift, transferred the resident into the bathroom and onto the toilet, unconnected the sling from the lift, moved the lift out of the bathroom, and then removed her gloves and washed her hands. The CNA (#2) failed to complete hand hygiene after performing perineal cares and before completing other tasks. - During an observation on 10/15/14 at 12:34 p.m., two CNAs (#3 and #4) transferred Resident #7 from her wheelchair to the bed. The CNA (#4) donned gloves, performed perineal cares, and removed her gloves. Resident #7 was incontinent of bowel. The CNA (#4) applied an incontinent product, pulled the resident's pants up, placed a pillow under her right side, attached the call light to the resident's shirt, lowered the bed, and then	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

(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 441	Continued From page 32 sanitized her hands. The CNA (#4) disposed of the trash and washed her hands. The CNA (#4) failed to complete hand hygiene after performing perineal cares and before completing other tasks. - During an observation, on 10/14/14 at 4:13 p.m., a certified medication aide (CMA) (#8) performed blood glucose monitoring for Resident #7. When the CMA (#8) completed the blood glucose monitoring she removed her gloves, sanitized the glucometer, placed it in storage, and assisted Resident #7 to the dining room. The CMA (#8) failed to wash her hands after glove removal. - During an observation, on 10/14/14 at 4:30 p.m., a CMA (#9) performed blood glucose monitoring for Resident #15. The CMA (#9) removed her gloves after obtaining the resident's blood glucose reading and sanitized the glucometer. Without performing hand hygiene, the CMA (#9) obtained and administered Resident #15's insulin. During an interview, on 10/15/14 at 12:23 p.m. an administrative nurse (#11) identified she expected staff to wash their hands after glove removal and before moving onto another task, such as taking residents to the dining room or administration of a medication.	F 441		