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 _____	10/09/2019

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 10/07/19 and concluded 10/09/19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility	F 609	1. Corrective Action: It is the practice of	11/12/19

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

Electronically Signed | 10/25/2019

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F 609	Continued From page 1 policy, the facility failed to identify and report to the State Survey Agency a potential incident of neglect for 1 of 1 sampled resident (Resident #3) who experienced a fracture during transport. Failure to report the incident to the State Survey Agency after the identified fracture placed all residents at risk of neglect and/or injury. Findings Include: Review of the facility policy titled "Resident Abuse" occurred on 10/09/19. The policy, dated February 2018, stated, "Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. . . . Reporting/Response: All cases of suspected abuse must be reported to the North Dakota Department of Health, as required by regulation, immediately upon receiving the allegation and again within 5 working days of the allegation with a complete written final report of the investigation. . . . A report shall be made immediately, or not later than 2 hours after forming the suspicion, if the events that causes the suspicion results in serious bodily injury . . ." Review of Resident #3's medical record occurred on all days of survey. The progress notes stated the following: * 9/26/2019 at 8:07 a.m., "Skin Issues: bruise . . . Location: above ankle in inner part of leg . . . Appearance: purple in color 3cm [centimeter] x 3cm in size . . . " * 9/26/2019 at 5:17 p.m., "New orders or change in orders: L [left] ankle fracture . . ." * 9/26/2019 at 6:36 p.m., ". . . resident got her	F 609	the facility report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources, and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. On 10/10/19, Resident #3 was reassessed by the Director of Nursing to verify the location and extent of injury, and to verify that there were no additional injuries or concerns. The incident was reviewed by the Director of Nursing and the facility Administrator. 2. Identify other residents: All residents have the potential to be affected by this deficient practice. 3. Measures put in place: Re-education will be provided to all staff on 11/7/19 and 11/8/19 and will address circumstances that require reporting, including appropriate timeframes. 4: Monitoring: A quality audit will be conducted to ensure any reportable allegations are identified, properly investigated, and reported to the appropriate agencies. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Director of Nursing and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance.	

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F 609	Continued From page 2 ankle caught under w/c [wheelchair] 9-25-19 [at] 4:30 p.m. going to supper. Through the night L ankle bruising started, very sore. Appt. [appointment] made MD [medical doctor] sent to [hospital] x-ray L foot, fractured ankle. . ." The facility completed an internal investigation into Resident #3's injury but failed to report their findings to the State Survey Agency within two hours after identifying serious bodily injury and failed to report the results of their investigation within five working days of the incident.	F 609	5. The facility will be in substantial compliance by November 12, 2019.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		11/12/19

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F 656	Continued From page 3 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident interview the facility failed to develop a comprehensive care plan for 1 of 12 sampled residents (Resident #3). Failure to develop a care plan that accurately reflected Resident #3's current status and care needs may negatively impact her quality of life, and affect the consistency of the care provided. Findings include: Observation on 10/07/19 at 11:10 a.m. showed Resident #3 resting in bed and had a cast on her left leg. The resident stated, "my foot hurts" and, "my foot slipped off the foot pedal of the wheelchair and some bones broke." Observation on 10/07/19 at 4:47 p.m. showed Resident #3 transferred from bed by two certified	F 656	1. Corrective Action: It is the practice of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the resident’s comprehensive assessment. On 10/10/19, the care plan of the resident #3 was reviewed and updated to reflect the ankle fracture, pain control interventions specific to the fracture, and the non-slip grip applied to the left foot pedal. 2. Identify other residents: All residents have the potential to be affected by this deficient practice. 3. Measures put in place: Re-education	

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F 656	Continued From page 4 nurse assistants (CNAs) (#3 and #4) using the mechanical lift. Resident #3 stated, "ouch." The left foot pedal of the wheelchair had a non-slip grip applied. Review of Resident #3's medical record occurred on all days of the survey and indicated a left ankle fracture on 09/26/19. The care plan failed to address the ankle fracture, pain control interventions specific to the fracture, and the non-slip grip applied to the left foot pedal.	F 656	will be provided to all staff on 11/7/19 and 11/8/19 and will include the importance of implementing the resident's care plan to enhance quality of life and the consistency of the care provided. 4. Monitoring: A quality audit will be conducted to ensure care plans are reflecting residents' current needs. These audits will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Director of Nursing and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by November 12, 2019.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and	F 880		11/12/19

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F 880	Continued From page 5 controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 6 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1of 5 sampled residents (Resident # 26) observed during personal care. Failure to provide infection control related to hand hygiene/glove usage during cares has the potential for transmission of microorganisms to residents and staff. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 10/09/19. This policy, revised November 2017, stated, ". . . Glove Hygiene: "Remove and discard gloves in appropriate receptacles after every procedure that involves potential exposures to blood or body fluids. Perform hand hygiene immediately after removal of gloves . . . " Observation on 10/08/19 at 2:06 p.m. showed the certified nursing assistant (CNA) (#1) donned gloves and provided bowel incontinent cares for Resident #26. The CNA (#1) removed her gloves and failed to perform hand hygiene prior to	F 880	1. Corrective Action: It is the practice of the facility that staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. On 10/9/19, the Director of Nursing re-educated the CNA team assigned to resident #26 on proper hand hygiene practices. 2. Identify other residents: All residents have the potential to be affected by this deficient practice. 3. Measure put in place: Re-education will be provided to all staff on 11/7/19 and 11/8/19 and will include proper hand hygiene practices. 4. Monitoring: Quality audits will be conducted to ensure proper hand hygiene. The audit will be conducted by the Director of Nursing and/or designee. This audit will be conducted weekly for four weeks, monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the	

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F 880	Continued From page 7 placing a new incontinence brief, completing other tasks, and prior to exiting the residents room. During an interview on 10/09/19 at 3:00 p.m., an administrative nurse (#2), expected all staff to perform hand hygiene after glove removal and before exiting the resident's room.	F 880	Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by November 12, 2019.	