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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 11/02/09 and completed on 11/04/09, the sample included 3 residents for complete review, 9 residents for focus review, and 1 closed record for review.	F 000	Maryhill Manor is committed to providing care to promote the proper healing of fractures. To that end, Maryhill staff members will do the following to enhance their fracture care and practices:	
F 309 SS=D	483.25 QUALITY OF CARE 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 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement appropriate pain controlling measures for 1 of 1 resident (Resident #12) with a current wrist fracture. Allowing and/or encouraging Resident #12 to utilize and bear weight with her fractured wrist resulted in the resident experiencing unnecessary pain, and may have impeded the healing process. Findings include: Review of Resident #12's medical record occurred 11/04/09, and included the resident's most recent quarterly Minimum Data Set (MDS) review completed 08/27/09. The MDS showed Resident #12 experienced short and long term memory problems, moderately impaired daily decision making skills, required extensive assistance of one person for transfer and limited	F 309	1. Nursing and C.N.A. staff were immediately instructed to use two people whenever transferring resident #12 and to discourage her from using the arm affected by the fracture. 2. Resident #12 is the only resident in the facility that has a fracture at this time. 3. New protocols and procedures for follow-up care after a fracture occurs will be put into place. Included in this protocol will be an evaluation by PT/OT to check for changes needed with transfer procedures, bed and chair positioning, and other adjustments needed for daily living functions. In addition, C.N.A.'s will be educated in their role in explaining and educating residents about proper techniques and the reasons for these practices. 4. A Quality Assurance check involving follow-up fracture care protocols will be completed under the Director of Nurses direction on a monthly basis for three months and quarterly thereafter for a minimum of one year to ensure that the new fracture protocols are being put into place and followed consistently.	12-04-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Fanslam — TITLE: CEO/Administrator — (X6) DATE: 11/23/09

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.

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F 309	Continued From page 1 physical assistance of one person for dressing and toilet use, and unable to stand without physical support/help. Nurses notes and a "Fall Event Report" dated 10/13/09 stated, "Resident standing with walker, went to turn and fell on left side. . . " The facility sent Resident #12 to the clinic following the fall, and the clinic report stated, "(L) [left] distal radial fracture. Splint on - remains on at all times. Arm sling as tolerated. Tylenol #3 1-2 tabs every 4-6 hours as needed for pain. F/U [follow-up] X-ray 6 weeks in clinic." A nurses note dated 10/15/09 stated, "Transferred with 2 from W/C [wheelchair] to recliner. Resident encouraged to push off using RUE [right upper extremity] (good arm) but doesn't cooperate." Random observations on November 02-04, 2009, showed Resident #12 often sitting in a recliner near the nurses station without an arm sling in place. On some occasions, observation showed a slightly folded blanket placed under Resident #3's left arm, and other observations showed no support or elevation of the resident's left arm. Resident #12's current plan of care included the following approaches/interventions in response to the resident's required assistance with toileting and transfer, "[Resident #12] needs limited to extensive assistance for the task of toileting. This tends to fluctuate. [last revision date 09/29/09], Staff provide limited to extensive assist of 1 - 2 with transfers [last revision date 10/14/09]." Observation at 9:30 a.m. on 11/04/09, showed a certified nurse assistant (CNA) (#7) assist	F 309		

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F 309	Continued From page 2 Resident #12 from the toilet to the resident's wheelchair. After assisting the resident to a standing position, the CNA (#7) cued the resident to hold onto the grab bar with both hands while the CNA provided the resident with peri-neal care and rearranged the resident's clothing. Resident #12 let go of the grab bar, and attempted to sit down several times while the CNA (#7) completed the resident's peri-neal care. Each time, the CNA (#7) would encourage Resident #12 to continue standing while holding on and supporting herself with the grab bar. Resident #12 continually moaned throughout the above described process. Observation showed no attempt to place Resident #12's left arm in a sling. During an interview with CNA (#7) at 3:45 p.m. on 11/04/09, the CNA indicated Resident #12 was toileted at 12:40 p.m. on 11/04/09, and verified this toileting occurred with one staff member in the same manner as the above observation. The CNA (#7) stated, "It was like this morning, she [Resident #12] had another loose BM [bowel movement] and it took awhile to get her cleaned up." Review of Resident #12's medication administration record (MAR) for the month of October 2009, showed Resident #12 received 43 doses of Tylenol #3 for left arm pain from 10/13/09 through 10/31/09. On 11/04/09, Resident #12's attending physician ordered Tylenol #3, 1 tablet two times daily, and Tylenol #3, 1 tablet every 4 hours PRN (as needed). An interview occurred the afternoon of 11/04/09 with an administrative nursing staff member (#2), for purposes of informing the staff member of the above described observations and interview. The	F 309		

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F 309	Continued From page 3 staff member (#2) indicated Resident #12 required two staff persons to assist with toileting and transfers. Lack of providing necessary assistance during transfer and toileting allowed Resident #12 to unnecessarily utilize her fractured left arm/wrist for self support and balance, contributing to additional pain and potentially impeding the healing process of the fracture.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, review of policies/procedures/professional references, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #3) with reoccurring pressure sores received adequate nutrition to aid in their healing, and prevent the reoccurrence of the pressure sores. Findings include: Review of a facility reference titled "NUTRITIONAL NEEDS FOR PRESSURE SORES" occurred on the morning of 11/03/09. The reference, provided by an administrative staff	F 314	F-314 Maryhill Manor is committed to providing care and measures to promote skin integrity for our residents. To that end, Maryhill will do the following to enhance the calculation of protein needs to promote skin healing: 1. The facility consultant dietitian re-evaluated the protein needs of resident #3 and increased protein offered to 1.2-1.5 grams/kg. Plan of care will be updated. Resident #3's intake of protein will be reviewed every two weeks. 2. The dietitian will review protein requirements for all residents with skin integrity issues or pressure areas per facility policy and standards of care and will increase protein needs as necessary. Plans of care will be updated as needed. The dietitian will review intake of protein every two weeks. --continued—	11-25-09

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F 314	Continued From page 4 member (#2), identified "Recommendations for Protein Needs for Pressure Sores" and defined needs based on kilograms (kg) of body weight as "1.25-1.5 grams/kg/day - Up to 2.0 grams/kg/day, Promote Positive Nitrogen Balance." The reference cited the "Clinical Practice Guideline-Treatment of Pressure Ulcers" and "Medical Nutrition Therapy Across the Continuum of Care." Review of a facility professional reference titled "Estimating Nutritional Requirements (Adults)," provided by an administrative staff member (#1), occurred on the afternoon of 11/03/09. The reference stated, ". . . Ideal body weight can be used for nutritional assessment purposes . . . Protein Requirements: Protein needs may vary greatly with the metabolic status of the patient. The average patient receiving nutritional intervention requires 0.8 - 2.0 g [grams] protein/kg usual body weight. The obese patient is unusual. Use of usual body weight can result in overfeeding. It is recommended to use Adjusted Body Weight (ABW) for reasonable estimation of nutrient requirements. The goals of nutrition support are to minimize protein breakdown, preserve lean body mass, promote protein synthesis, and optimize immune responses. The factors listed in Table 1 can be used to estimate protein requirements . . . Table I: Estimating Protein Requirements, Clinical Status: Maintenance 0.8-1.0 [g/kg/day]; Mild to Moderate Depletion 1.0-1.5 [g/kg/day]; Post-operative 1.2-2.0 [g/kg/day]." An administrative staff member (#1) identified Resident #3 as overweight, however not categorized as obese. The staff member (#1) stated Resident #3's protein requirements would be based on ideal body weight (IBW) verses current body weight.	F 314	--continued— 3. The dietitian and Certified Dietary Manager will review the facility policy and standards of care for pressure areas and apply this information when calculating protein needs. 4. Infection control Quality Assurance checks on protein offered to residents with pressure areas will be completed under the direction of the Director of Nursing on a monthly basis for three months and quarterly thereafter for a minimum of one year.	

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F 314	Continued From page 5 Review of a facility policy titled "Skin Treatment: Protocols" occurred on 11/04/09. This policy, revised 05/07, stated: "PURPOSE: Alterations in skin integrity will be treated to prevent infections and promote healing. OBJECTIVE . . . To promote healing of skin tears, skin breakdown, blisters, and burns . . . TREATMENT FOR ALTERED SKIN INTEGRITY . . . Resident is at high risk for pressure sore if Braden score is 12 . . . STAGE I . . . Document on Skin Concern list so Dietary will address . . . Stage III . . . Document on Skin Concern list for intervention from dietary department . . . The skin concern list is used by nursing to document any alterations in skin integrity that need to be addressed by the Director of Nursing and Dietary Manager. . ." Review of Resident #3 medical record occurred on all days of survey. Resident #3's medical diagnoses included cerebrovascular accident (CVA) with right sided paralysis, coronary artery disease, hyperlipidemia, and on 06/30/09, profound peripheral vascular disease of the right lower extremity. Review of Resident #3's Minimum Data Sets (MDS) identified the following: * A quarterly MDS, dated 01/03/09, identified the resident with no ulcers, pressure or stasis, and a history of resolved ulcers. * A quarterly MDS, dated 04/30/09, identified the resident with five stage two (II) pressure ulcers. * An annual MDS, dated 07/30/09, identified the resident with one stage I, one stage II, one	F 314		

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stage III pressure ulcer.

* A quarterly MDS, dated 10/30/09, identified the resident with one stage I and one stage III pressure ulcer.

Resident #3's pressure ulcer resident assessment protocol summary, dated 07/30/09, stated, "Pressure ulcer triggered due to res [resident] needs limited assistance for bed mobility and is usually continent of bowel . . . Res [resident] has had a CVA in the past and does have some RT [right] sided hemiparesis [paralysis] and has skin that is desensitive [sic] due to this. Res does have skin issues. Currently has ulcer to his heel due to peripheral vascular disease. Res skin on his coccyx is reddened off and on. Res is noncompliant about repositioning. Res likes to sit up all day. Res also has skin tear like area on his scrotum . . . Res ulcer to foot has been on going [sic] for a while and was referred to a podiatrist and has had an Angiogram with positive results. Different medications/ointments have been tried for his coccyx and scrotum they seem to come and go depending if res repositions . . . Protein needs are being met . . ."

A "Nutrition Risk Assessment" form, completed 07/25/08, identified Resident #3's body weight as 204 pounds or 93 kg, and total protein needs as 93 grams per day at 1.0 gram/kg. The nutrition risk assessment identified the resident with no alterations in skin integrity. The form identified the resident on a regular diet, snacks offered and moderate nutritional risk. The record lacked evidence of the resident's IBW. On 11/03/09, an update to the assessment occurred which identified total protein needs as "81-101 (1-1.25 gm/kg IBW [ideal body weight])." The assessment form lacked an update to identify the resident's

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F 314	Continued From page 7 IBW. Resident #3's current care plan, on 11/02/09, identified the following problems and interventions: * ". . . potential for SKIN breakdown r/t [related to] CVA and right hemiplegia. Buttock skin irritated (dry and scaly) . . ." with interventions which included turning every two hours, a cushion to the wheelchair, alternating pressure air mattress to the bed, and encouraging repositioning and lying down and a multivitamin/mineral supplement. The care plan identified the resident's Braden score as 15. A Braden score of 16 or less identifies a resident as at risk for pressure ulcer development. * ". . . Nutrition/Hydration . . . and Hx [history] of skin impairment" with interventions including "Will be offered 93 grams of protein daily . . . Receives MVT [multivitamin] . . . Offer Cottage cheese and meat." On the afternoon of 11/03/09, changes to the care plan included removing the "history of" skin impairment to "skin impairment" and a deletion of the 93 grams of protein daily, and an addition of resource juice eight ounces at bedtime and in the evening. The care plan lacked the resident's current protein needs. Resident #3's interdisciplinary progress notes identified and described the presence and reoccurrence of the skin tear to the penis, and open areas to the buttocks: * 03/10/09 at 10:45 p.m.: "a small slit in his scrotum below his penis." * 03/12/09 at 2:30 p.m., "Skin assessment completed - noted that [resident] has a 1 cm [centimeter] excoriated area on the top Rt [right] side of the scrotum . . ." * 03/14/09 at 1:00 p.m., "assessed scrotum.	F 314		

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F 314	Continued From page 8 Noted 1.5 cm skin tear. Will use Aquaphor and monitor for improvement." * 03/27/09 at 7:30 a.m., "Skin on scrotum assessed 1.5 cm skin open on top of scrotum under the penis area is healing . . ." * 03/30/09 at 10:30 p.m., "Open area on scrotum smaller but had mod [moderate] amt [amount] of bleeding this shift . . ." * 03/31/09 at 4:30 p.m., "Open area on scrotum is improving . . ." * 04/08/09, by dietary department, "Nutrition: Eating 100%. Wt [weight] 204 [pounds]. See nurses notes regarding impaired skin integrity. Protein intake 87-91 gm [grams]. Pro [protein] needs met. MVT [multivitamin]." * 04/10/09 at 10:00 p.m., "When being settled for bed - RA [resident assistant] noted resident has a tiny "1 cm" fluid filled blister on scrotum next to previous healed site . . ." * 04/15/09 at 12:30 p.m., by dietary department, "Nutrition: See nurse's notes regarding impaired skin integrity to heel. Wt 205 # [pounds]. Eats 100% of meals. Protein intake 94 gm. Edema. Lasix ordered. MVT. Fluids encouraged." * 04/15/09 at 11:00 p.m., ". . . Res has 3 sm [small] open spots on R) buttock . . ." * 04/17/09 at 7:30 a.m., "R buttock has 1 cm area [with] a few excoriated spots . . ." * 04/17/09 at 1:00 p.m., "Skin . . . [two] area[s] on buttocks bright red blood spots from area et [and] one pin spot noted on front part of scrotum . . ." * 04/21/09 at 12:00 noon, "1.6 cm open wound lower R buttocks . . ." * 04/22/09 at 11:00 p.m., "Rt heel and buttocks wounds assessed. See wound assessment forms." The wound assessment form identified three superficial two mm [millimeter]	F 314		

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open areas to the lower right buttocks, 1.5 cm in size, and identified as stage II.

* 04/23/09 at 9:30 a.m., "Nutrition: See nurse's notes regarding impaired skin integrity. Eating 100%. Protein intake 94 gm. MVT, diuretic use. Prot [protein] req [requirements] 91 gm."

* A Care Plan Summary, dated 04/24/09, identified the resident with a pressure ulcer to the heel, scrotum and coccyx area.

* 04/28/09 at 1:30 p.m., "Nutrition: Improved skin integrity, edema. Eats 100% of meals. Protein intake 90-95 gm."

* 04/29/09 at 10:30 p.m.,"R buttock has 2/.5 cm open areas incontinence care given . . . Under penis on top of scrotal sac rash small slit scant bleeding cleaned . . ."

* 05/03/09 at 8:00 a.m., ". . . has 2 tiny areas on his Rt [lower] buttocks approx [approximately] each one .5 cc in size . . . scrotum . . . not open."

* 05/04/09, dietary for assessment period of 04/18/09 to 04/24/09: ". . . receives a Regular diet . . . protein intake average was 99 gm. His needs are 93 gm [sic]. Does receive p.m. and hs snacks . . . wt [weight] is 202 # . . . Receives whole milk at mealtimes . . . Has skin impairments see dietitian's note from 4/23/09. Has hx of skin impairment."

* 05/06/09 at 2:45 p.m., "Nutrition: Impaired skin integrity. Eating 100% of meals. Continue as noted 5-4."

* 05/19/09 at 4:00 p.m., "Has small pin point open area on scrotum scant amount of bleeding . . ."

* 05/20/09 at 4:30 p.m., "Nutrition: Impaired skin integrity. Intake 100%. Protein intake 90-99 gm. Protein req 91 gm . . ."

* 05/26/09 at 10:30 p.m., "Open slit noted under penis on top side of scrotum . . ."

* 05/28/09 at 8:30 p.m., "Dressing removed

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from R heel . . . wound is 2 cm x [by] 3 cm & .5 cm deep . . ."

* 06/03/09 at 8:20 p.m., "Nutrition: Impaired skin integrity to heel. Meal intake 100%. Protein intake 90-100 gm. Prot req 91 gm. Receives MVT . . ."

* 06/06/09 at 11:45 p.m., "CNA reported open slit @ [at] coccyx. Checked area sm [small] amt [amount] of bleeding . . ."

* 06/10/09 at 9:30 a.m., "Nutrition: See nurse's notes regarding skin integrity. Prot intake 94 gm. Meal intake [greater than] 75%. Prot req 91 gm . . . Wt stable."

* 06/13/09 at 10:30 p.m., "CNA reported Res has sm slit in scrotum [with] small amt of bleeding noted . . ."

* 06/24/009 at 10:00 a.m., "Nutrition: Impaired skin integrity. Meal intake [greater than] 75% of nut [nutritional] needs. Protein intake 80-90 gms [grams]. Wt. 205 #."

* 07/13/09 at 10:30 p.m., "Res has a .7 cm fluid filled blister on the top center of his scrotum. Aquaphor was applied."

* 07/15/09 at 9:15 a.m., "Nutrition: Impaired skin integrity to heel. Meal intake Breakfast & Supper 100%. Noon meal 25-50%. Wt 190 #. Down 6# past week. Protein intake 74 gm-90 gm. Receives MVT. Reg. [regular] diet . . . Followup wt 1 week."

* 07/16/09 at 6:45 p.m., "Res has a superficial open area on mid upper buttock . . ."

* 07/29/09 at 10:30 a.m., "Resident buttocks area cont [continue] to have a large dark pink area above the buttocks crease - has a tiny split [with] in 1 cm hair line crack a) [assessment] Will monitor & pass on info [information]."

* 07/30/09, dietary for assessment period of 07/18/09 to 07/24/09, ". . . receives a Regular diet. Average Fluid intake was 1565 cc plus other

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fluids not charted. His oral intake is 90%. His protein intake average was 95 gm. His needs are 93 gm . . . Meds [medications] are MVT [multivitamin] . . . Has hx of skin impairment. Skin turgor was good on 6/22/09 with skin impairments."

* 08/03/09 at 10:30 p.m., "See wound photo for open area on buttock." The weekly "Skin-Wound Assessment" form identified the presence of a stage 2 pressure ulcer, size 1 cm by 2 cm in size.

* 08/05/09 at 1:00 p.m., "Nutrition: Refusing noon meals. Visited [with] Res. offered meal, alternatives, bring meal to his room, he refused. He indicated he'd let us know when he wants to eat . . . open areas to buttocks. Eats large breakfast & supper . . . Protein intake 75-95 gm. Prot req 91 gm."

* 08/17/09 at 10:45 p.m., "Res coccyx continues to be reddened [with] a 2 mm [millimeter] open area. Res has a small 2 mm slit to scrotum, area cleanse (sic) and aquaphor applied."

* 08/19/09 at 10:00 a.m., "Nutrition: Impaired skin integrity . . . Protein intake 87-95 gm. Prot req 91 gm."

* 10/01/09 at 10:30 p.m., "Res has open areas on both sides of buttocks incontinence cares given et aquaphor applied."

* 10/07/09 at 9:00 a.m., "Nutrition: Impaired skin integrity . . . Wt [weight] 197 # [pounds] . . . Protein intake 87-95 gm. Prot req 91 gm. Receives MVT. Fluids encouraged." A weekly "Skin-Wound Assessment" form, dated 10/07/09 identified a stage 2 pressure ulcer, 1 cm by 1 cm, to the right buttock.

* 10/10/09 at 11:15 p.m., "R lower buttock has 1 cm open area . . ."

* 10/12/09 at 11:30 a.m., "Skin/Nutrition: ". . .

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F 314	Continued From page 12 is eating greater than 25% of his meals. Protein intake is 80-100 gm. Is receiving a MVT." * 10/21/09 at 9:00 a.m., "Nutrition: Impaired skin integrity. Protein intake 85-95 gm. Prot req 91 gm. Receives MVT. Fluids encouraged." * 11/02/09 at 10:45 p.m., ". . . Buttocks dull pink in color. No open areas noted." * 11/03/09 at 9:30 a.m., [Day of survey], "Intake [greater than] 75% of meals. Impaired skin integrity. Protein intake 85-95 gm. Receives MVT. Fluids encouraged . . . Refusing Bedtime milkshake. Will offer Res [resource] juice 8 oz [ounces] instead . . . Protein req based on IBW [ideal body weight] & current wt 81-112 (1 - 1.25 gm/kg) - Res [resource] juice will increase Protein intake to 97 gm. Add Res [resource juice] to increase protein intake to 107 gm." Review of Resident #3's weight records identified the resident's weight consistently in the range of 197 and 207 pounds (89-94 kg) between the months of January and October 2009. Increasing protein requirements to 1.25 g/kg of body weight to promote healing would require between 111 to 117 grams of protein intake daily. Nutrition notes consistently identified Resident #3's protein requirement beginning on 04/08/09 as 87-94 g/kg of body weight maximum for this weight range. This calculation provided for one gram per kilogram of body weight for total protein, and did not include an adjustment due to the impaired skin integrity identified in the interdisciplinary progress notes. An interview occurred on 11/03/09 between 2:15 p.m. and 3:10 p.m. with an administrative dietary staff member (#1). The staff member (#1) stated Resident #3's Nutrition Risk Assessment, dated 07/25/09, calculated the resident's total protein	F 314		

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F 314	Continued From page 13 needs based on no skin conditions (skin intact). The staff member (#1) stated no change in that calculation occurred after nursing staff identified the impaired skin integrity. The staff member provided no explanation of why the resident's protein needs were not increased to promote healing of Resident #3's wounds. The staff member stated they did not know what the resident's IBW was, as the 07/25/09 Nutrition Risk Assessment lacked this calculation. An interview occurred on 11/04/09 at 2:30 p.m. with an administrative nursing staff member (#2). This staff member (#2) agreed Resident #3's nutritional protein requirements should have been increased due to the pressure ulcer development on the scrotum and buttocks to promote healing. Record review identified an adjustment for protein requirements occurred on 11/03/09 on Resident #3's Nutrition Risk Assessment, care plan and interdisciplinary progress notes. The increase occurred without identifying the resident's current body weight or IBW. Failure to recognize Resident #3's increased protein requirements to promote healing of Resident #3's pressure areas may have resulted in the delayed healing and frequent reoccurrence of the areas to the scrotum and buttocks.	F 314		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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.	F 323	Plan of correction for F-323 begins on the following page.	

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F 323	Continued From page 14 This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility policy/procedure, and staff interview, the facility failed to adequately assess the circumstances and causative factors contributing to the recurring falls experienced by 1 of 1 sampled resident (Resident #6) requiring extensive assistance with toileting, and failed to implement/provide appropriate interventions and/or assistance to prevent falls and potential injury/harm from occurring. Failure to assess and implement appropriate interventions for Resident #6 resulted in the resident experiencing recurring falls while attempting to toilet unassisted. Findings include: Review on 11/04/09 of the facility's "Reporting Fall Events" policy/procedure (Last reviewed/revised 10/07) stated: ". . . Procedure: 1. The fall will be documented in the nurses notes in a fall event report form during the shift that it occurs. 2. The Statement of the Event is to be completed by the witness to the fall or by the first person to arrive at the event. 3. The Nursing assessment should then be completed, addressing: . . . Any other contributing data. 4. The Investigation Summary should include how the fall may have been prevented or any interventions to prevent recurrence." Review of Resident #6's medical record occurred November 02-04, 2009, and included Resident #6's most recent annual Minimum Data Set dated 12/12/08, and the most recent quarterly MDS review dated 09/12/09. The 12/12/08 MDS	F 323	F-323 Maryhill Manor is committed providing a safe environment so our residents can be as accident free as possible. To that end, Maryhill staff members will do the following to enhance the safety of our residents: 1. a. A new bowel and bladder assessment was completed for resident #6. Her individualized toileting plan now includes the following schedule: Resident #6 will be offered assistance to the toilet at the end of the pm shift on their last rounds. The night shift will allow the resident to sleep uninterrupted until last rounds of their shift. They will wake her and offer toileting assistance between 5:00-6:00a.m. The day shift will also wake and offer toileting assistance during their first rounds, between 7:30-8:30a.m. b. C.N.A.'s were instructed to tighten the harness snugly when transferring resident #2 and loosen the harness and remove the lift from the bathroom when assisting this resident with toileting. 2. a. All residents have bowel and bladder assessments at the time of admission or re-admission. New plans are re-evaluated one month after initiation. Effectiveness of bowel and bladder plans is evaluated at the quarterly care plan conference. b. All residents who use the standing lift may be affected by this practice. At the current time there are six residents who use this lift. --continued--	12-04-09

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F 323	Continued From page 15 identified Resident #6 as requiring extensive assistance of two persons for transfer and toileting. The 09/12/09 MDS identified Resident #6 required limited assistance of one person for toileting and limited assistance of two persons for transfer. Both MDSs identified Resident #6 as not attempting ambulation during the review period, exhibiting short and long term memory impairment, moderately impaired daily decision making skills, and having highly impaired vision. Resident #6's current plan of care included: "Problem - 09/08/09 - [Resident #6] requires limited to extensive assist of one to two for the physical process of TOILETING related to: Cognitive impairment, impaired mobility. . . . Interventions: . . . Staff will offer to [Resident #6] to the bathroom every 2-3 hours while awake and as she requests. On the night shift she will be checked at 0100, 0300, 0500, and they will offer the BR [bathroom] or change brief as needed. AM shift will offer to take resident to the toilet at the beginning of their shift between 7-8 a.m., as a trend was noted with falls at that time." Review of Fall Event Reports included the following: *10/14/09 - 9 a.m., "Resident was incontinent large BM [bowel movement]. Was attempting to take self to bathroom - found on knees beside bed. Knees slightly reddened - no open areas." *10/01/09 - 8 a.m., "CNA [certified nurse assistant] reported that resident was found sitting on the floor by her bed. question if resident was trying to self transfer." *06/20/09 - 6:45 a.m., "Resident found on floor matt on right side and leg - Incontinent of BM XL [extra large]. No apparent injury." *03/10/09 - 8 a.m., ". . . Found resident on	F 323	3. a. Education will be conducted by the Director of Nursing and Resident Care Coordinator with the C.N.A. staff regarding the following: *Review of bowel and bladder assessment process, reason for individualized plans, and importance of following the plans with all C.N.A.'s. *Education of proper lift use, including snug tightening of harness when lifting resident and gradual tightening as the resident is lifted from sitting to standing position, to adjust for shift in body weight while standing. Also included will be the removal of the lift from the bathroom when assisting a resident to the toilet. b. The facility policy on proper use of the standing lift will be revised to include tightening of the harness as the resident is lifted and removal of the lift from the bathroom and unbuckling, loosening or removal of the harness while the resident is toileting. 4. Quality Assurance checks involving proper use of the standing lift and effectiveness of bowel and bladder programs will be completed under the Director of Nurses direction on a monthly basis for three months and quarterly thereafter for a minimum of one year.	

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floor beside bed. Resident said she was ok . . . Resident also stated she was trying to go to the bathroom."

*03/07/09 - 10 a.m., "Resident found on floor by bed with RUE [right upper extremity] on grab bar. . . . last checked on at 5 a.m. by noc [night shift]."

*02/23/09 - 8:30 a.m., ". . . CNA entered room and found resident sitting on the floor. Lg [large] bm present."

*01/27/09 - 2:30 a.m., "Resident found sitting on the floor next to her bed. Resident states she was trying to get to the bathroom and missed her w/c [wheelchair]. Amount of time since last taken to toilet - questionable."

During observation of two CNAs (#10 and #11) assisting Resident #6 with toileting at 10 a.m. on 11/03/09, showed the CNAs assist Resident #6 from bed to a standing lift, and transport the resident via the lift into the bathroom and onto the toilet. Resident #6 had been incontinent of bladder prior to being assisted to the toilet.

The CNAs (#10 and #11) assisting Resident #6 indicated they check on Resident #6 at the beginning of their shift - usually right after report, and then will check on the resident periodically during the morning until she starts to stir and wake up, then they get her up - "usually around this time." The CNAs indicated "they do not assist Resident #6 to the toilet prior to getting her up for the day, usually around 10 a.m."

The record included the most recent "Bowel and Bladder Record" dated January 02-04, 2009, and January 30-February 01, 2009. The Bowel and Bladder Record, used "to identify resident toileting pattern and to identify incontinency" indicated

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F 323	Continued From page 17 staff did not assist Resident #6 to the toilet during the night, but the resident typically remained "dry" throughout the night. The form also showed Resident #6 experienced incontinence prior to the time staff first assisted her to the toilet on the day shift (at 10 a.m. on six of the seven days of monitoring). Failure to assess Resident #6's toileting needs, implement an individualized toileting schedule consistent with the resident's established toileting/voiding pattern, and monitor the implementation and effectiveness of the existing plan of care following falls related to the resident attempting to self toilet, resulted in Resident #6 experiencing recurring falls and placed the resident at risk for potential harm/injury. 2.) Based on observation, record review, review of facility policy, review of the Medcare stand operator's manual, resident and staff interview, the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for 3 of 3 sampled residents (Resident #2, #3, and #6) observed transferred with a stand lift. This practice placed the residents at risk for injury during lift transfers and when the residents remained secured in the lift while sitting. Findings include: Review of the Medcare Lifts & Stands Operator's Manual occurred on 11/04/09. The instructions stated, "Stand Operations - Harness Features - 1. Standard Harness The harness offer comfortable support for resident's capable of standing upright and grasping the lift bar. . . . . 3. The standard harness is used for resident's that have more	F 323		

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consistent and reliable motor functions. Position the top of the harness around the upper body of the resident, just below the shoulder blades and under the arms. Fasten safety strap around patient to secure resident in harness. . . . Resident Transfer & Positioning Procedure - 1. Transfer resident to commode chair, toilet, wheelchair, bed etc. Before lowering resident, make necessary adjustments to clothing, incontinence pads, etc. while resident is raised. 2. Lower resident by using handset control. 3. When resident is seated, disconnect straps and remove sling and push stand away. . . "

Review of the facility policy titled "Use of the Medcare Stand Lift" occurred on 11/04/09. This policy, dated 6/07, stated, "General Instructions: . . . 3. The STANDARD HARNESS offers comfortable support for residents capable of standing upright and grasping lift bar. Position the top of the harness around the upper body of the resident, just below the shoulder blades and under the arms. 4. Fasten the safety strap around resident to secure resident in harness. . . . 8. . . .Have the resident place their feet on the foot support plate, with their shins against the shin support. 9. Apply the additional leg strap support. . . . 12. Lower resident by pressing the Down button on the hand control. Once you have sufficient slack in the lifting straps you may disconnect the straps from the stand. Move stand away from resident and remove harness. . . . 15. When resident is seated, disconnect straps and remove sling and push stand away."

- The following observations for Resident #2 showed improper use of the Medcare Stand, a brand of mechanical lift:

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F 323	Continued From page 19 On 11/03/09 at 7:40 a.m., two CNAs (#3 and #4) assisted Resident #2 with cares. As the resident sat on the edge of the bed, the CNAs (#3 and #4) placed the harness around Resident #2's upper abdomen, and secured the buckle without tightening the harness strap. As the CNAs (#3 and #4) raised Resident #2 to a standing position, the loose harness slid up to her axillae (armpits), pushing her shoulders up towards her neck. In this position, the CNAs (#3 and #4) transferred Resident #2 to the bathroom. On 11/03/09 at 9:45 a.m., two CNAs (#3 and #4) assisted Resident #2 with cares. As the resident sat in her wheelchair, the CNAs (#3 and #4) asked the resident to lean forward so they could place the harness behind the resident's back. The CNAs (#3 and #4) failed to position the harness below Resident #2's shoulder blades as per facility policy and manufacturers recommendations. The CNAs (#3 and #4) secured the buckle without tightening the harness strap and raised Resident #2 to a standing position. As Resident #2 stood the loose harness slid up to her axillae pushing her shoulders up towards her neck. In this position, the CNAs (#3 and #4) transferred Resident #2 to the bathroom. After Resident #2 had completed toileting, the CNAs (#3 and #4) raised the lift bar assisting Resident #2 to a standing position. The CNAs (#3 and #4) did not attempt to tighten the harness and Resident #2 continued to have the harness in her axillae, pushing her shoulders up towards her neck as the CNAs (#3 and #4) provided care and transferred the resident to her bed. On 11/03/09 at 4:55 p.m., two CNAs (#5 and #6) assisted Resident #2 with cares. The CNAs (#5 and #6) had already transferred the resident into	F 323		

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the bathroom. After completion of cares, the CNAs (#5 and #6) reattached the harness, and engaged the lift mechanism. As Resident #2 stood the loose harness slid up into her axillae, causing her shoulders to move up toward her neck and pushed her elbows out away from her body. In this position, the CNAs (#5 and #6) transferred Resident #2 to her wheelchair.

Review of the medical record for Resident #2 occurred November 2-4, 2009. A quarterly MDS, completed 10/02/09, identified the resident has no long or short term memory problems, needs extensive assistance of two staff members for transfers, bed mobility, and toilet use. The current care plan for Resident #2 indicated, "Transfers with a standing lift and assist of 2."

During an interview with Resident #2, on 11/04/09 at 1:05 p.m., she indicated the harness hurts her lungs and (pointed to her axilla) "so the girls go as fast as they can." Resident #2 clarified the transfers do not always hurt her lungs, but now while she has cold symptoms they (breathing) hurt when supported by her axillae in the lift.

During an interview with an administrative nursing staff member (#2) , on 11/04/09 at 2:50 p.m., this staff member identified her expectation is that staff position the harness around the abdomen, below the shoulder blades, and secure the harness so that it does not slide up into a resident's axilla.

- Review of Resident #3 medical record occurred on all days of survey. Resident #3's medical diagnoses included cerebrovascular accident (CVA) with right sided paralysis, global aphasia (communication deficit), chronic low back pain,

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F 323	Continued From page 21 and on 06/30/09, profound peripheral vascular disease of the right lower extremity. Review of Resident #3's care plan identified the resident with a mobility problem with interventions which included "Use PAL lift [stand lift] for all transfers with Extensive assistance of 2 make sure that res [resident] is even (level) throughout hips and pelvis . . ." An observation occurred on 11/02/09 at 4:30 p.m. while two certified nursing assistants (CNAs) (#6 and #8) transferred Resident #3 with the PAL lift from his recliner to the toilet in the bathroom. Following positioning the resident onto the toilet, the CNAs left the resident connected to the stand lift. This resulted in the resident having the harness connected across the resident's back, the resident's feet firmly planted on the foot support plate, and his shins strapped against the shin support of the PAL lift, while seated on the toilet. The CNAs (#6 and #8) then exited the bathroom, allowing the resident privacy, while the resident used the toilet. Leaving the resident harnessed into the PAL lift during toileting placed the resident at risk of injury if he lost his balance or attempted to move while seated. In addition, positioning a resident on a toilet while harnessed to a lift does not follow facility policy nor the manufacturer's instructions for the use of the standing lift. - An observation occurred on 11/02/09 at 4 p.m., while two CNAs (#6 and #8) transferred Resident #6 with a standing mechanical lift from her wheelchair to the toilet. Following lowering the resident onto the toilet, the CNAs left the resident connected to the standing lift. This resulted in the	F 323		

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F 323	Continued From page 22 the harness remaining connected across the resident's back, the resident's feet firmly planted on the foot support plate, her shins remaining strapped against the shin support of the lift, and her hands grasping the lift grab bars while seated on the toilet. While Resident #6 used the toilet, the CNAs (#6 and #8) exited the bathroom, allowing the resident privacy. Leaving the resident harnessed into the PAL lift during toileting placed the resident at risk of injury if she lost her balance or attempted to move while seated. In addition, positioning a resident on a toilet while harnessed to a lift does not follow facility policy nor the manufacturer's instructions for the use of the standing lift.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	Plan of correction for F-425 begins on the following page.	

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 _____	11/04/2009

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 425	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the removal of and replacement of expired medications occurred for 1 of 1 emergency drug box on 2 of 3 days of survey (November 2 and 3, 2009). Failing to ensure the removal of expired medications in the emergency drug box has the potential to affect all residents who may require life saving measures with these medications. Findings include: On 11/03/09 at 4:10 p.m., observation of the facility emergency box and attached medication list identified expired dates for three of the enclosed emergency drugs. Observation of the drugs inside the emergency box identified the following expired medications: * Two four cubic centimeter (cc) vials of injectable Lasix (a potent diuretic), expired August 2009 * Three vials of Epinephrine 1:1000 (emergency drug used for bronchospasms, hypersensitivity reactions, anaphylactic reactions), expired October 1, 2009 * Three containers of Glutose 15 (an oral glucose gel), expired September 2009 On the afternoon of 11/03/09, an administrative staff member (#2) stated the consulting pharmacist is responsible for ensuring outdated drugs are replaced in the emergency box. The staff member stated the facility did not have a policy to ensure outdated drugs were replaced.	F 425	F-425 Maryhill Manor is committed to having supplies on hand to react to emergency situations. To that end, Maryhill staff members will do the following to ensure the emergency drug box does not include any outdated drugs: 1. The three outdated medications were removed immediately upon discovery of the expiration dates. 2. The medications in the emergency drug box have the potential to affect all residents who may require life saving measures with these medications. 3. The nursing staff at Maryhill will be given the responsibility to check the emergency drug box for outdated medications on a monthly basis. This responsibility had previously been that of the consultant pharmacist. A policy will be written with procedures to ensure outdated drugs are placed in a timely manner. 4. Quality Assurance checks on medication expiration dates in the emergency drug box will be completed under the direction of the Director of Nursing on a monthly basis for three months and quarterly thereafter for a minimum of one year.	12-04-09