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 _____	11/09/2011

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 For the standard Medicare/Medicaid survey, started on 11/07/11 and completed on 11/09/11, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure staff followed professional standards of care regarding blood glucose monitoring for 1 of 1 sampled resident (Resident #12) with physician's orders for daily blood glucose monitoring. Failure to record blood glucose readings in the medical record could result in staff not reporting levels outside the desired range to the physician. Findings include: Kozier and Erb's Fundamentals of Nursing, 8th Edition, 2008, Prentice Hall, Upper Saddle River, New Jersey, pages 806 - 807 stated, "Obtaining a capillary blood specimen to measure blood glucose . . . Document the method of testing and results on the client's record . . . Evaluation . . . Relate blood glucose reading to previous readings . . . Report abnormal results to the	F 281	**F-281:** Maryhill Manor is committed to following professional standards in order to deliver high quality care to residents at all times. To that end, Maryhill Manor will do the following to enhance our services: 1. The primary physician for resident #12 discontinued the monitoring of blood sugars on 11/17/11 and stated there was no diagnosis of diabetes. 2. All residents with diabetes or having blood sugars monitored have the potential to be affected by this standard. 3. a. Nurses have been reminded at a department meeting on 11/29/11 to chart results of all blood sugars and write a progress note whenever the physician is called. b. All accu-checks will be moved to the electronic MAR (Medication Administration Record) from the electronic TAR (Treatment Administration Record) where they had been placed. This systematic change will aid in consistency of recording. Continued on next page	12-13-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Fenstad	CEO/Administrator	12/2/11

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 281	Continued From page 1 primary care provider . . ." Review of the facility policy titled "Diabetic Blood Glucose Checks" occurred on 11/09/11. The policy, revised December 2002, stated, ". . . The blood glucose ranges will also be established per order of the attending physician as to exactly when to notify the physician of hypo/hyperglycemic values . . . Documentation will be in the MAR [Medication Administration Record]. . . ." Review of Resident #12's record occurred on November 8-9, 2011. The record identified diagnoses including diabetes mellitus. The record indicated Resident #12 was hospitalized from 10/15/11 to 10/19/11. A physician's order, dated 10/19/11, stated, "Accuchecks [blood glucose monitoring] q [every] AM [morning] - Call MD [Medical Doctor] if > [greater than] 150." On 11/09/11 at 10:30 a.m., facility staff members (#4 and #5) assisted the surveyor to view Resident #12's accucheck results on the electronic record and provided printouts of the results. Review of the printouts identified the accuchecks initialed as completed October 20-November 8, 2011. However, the record identified staff failed to record results for accuchecks completed October 20-28, 2011 in the medical record. Resident #12's progress notes identified the following: 10/22/11 at 11:06 a.m.: "Accuchecks . . . Missed d/t [due to] not knowing this was added to resident's orders." 10/28/11 at 2:50 p.m.: ". . . Resident had eaten	F 281	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. Are the blood sugar parameters documented on the eMAR as to when to notify the physician? b. Was the accu-check result recorded? c. Was the doctor notified if indicated? d. Was a progress note completed if indicated?	

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F 281	Continued From page 2 breakfast already so BS [blood sugar] was not done." The progress notes failed to identify further documentation regarding Resident #12's accuchecks. During an interview on 11/09/11 at 1:30 p.m., an administrative nurse (#1) stated she expects staff to record accucheck results in the medical record.	F 281		
F 309 SS=D	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 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed facility policy and parameters set by the physician for 2 of 2 sampled residents (Resident #8 and #11) with physician's orders for sliding scale insulin (insulin dose based on blood glucose level). Failure to perform glucose monitoring, administer insulin as ordered, and notify the physician according to parameters could result in the residents experiencing hyperglycemic (elevated blood glucose) and/or hypoglycemic (low blood glucose) episodes. Findings include:	F 309	F-309: Maryhill Manor is committed to providing services to residents with Diabetes to ensure that they maintain their highest practicable well being. To that end, we will do the following to enhance the services we provide: 1. Resident #8 has been discharged. Resident #11 will have a review of the individual parameters on the care plan and the eMAR. The nurses have been reminded at a department meeting on 11/29/11 to record accu-check results and notify the physician if the results fall outside the parameters set by the physician. 2. Maryhill Manor currently has 16 residents with the diagnosis of Diabetes who could be affected by these practices. Continued on next page	12-13-11

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F 309	Continued From page 3 Review of the facility policy titled "DIABETIC BLOOD GLUCOSE CHECKS" occurred on 11/09/11. This policy, revised December 2002, stated, "POLICY: Any resident newly diagnosed with diabetes or diabetic resident newly admitted (either on insulin therapy or oral products) will have his/her blood glucose monitored as ordered by his/her physician. The blood glucose ranges will also be established per order of the attending physician as to exactly when to notify the physician of hypo/hyperglycemic values . . . Acceptable blood glucose levels will be defined as between 40 to 350 mg/dl [milligrams per deciliter] under the following conditions: 1. Resident is asymptomatic . . . Documentation will be in the MAR [Medication Administration Record]. The nurse will indicate the results and initial in the appropriate area. Documentation will appear in the nurses' notes on any blood glucose reading of less than 40 mg/dl OR greater than 350 mg/dl. Nurses will recheck any blood sugar that is 350 mg/dl or above and document accordingly." - Resident #8's medical record, reviewed on all days of survey, identified diagnoses including diabetes mellitus. A physician's order, dated 09/16/11, stated, "Blood Sugar QID [four times a day], Less than 50 [mg/dl] or greater than 400 [mg/dl] notify physician." Review of Resident #8's September 2011 blood glucose records identified the following: *3 times staff failed to check the resident's blood glucose as ordered *3 times staff failed to recheck a blood glucose level > 350 mg/dl *The record showed, on 09/22/11 at 4:22 p.m.,	F 309	Continued 3. a. All accu-checks will be moved to the electronic MAR (Medication Administration Record) from the electronic TAR (Treatment Administration Record) where they had been placed. This systematic change will aid in consistency of recording. b. Individual parameters will be documented in the care plan and the individual's eMAR. c. Specific signs of hypoglycemia and hyperglycemia will be noted in the care plan for each resident with diabetes. d. Nurses will record blood sugar either in the eMAR or progress note and will complete a progress note if the physician is called. 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. Are the blood sugar parameters documented on the eMAR as to when to notify the physician? b. Was the accu-check done the number of times ordered by the physician? c. Was the accu-check result recorded? d. Was the doctor notified if indicated? e. Was a progress note completed if indicated?	

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F 309	Continued From page 4	F 309		

Resident #8 had a blood glucose level of 393 mg/dl. Facility staff informed the physician and received an order to increase Resident #8 's insulin dose.

Resident #8's blood glucose records for October 2011 identified the following:

*19 times staff failed to check the resident's blood glucose as ordered

*14 times staff failed to recheck a blood glucose level > 350 mg/dl

*4 times staff failed to notify the physician of a blood glucose > 400 mg/dl, as per physician's orders.

*The record showed, on 10/13/11, at 4 p.m. Resident #8 had a blood glucose level of 568 mg/dl. Facility staff notified the physician and received an order for sliding scale Novolog insulin. After implementation of the sliding scale, the record identified 20 times staff failed to administer insulin in accordance with the sliding scale orders. Blood glucose levels at those times ranged from 218 mg/dl to 376 mg/dl.

*On 10/29/11 at 8:46 p.m., the record showed a blood glucose level of 223 and the MAR indicated staff administered 5 units of insulin. However, the nurse's notes identified the blood glucose level as 273 mg/dl. The record identified staff should administer 3 units insulin for a blood glucose of 201-250 mg/dl and 5 units for a blood glucose of 251-300 mg/dl.

Review of Resident #8's MAR and blood glucose records for November 1-8, 2011 identified the following:

*2 times staff failed to check the resident's blood glucose as ordered.

*3 times staff failed to administer insulin in

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F 309	Continued From page 5 accordance with the sliding scale orders. Blood glucose levels at those times ranged from 212 mg/dl to 238 mg/dl. *On 11/04/11 at 8:01 p.m., the record identified a level of 192 mg/dl. The MAR showed staff administered 2 units of insulin. However, the nurses notes identified staff administered no insulin, in accordance with the sliding scale orders. - Review of Resident #11's medical record occurred on November 8-9, 2011. Diagnoses included type II diabetes mellitus. Current medications included Levimer insulin 30 units twice daily, initiated on 11/02/11, and Novolog insulin 10 units before meals, initiated on 10/07/11. The care plan failed to identify high and low blood glucose parameters; and signs, symptoms, and interventions of hypoglycemia and hyperglycemia. The physician's orders identified Novolog insulin per sliding scale four times a day, ordered on 08/03/11, with parameters to call the physician with blood glucose values less than 80 mg/dL (milligrams per deciliter) or greater than 400 mg/dL. On 10/07/11 Resident #11's physician discontinued the sliding scale of Novolog insulin and ordered 10 units before each meal. Review of Resident #11's September 2011 MAR identified the following: *10 times staff failed to check the resident's blood glucose level as ordered *64 times staff failed to specify the amount of insulin administered (MAR showed a check indicating insulin was administered, but lacked the specific amount of units)	F 309		

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F 309	Continued From page 6 *5 times staff failed to administer the correct dose of insulin or administer any insulin when indicated Review of Resident #11's October 2011 MAR revealed the following: *12 times staff failed to check the resident's blood glucose level as ordered *7 times staff failed to specify the amount of insulin administered (MAR showed a check indicating insulin was administered, but lacked the specific units) *8 times staff failed to notify the resident's physician (or on-call physician) when blood glucose values fell below identified parameters (values ranged from 65 mg/dL to 76 mg/dL) During an interview on 11/09/11 at 9:45 a.m. an administrative nurse (#1) stated she expected staff to call a resident's physician when blood glucose values fell outside the ordered parameters and agreed staff members should document the exact dose of insulin given on the MAR with each administration.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	**F-315:** Maryhill Manor is committed to providing personal care to assist residents to remain as continent, clean, and free of infections to the greatest extent possible. To enhance the care provided, Maryhill will: 1. C.N.A's #13 and #14 have been addressed regarding the lack of care provided and are being retrained and monitored frequently for completeness of cares. 2. All residents requiring assistance with toileting have the potential to be affected by this practice. Continued on next page	12-13-11

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F 315	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible for 3 of 9 sampled residents (Resident #7, #9, and #11) who required extensive assistance with toileting. Failure to complete perineal cares (Resident #7) and failure to implement residents' toileting plans (Resident #9 and #11) does not allow residents to maintain or improve their continence and may lead to impaired skin integrity, urinary tract infections, and a loss of dignity and comfort. Findings include: Review of the facility policy titled "Bowel and Bladder Program" occurred on 11/09/11. This policy, revised July 2007, stated, "PURPOSE: Maryhill Manor will provide appropriate programs and treatments for our residents to prevent urinary tract infections, constipation, and to restore and maintain as much normal bowel and bladder function as possible . . . PROCEDURE: . . . 4. From findings from the bowel and bladder assessment a corresponding Bowel [and] bladder retraining program/plan will be implemented for that individual resident and documented on their plan of care . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis, overactive bladder, and history of urinary tract infections. A quarterly	F 315	Continued 3. a. A review of proper perineal cares and handwashing procedures was conducted with nurses and C.N.A.'s on 11/29/11. b. C.N.A.'s were reminded to notify nursing if residents are refusing toileting plans or if the plans do not appear to fit the residents' needs. c. Toileting plans are being reviewed. The nurse establishing the toileting plan will go directly to the care plan to enter this plan. d. A systemic change will be made by utilizing the computerized care plan which is designed specifically for C.N.A. tasks and is generated from the full care plan. These C.N.A. care plans will be generated whenever there is a change in the care plan. d. The toileting plan will be entered into the C.N.A. documentation record with the specific times indicated for toileting. 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 proper peri-care technique followed? b. Was proper handwashing protocol followed? In addition, a QA check will be completed quarterly to determine if the bowel and bladder program is being carried out.	

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F 315	Continued From page 8 Minimum Data Set (MDS), dated 10/20/11, identified Resident #7 as frequently incontinent of urine, occasionally incontinent of bowel, and required extensive assistance with toileting and personal hygiene. Medications included one gram of Hiprex (methenamine) taken orally twice daily (an antibiotic used to eliminate bacteria that cause urinary tract infections and usually used on a long-term basis). A urine sample obtained on 07/13/11 identified the presence of Escherichia coli (a bacteria found in the intestines and excreted in the stool which can cause urinary tract infections). Resident #7's care plan, dated 08/09/11, stated, "ELIMINATION: I require extensive assistance of two with toileting r/t [related to] Rheumatoid Arthritis. Goals: I will remain free from skin breakdown. I will remain free from infections. Interventions . . . I am continent of bowel. Incontinent of bladder . . . I will let you know when I have to use the bathroom during the day . . ." On 11/08/11 at 10:00 a.m., two certified nursing assistants (CNAs) (#13 and #14) assisted Resident #7 with toileting. Observation showed the resident's incontinence pad wet with urine. A CNA (#14) used a gait belt to assist the resident to stand and another CNA (#13) pulled up the resident's pants and proceeded to pivot transfer the resident to her wheelchair. Observation showed both stool and urine in the toilet. The staff members failed to perform perineal cares prior to pulling up the resident's pants and transferring her back into her wheelchair. When staff toileted the resident again on 11/08/11 at 1:25 p.m. observation showed stool present on her incontinence pad.	F 315		

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F 315	Continued From page 9 During an interview on 11/09/11 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to always complete perineal cares when assisting Resident #7 with toileting. - Review of Resident #11's medical record occurred on November 8-9, 2011. Diagnoses included multiple sclerosis and history of a cerebrovascular accident. A quarterly MDS, dated 10/24/11, identified Resident #11 as frequently incontinent of urine and bowel, and required extensive assistance with toileting and personal hygiene. Resident #11's admission care plan identified the problem of "ELIMINATION" on 08/06/11. The care plan stated, ". . . Incontinent . . . Bladder and bowel assessment . . ." The admission care plan also identified the problem of "MOBILITY" on 08/04/11. Approaches included, ". . . Transfer: amount of assistance needed: ii [2] . . . 10/11/11 - Pal lift . . ." The care plan failed to identify the resident's specific toileting plan. Resident #11's current bowel/bladder assessment, dated 10/27/11, stated, "Focus: bowel and bladder retraining, Observation: resident is still unable to tell staff when she has to go to the bathroom, but resident is able to stand in pal lift for transfers, will try habit training, Action: will start toileting resident when she get [sic] up in the morning, before dinner, and again around 1300 [1:00 p.m.]. Staff will toilet resident before supper, and with HS [bedtime] cares and check and change on last rounds on PM shift. NOC [night] staff will check and change resident in bed."	F 315		

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F 315	Continued From page 10 Observation on 11/08/11 at 4:50 p.m. showed two CNAs (#11 and #12) checked and changed Resident #11's wet pad/underwear as she lay in bed. The CNAs (#11 and #12) used a mechanical lift to transfer the resident to her wheelchair and then took the resident to the dining room for supper. The staff members failed to toilet Resident #11 before supper, as per her toileting plan. During an interview on 11/09/11 at 9:45 a.m., an administrative nurse (#1) stated staff are aware of Resident #11's toileting plan, initiated on 10/27/11, and should toilet the resident accordingly. - Review of Resident #9's medical record occurred on November 8-9, 2011. A quarterly MDS, dated 10/23/11, identified the resident required extensive assistance with toilet use, frequently incontinent of bowel and bladder, on a current urinary toileting program, and not on a current bowel toileting program. A "Bowel and Bladder Training Program Review," dated 09/14/11, stated, ". . . staff will continue to check and toilet resident at the beginning and before the end of each shift and also before meals and any activities . . . No improvement noted at this time, resident continues to have episodes of incontinence on each shift . . . No change needed at this time. . . ." On 11/08/11 at 5:50 p.m., observation identified a CNA (#16) assisted Resident #9 with bedtime cares. The CNA stated she would not be toileting Resident #9, but would check his brief for incontinence and change it if necessary. The	F 315		

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F 315	Continued From page 11 CNA (#16) stated staff toilet Resident #9 only for bowel movements. Observation on 11/09/11 at 9:05 a.m. showed a CNA (#17) assisted Resident #9 with morning cares. Observation showed the CNA changed Resident #9's brief, wet with urine, and transferred him from the bed to the wheelchair. The CNA (#17) did not offer to toilet Resident #9 prior to transporting him to breakfast. The CNA stated Resident #9 uses the toilet only for bowel movements. On 11/09/11 at 10:20 a.m., observation identified a CNA (#17) assisted Resident #9 from the wheelchair to his bed. The CNA (#17) stated it is the resident's preference not to use the toilet to void. She stated Resident #9 has stated he is unable to feel the urge to void and prefers to be checked and changed for urinary incontinence. During an interview on 11/09/11 at 10:30 a.m. an administrative nurse (#5) stated the interdisciplinary team expects staff to follow Resident #9's bowel and bladder program to "keep him as dry as possible."	F 315		
F 372 SS=B	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the containment of garbage in 1 of 1 garbage dumpster for 2 of 3	F 372		

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F 372	Continued From page 12 days of survey (11/07/11 and 11/09/11). Failure to ensure containment of garbage increases the potential for pest and rodent infestation. Findings include: - Observation on 11/07/11 at 12:30 p.m., showed the facility dumpster with garbage piled approximately three to four feet above the rim of the dumpster and three bags of garbage stacked beside the dumpster. During an interview on 11/07/11, at 12:35 p.m. a maintenance supervisor (#8) stated the facility provider empties the garbage dumpster on Monday and Thursday. - Observation on 11/09/11, at 1:15 p.m., showed the facility dumpster with one lid open and a bag of garbage protruding above the rim of the dumpster. A second lid of the dumpster showed the lid could not close completely due to the tied top of another protruding garbage sack. During an interview on 11/09/11 at 1:20 p.m., a maintenance supervisor (#8) stated staff know when the front of the dumpster is full, and they are to place garbage to the back of the dumpster so the lids will close.	F 372	F-372 Maryhill Manor is committed to providing a safe and sanitary environment for our residents. To that end, Maryhill will do the following to enhance sanitation: 1. On the 11/7/11 date, the garbage company was delayed in coming to Maryhill to pick up garbage due to a truck breakdown. All staff are being instructed and reminded to ensure garbage is completely contained in the dumpster and the lids are totally closed. 2. All residents have the potential to be affected by sanitation practices. 3. In addition to instructing staff on proper garbage containment, we are arranging alternate pick-up days with the garbage company. 4. A Quality Assurance check will be completed by a nurse under the direction of the Support 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 all garbage contacted in the dumpster? b. Were the dumpster lids completely closed?	12-13-11
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

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F 431	Continued From page 13 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of professional literature, the facility failed to date opened multi dose vials in 1 of 2 medication storage areas (Sweat Pea/Dogwood and Primary) in accordance with currently accepted professional standards and facility expectation. Failure to record the open date on the vials and to ensure a current date prior administering insulin	F 431	F-431 Maryhill Manor is committed to providing the safe handling and distribution of all drugs and biologicals. To that end, Maryhill will do the following to enhance our practices: 1. The dating and labeling of multi-dose vials was reviewed at a nurses meeting on 11/29/11. 2. A systematic change will take place with the checking of outdates on every two weeks instead of the current monthly practice. 3. A Quality Assurance check of the ER kit and medication carts will be completed by the Nursing Services Coordinator or their designee once a month for three months and quarterly for one year as follows: a. Was the bottle/vial labeled? b. Was the date within the expiration date?	12-13-11

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F 431	Continued From page 14 allows use beyond the recommended discard time frames. This practice may affect the potency and sterility of the insulin. Findings include: Diabetic Care, Volume 26, Number 9, September, 2003, pages 2666-2667, "How Long Should Insulin Be Used Once a Vial Is Started?" states, ". . . Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been in use for >1 [more than 1] month . . . Insulin products are sterile until the first dose is withdrawn by syringe...After first use, the contents of the vial . . . are technically no longer sterile . . . Sterile products should be used in as short a time as possible to minimize concerns about microbiological contamination once the container has been punctured. - An observation of medication pass, on the Sweet Pea/Dogwood team station, occurred with a certified medication aide (CMA) (#7), on 11/07/11 at 5:41 p.m. The CMA (#7) obtained an opened vial of insulin for Resident #16, identified an opened date of 09/29/11, and discarded the bottle. - Observation of the Sweet Pea/Dogwood medication storage area occurred on 11/08/11 at 2:40 p.m. with a staff nurse (#10). The refrigerator contained an open multi dose vial of Lantus insulin, which lacked a date opened. During an interview on 11/09/11 at 12:07 p.m., an administrative nurse (#1) stated the facility expectation is for nursing staff to date a	F 431		

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F 431	Continued From page 15 multi-dose vial when opened. The nurse stated an opened insulin vial is good for 28 days.	F 431		
F 441 SS=E	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 Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F-441 Maryhill Manor is committed to providing a safe and sanitary environment that prevents the spread of disease and infection to the greatest extent possible. To that end, we will do the following to enhance our practices: 1. Proper infection control procedures have been reviewed with the individual nurses observed during survey. 2. All residents have the potential to be affected by infection control practices. 3. a. A review of proper infection control procedures, particularly related to dressing changes and gloving/handwashing practices was held with nurses and C.N.A.'s on 11/29/11. b. C.N.A.'s and nurses were reminded at the meeting on 11/29/11 to assist/encourage residents to wash their hands, particularly after using the toilet. c. Each nurse will be observed performing wound care/dressing changes by the Nursing Services Coordinator to demonstrate proper procedures. Continued on next page	12-13-11

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F 441	Continued From page 16 infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow effective infection control techniques for 2 of 3 sampled residents (Resident #4 and #6) observed during dressing changes and 3 of 10 sampled residents (Resident #2, #4, and #11) observed receiving personal cares. Failure to follow infection control practices/hand hygiene has the potential to transmit diseases and infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "APPLICATION OF CLEAN DRESSING" occurred on 11/09/11.This policy, revised May 2007, stated, "PURPOSE: 1.To remove soiled dressing without spreading infection. 2. To apply dressings without contamination of the wound .... GENERAL INSTRUCTIONS: 1. Wash your hands before, during, and after the procedure .... 5. Apply clean gloves. 6. Remove wound dressing and place in plastic bag 7. Remove gloves and wash hands. 8. Apply clean gloves .... 10. Cleanse the wound 11. Apply new dressing ... and tape in place .... 12. Remove gloves and wash hands. . . ." Review of the facility policy titled "MRSA [methicillin resistant staphylococcal aureus] CONTACT PRECAUTION GUIDELINES"	F 441	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. Did the nurse follow proper handwashing techniques? b. Did the nurse use gloves appropriately? c. Did any equipment used (i.e. scissors) receive proper sanitation after completing the procedure? In addition, a check to ensure that residents were cued to wash their hands will be included with the C.N.A. peri-care/handwashing QA conducted for F315.	

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F 441	Continued From page 17 occurred on 11/09/11. This policy, revised October 2011, stated, "PURPOSE: 1. To provide a safe, sanitary and comfortable environment for our personnel, residents, and visitors. 2. To prevent the development and transmission of MRSA infections .... 7. Gloves ... should be worn if contact with secretions is anticipated ... A handout is included to demonstrate the appropriate procedure for donning and removing personal protective equipment [PPE .... PPE-Gloves: Gloves should be changed - Between tasks and procedures on the same client - After contact with material that may contain a high concentration of microorganisms - After contact with infective material that may have high concentration of bacteria or virus ... Between client care procedures as soon as safety permits. Gloves should be removed as soon [sic] after the task is completed. Hands should be washed before touching the environment .... " Review of the facility policy titled "INFECTION PREVENTION AND CONTROL PROGRAM" occurred on 11/09/11.This policy, revised September 2010, stated, "... Hand Hygiene, 1. Hand hygiene continues to be the primary means of preventing the transmission of infection ... 6. Because ABHR [alcohol based hand rub] 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, antimicrobial agents such as ABHR are also appropriate for cleaning hands and can be used for direct resident care: ... Before and after changing a dressing ... 9. Residents will be	F 441		

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F 441	Continued From page 18 encouraged and assisted as needed to perform hand hygiene after any personal cares and prior to eating meals. Individual ABHR wipes will be available for resident use in their bathrooms, in the public restrooms, and in the dining room ... " - During the initial tour of the facility, on 11/07/11 at 12:30 p.m., a nursing staff member (#18) identified Resident #6 is in contact isolation with a right lower extremity venous ulcer infected with MRSA. On 11/08111 at 9:25 a.m., observation showed a licensed nurse (#3) entered Resident #6's room to perform a dressing change to her right lower extremity (RLE). The nurse (#3) washed her hands, donned gloves, and cut a new dressing to the size of the wound. Using the same scissors, she cut off the dressing wrapped around Resident #6's RLE and removed the soiled dressing from the wound. Observation showed a moderate amount of brown drainage on the soiled dressing. Without changing her gloves and performing hand hygiene, the nurse (#3) applied the new dressing, covered it with a non-stick dressing and wrapped the wound with gauze. Wearing the same gloves, the nurse entered the drawers of the supply cart in the room and put away the dressing supplies and scissors. The nurse did not remove her gloves and wash her hands until she was ready to exit Resident #6's room. During an interview on 11/08/11, at 9:45 a.m., when asked, the nurse (#3) stated she did not sanitize the scissors prior to replacing them in the resident's dressing cart. - Review of Resident #4's medical record	F 441		

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F 441	Continued From page 19 occurred on all days of survey. A progress note, dated 11/04/11 at 1:39 p.m., identified a 3 centimeter open area on the resident's right hip. On 11/08/11 at 9:45 a.m., observation showed a licensed nurse (#3) entered Resident #4's room to perform a dressing change. The nurse (#3) washed her hands, donned gloves, and removed the soiled dressing from Resident #4's right hip. Without removing her gloves or performing hand hygiene, the nurse (#3) cleansed the wound with a saline soaked gauze and applied a fresh dressing to the wound. During an interview on 11/09/11at 9:45 a.m., an administrative nurse (#1) stated she expects staff to change gloves and perform hand hygiene after the removal of a soiled dressing, before cleansing the wound and applying a clean dressing. - Review of Resident #4's medical record occurred on all days of survey. A significant change Minimum Data Set (MDS), dated 09/07/11, identified the resident as occasionally incontinent of urine and required extensive assistance with toileting and personal hygiene. On 11/08/11 at 7:55 a.m., observation showed a CNA (#6) responded to a bathroom call light and assisted Resident #4 off the toilet After assisting the resident, the CNA washed her hands, but did not encourage or assist Resident #4 to wash his hands. - Review of Resident #2's medical record occurred on all days of survey. A quarterly MDS, dated 09/13/11, identified the resident as continent of urine, occasionally incontinent of	F 441		

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F 441	Continued From page 20 bowel, and requiring extensive assistance with toileting and personal hygiene. On 11/08/11 at 9: 15 a.m., observation showed a CNA (#6) assisted Resident #2 with toileting. The resident voided in the toilet and completed perineal cares independently. After assisting the resident, the CNA used hand sanitizer to cleanse her own hands, but failed to encourage or assist Resident #2 to perform hand hygiene. Resident #2 then walked to the dining room for breakfast. Observation on 11/08/11at 10:20 a.m. showed a CNA (#6) assisted Resident #2 with toileting. The resident voided in the toilet and completed perineal cares independently. After assisting the resident, the CNA used hand sanitizer to cleanse her own hands, but failed to encourage or assist Resident #2 to perform hand hygiene. - Review of Resident #11's medical record occurred on November 8-9,2011. A quarterly Minimum Data Set (MDS), dated 10/24/11, identified the resident as frequently incontinent of urine and bowel and required extensive assistance with toileting and personal hygiene. Observation on 11/08/11 at 4:50 p.m. showed two certified nursing assistants (CNAs) (#11 and #12) checked and changed Resident #11's wet pad and underwear as she lay in bed. A CNA (#11) performed perineal cares, changed the resident's wet clothing, placed a new pad and a clean pair of underwear, and removed her gloves. Without performing hand hygiene, the CNA (#11) left the resident's room to get the mechanical lift. The CNA (#11) transferred the resident to her wheelchair, put a jacket on Resident #11,	F 441		

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F 441	Continued From page 21	F 441		

brushed her hair, placed a blanket on the resident's lap, applied the footpedals to the wheelchair, bagged the soiled linen and garbage, left the resident's room, and washed her hands in the soiled utility room. The CNA (#11) failed to perform hand hygiene after completing perineal care and before performing other tasks.

Observation on 11/09/11 at 8:25 a.m. showed a CNA (#13) checked and changed Resident #11's wet pad and underwear as she lay in bed. The CNA (#13) performed perineal cares, placed a new pad and a clean pair of underwear, and removed her gloves. The CNA (#13) then placed the supplies in the resident's drawer, finished dressing Resident # 11, rinsed out and bagged the wash basin used for morning cares, placed the resident's bilateral hearing aides, brushed the resident's hair, left the resident's room to get the mechanical lift, and transferred the resident onto the toilet. While Resident #11 remained on the toilet, the CNA (#13) washed her hands for the first time since beginning morning cares. After a few minutes, the CNA (#13) donned gloves, completed perineal cares, removed her gloves, pulled up the resident's pants, transferred her back to her wheelchair, completed oral cares using a mouth swab, brushed her hair again, placed a blanket on the resident's lap, applied the footpedals to the wheelchair, and then took Resident # 11 to the dining room for breakfast. The CNA (#13) failed to perform hand hygiene after completing perineal care and prior to performing other tasks.

During an interview on 11/09/11 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene immediately after

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F 441	Continued From page 22 completing perineal cares and prior to completing other tasks. This nurse also stated she expects staff to offer residents the opportunity to wash their hands after toileting.	F 441		