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	355057	A. BUILDING _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBILIER NURSING CENTER	500 DELANO AVE WALHALLA, ND 58282

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/29/23 and concluded 02/01/23.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 1 of 12 sampled residents (Resident #8). Failure to accurately complete Section N (Medications) of the MDS, may negatively affect the development of a comprehensive care plan, and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2019, page N-7, states, ". . . N0410H, Opioid: Record the number of days an opioid medication was received by the resident at any time during the 7-day look-back period. . . ." Review of Resident #8's medical record occurred on 01/31/23. The current physician's orders lacked an order for an opioid. A quarterly MDS, dated 10/27/22, identified staff coded section N for opioid use all seven days of the look-back period.	F 641	1. Resident #8 MDS's dated 10/27/2022 and 01/27/2023 were modified on 02/23/2023 and submitted to the state on 02/23/2023 reflecting the change in opioid medications administered during the assessments. Resident #8 had been on Tramadol for a short time on March 19th of 2021 and the medication was discontinued on 03/25/2021 per physician orders. The MDS did not reflect this change. Opioid administration was changed to 0 times administered in last 7 days on both assessments. 2. All residents current MDS assessments were reviewed on 02/23/2023 for proper coding of Section N. No other areas were identified. 3. The MDS Coordinator will continue to monitor medication information with each MDS completion. Medications administered will be correctly entered into Section N of the MDS based on prior 7 day usage and current physician orders. 4. A QA study will be conducted monthly for 6 months on all MDS assessments to include Section N (Medications) to ensure	2/24/23

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

Electronically Signed | 02/24/2023

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F 641	Continued From page 1 During an interview on the afternoon of 01/31/23, an administrative nurse (#1) confirmed staff coded section N of the MDS incorrectly for Resident #8.	F 641	correct data entry of current medications. The QA team will review findings immediately and quarterly to ensure continued compliance. 5. February 28th, 2023	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of the facility reported incident, record review, review of facility policy, review of facility documents, and resident and staff interview, the facility failed to provide adequate assistance for 1 of 2 sampled residents (Resident #32) reviewed for transfers with a full body mechanical lift. Failure to ensure the correct use of transfer devices resulted in an injury for Resident #32, and placed all residents requiring full body mechanical lifts at risk for falls and injury. Findings include: A review of the facility policy titled "Safe Resident Handling/Transfers" occurred on 02/01/23. This undated policy stated, ". . . Two staff members must be utilized when transferring residents with a mechanical lift. . . ."	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

Review of the initial incident report sent to the State Survey Agency (SSA), dated 05/12/22, concerning Resident #32 and a certified nursing assistant (CNA) (#3) on 05/11/22 stated, ". . . Staff member was transferring resident with a hoyer lift [full body mechanical lift]. Lift tilted to side and resident slid out of hoyer canvas and bumped her head on arm of hoyer. TLC [tender loving care] was provided and first aid (ice) provided to resident as a comfort measure only." The facility's plan to protect all residents during the investigation stated, ". . . Staff were brought together at shift change and reviewed policy which states two people with hoyer transfers."

During an interview on 01/29/23 at 4:35 p.m., Resident #32 stated "No" if she had ever fallen, and further stated, "A long time ago I slid in that thing [full body mechanical lift] and bumped my head. I had a little goose egg."

Review of Resident #32's medical record occurred on 01/31/23 and 02/01/23, and included diagnoses of Alzheimer's disease, and osteoarthritis. The current care plan stated, ", , , I need extensive to total assistance with ADLs [activities of daily living] . . . Transfers - Hoyer lift with staff assist of 2. . . ."

Review of the facility provided documentation regarding Resident #32's injury with the hoyer lift identified the following:
* 06/14/22 Nurse (#2) reported "[CNA #3] reported to me last evening that she didn't have the legs set wide enough apart on the lift and that the swinging bars on the hoyer lift swung against a residents [sic] forehead, [resident name]. [Resident #32's name] was laying [sic] in bed

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with no bruising or any bumps observed to forehead or anywhere. She said it 'Hurt a little' but declined offer of Tylenol. Vitals and neuro [neurological] assessment were normal. I was able to get another set of vitals this morning, which were also normal, and still no bumps or bruises present."

Review of the facility's investigation report identified the following:
". . . [CNA #3] was attempting to raise the lift up over the bed to sit [resident name] up but 'did not have the legs open far enough so it started to tip forward. . . . the crossbars were swinging, did not hit her directly in the head but swung across her forehead.' She then stated that she was immediately able to stabilize the lift and [resident name] was laying on the bed, she then called another CNA on the walkie [portable voice system] that came to assist her and [resident name] was transferred safely into her wheelchair. . . ."

During an interview on the afternoon of 01/31/23, an administrative nurse (#1) stated the facility conducted annual skills validations, which included mechanical lifts, for all staff in July 2022, and further stated the Quality Assurance committee monitored competencies and any risks for falls or injury.

Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient practice by:
* CNA (#3's) counseling form, dated 06/14/22, stated the following: "1. Observation of

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F 689	Continued From page 4 employee's conduct: Will monitor proper use of transfers using lifts for minimum of 90 days (and ongoing). . . ." * Documentation dated June 14-16, 2022 titled, "Electronic Total Lift Competency *Hoyer Lift" showed the facility assessed all the CNAs' competency with full body mechanical lifts. * Completed an investigation with interviews of the resident and staff involved during the incident on 05/11/22. * Determined the investigation showed CNA #3 failed to follow the mechanical lift policy, which resulted in minor harm (little goose egg) per the nurse (#2's) assessment. * Provided education to staff following incident regarding the requirement of two staff with all mechanical lift transfers. The facility addressed measures put in place to ensure the deficient practice does not recur by: * Providing competency validation for mechanical lifts with all staff in July 2022. * Providing monitoring by the Quality Assurance committee of staff competence with mechanical lifts.	F 689		
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.	F 880		2/24/23

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F 880	Continued From page 5 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 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	F 880		

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F 880	Continued From page 6 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 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 interviews, the facility failed to follow standards of infection prevention and control for 1 of 1 sampled resident (Resident #22) observed during nebulizer treatment. Failure to follow infection control standards related to performing aerosol-generating procedures has the potential to transmit infections to other residents, staff, and visitors. Findings Include: Review of the facility policy/procedure titled "Coronavirus Preventions and Response" occurred on 01/31/2023. This policy, dated October 2022, stated, ". . . consider implementing broader use of respirators and eye protection by HCP [healthcare personnel] during resident care encounters . . . having HCP use PPE [personal	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensure staff have adequate knowledge of following precautions during aerosol-generating procedures. The DON, staff development coordinator	

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F 880	Continued From page 7 protective equipment] . . . particulate respirators with N95 filters or higher used for . . . all aerosol-generating procedures . . . Observation on 01/30/23 at 10:32 a.m., showed Resident #22's resting in bed receiving a nebulizer [breathing] treatment. The open door lacked signage for aerosol precautions and the staff nurse (#5) administering the treatment failed to wear an N95 mask. During an interview on 02/01/23 at 08:30 a.m., with two administrative staff members (#1 and #4), confirmed staff should follow infection control guidelines.	F 880	(SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all staff on appropriate precautions during aerosol-generating procedures. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 03/03/2023 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to follow the correct precautions when administering aerosol-generating medications/treatments. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable	

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F 880	Continued From page 8	F 880	designee will ensure the following: a. Educate staff on following infection control precautions and personal protective equipment (PPE) use when administering aerosol-generating medications/treatments. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of staff types to ensure proper infection control practices and PPE use when administering aerosol-generating medications/treatments. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms.	

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F 880	Continued From page 9	F 880	After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 03/03/2023	