STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355057	A. BUILDING _____ B. WING _____	09/30/2021

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 09/27/21 and concluded 09/30/21.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and review of the facility policy, the facility failed to follow professional standards of practice for 1 of 4 residents (Resident #26) observed receiving oral medications. Failure to administer medications as recommended may affect the absorption and efficacy of the medication. Findings include: Review of a professional reference found at https://www.drugs.com/drug-interactions/levothyroxine.html, updated May 2021, indicated, ". . . Levothyroxine (a thyroid hormone replacement) oral works best if you take it on an empty stomach, 30 to 60 minutes before breakfast. . . . Certain medicines can make this medicine less effective if taken at the same time. If you use any of the following drugs, avoid taking them within 4 hours before or 4 hours after you take levothyroxine: calcium carbonate [calcium supplement] . . . ferrous sulfate [iron supplement] . . . vitamins . . ."	F 658	1. The DON reviewed the policy titled Medication Administration on 9/29/21. Resident #26 (and 3 other residents) who were receiving Levothyroxine with other medications at close proximity to breakfast were all adjusted to be administered 1 hour prior to breakfast without other medications. 2. All nursing staff reviewed the policy titled Medication Administration on 9/30/21 and verbalized that they understood that Levothyroxine should be given 30-60 minutes prior to breakfast without other medications, as well as understanding all other medication administration guidelines as stated in policy. The consultant pharmacist reviewed all resident medication administration records on 10/14/21, with no further medication administration issues noted. 3. The consultant pharmacist will monitor all medication administration and resident administration records on a	10/21/21

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

Electronically Signed | 10/21/2021

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F 658	Continued From page 1 Review of the facility policy titled "Medication Administration" occurred on 09/30/21. This policy, reviewed 2021, stated, ". . . Medications are administered . . . as ordered by the physician and in accordance with professional standards of practice . . . Medications requiring administration on an empty stomach: Levothyroxine . . ." Review of Resident #26's medication administration record (MAR) for September 2021 included the following medications: * Levothyroxine tablet; 200 mcg (micrograms); oral, once a day * Levothyroxine tablet; 50 mcg; oral, once a day * Viactiv (a calcium-vitamin D3-vitamin K supplement * Ferrous sulfate once a morning Observation on 09/29/21 at 8:44 a.m. showed a nurse (#7) administered to Resident #26 the levothyroxine, along with other scheduled morning medications which included Viactiv and ferrous sulfate. The facility failed to administer Resident #26's levothyroxine according to the professional recommendations.	F 658	monthly basis and report any deviations from Medication Administration policy to DON immediately for review and correction. 4. The DON will perform QA study weekly for 1 month, then bi-weekly for one month, then monthly for 6 months on medication administration, in conjunction with consultant pharmacist. Findings will be shared quarterly at Medical Staff meeting. 5. October 29, 2021	
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	F 689		10/21/21

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F 689	Continued From page 2 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 2 sampled residents (Resident #134) observed during a transfer. Failure to use a gait belt when transferring a resident placed the resident at risk for falls and injury. Findings include: Review of the facility policy titled "Use of Gait Belt Policy" occurred on 09/29/21. This policy, revised 2021, stated, "Policy: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. . . ." Review of Resident 134's medical record occurred on all days of survey. The care plan stated, "At risk for falls: [Resident #134] needs hands on assist with ambulation and transfers. . . . Transfers - limited to extensive assist of 1. . . ." Observation on 09/28/21 at 10:10 a.m. showed two certified nursing assistants (CNAs) (#2 and #3) transferred Resident #134 from the bed to the bath chair. Both CNAs lifted under the resident's arms during the transfer. The CNAs failed to use a gait belt during the transfer. Observation on 09/28/21 at 10:35 a.m. showed a CNA (#2) transferred resident #134 from the bath chair to a standing position and lifted under the resident's arm. The CNA failed to use a gait belt	F 689	F689 Free of Accidents/Hazards 1. Resident #134 care plan was reviewed on 9/30/21 with all CNA staff. Policy titled use of Gait Belt was reviewed at this time and staff verbalized understanding. 2. All CNA staff did return demonstration of safe and proper transfer technique with use of gait belt to DON/Nurse on 10/18/21. Policy titled use of Gait Belt was reviewed again with all CNA staff, all CNA signed policy stating understanding. 3. A QA study will be conducted by the DON weekly x1 month, then bi-weekly x1 month, then monthly for 6 months, during various shifts, on proper use of gait belts during transfers. Results will be communicated at our quarterly QA meeting and also monthly with all staff. 4. Annual training will be provided to all CNA staff to ensure proper transfer techniques continue to be used when using a gait belt for transfer. 5. October 29, 2021	

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F 689	Continued From page 3 to assist the resident to a standing position. Observation on 09/28/21 at 12:05 p.m. showed a CNA (#2) lifted under Resident #134's arm to transfer the resident from the wheelchair to a dining room chair. The CNA failed to use a gait belt during the transfer. During an interview on 09/30/21 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt when transferring residents.	F 689		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of a professional reference, the facility failed to ensure each resident received food in a form designed to meet the individual resident needs for 1 of 1 sampled resident (Resident #14) with physician's orders for a texture modified diet. Failure to serve food according to physician's orders placed the resident at risk for reduced meal intake, choking, and aspiration pneumonia. Findings include: Review of the facility policy titled "Texture and Consistency-Modified Diets" occurred on 09/30/21. This undated policy stated, ". . . Nursing staff will notify the director of food and	F 805	1. Resident #14 diet order was reviewed on 09/30/2021. The care plan along with the dietary manager determined resident #14 will receive ground meats per physician order. 2. All diet orders were reviewed for accuracy to include current diet/texture orders and matched against dietary nutrition cards on October 4th, 2021. No other diet textures were found to be out of compliance 3. The dietary manager will monitor meal serving monthly for 6 months on various shifts and inspect resident trays as they	10/21/21

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F 805	Continued From page 4 nutrition services of consistency changes ordered by the physician . . . The food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency ordered. . . ." Review of Resident #14's medical record occurred on all days of survey and identified the physician ordered a regular diet with ground meats on 06/04/20. The nutritional assessment, dated 08/04/21, the current care plan, and the resident's tray card also identified Resident #14 received a regular diet with ground meat. Observations of Resident #14 included the following: * 09/27/21 at 6:14 p.m., a meal plate containing a whole piece of country style sausage. * 09/28/21 at 12:15 p.m., a CNA (#9) placed to the resident's mouth and encouraged the resident to eat a hamburger in a bun. * 09/29/21 at 12:07 p.m., a CNA (#10) fed the resident bone-in chicken wings cut up into small pieces, and stated, "She really doesn't eat the food. She just chews on it for the flavor then spits it out." The facility provided a copy of the "ORAL FEEDING RISK RESPONSIBILITY WAIVER." Review of the waiver, dated and signed by Resident #14's power of attorney (POA) on 01/13/21, identified the facility counseled the POA on the risks and health complications associated with oral feedings. The waiver failed to identify the specific diet desired by the POA or that the POA did not want ground meats for Resident #14.	F 805	are dished in the kitchen for accuracy in diet textures. Any issues with non-compliance will be reported to the DON immediately. 4. The dietary manager will perform a QA weekly x1 month, then bi-weekly x1 month, then monthly for 6 months on diet orders and textures. Findings will be shared with the QA committee at the quarterly medical staff meeting. 5. 10/04/2021	

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F 805	Continued From page 5 The facility staff failed to ensure Resident #14 received ground meats as per physician's orders and care plan.	F 805		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and 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	F 880		10/21/21

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F 880	Continued From page 6 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 4 days of	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and	

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F 880	Continued From page 7 survey (September 27-29, 2021). Failure to follow infection control practices related to hand hygiene/glove use (Resident #3, #5, and #7) and properly donning personal protective equipment (staff member #5) has the potential to transmit infections to other residents, staff, and visitors. Findings include: HAND HYGIENE/GLOVE USAGE Review of the facility policy titled "Personal Protective Equipment" occurred on 9/29/21. This policy, revised 2021, stated, ". . . Wear gloves when direct contact with blood, body fluids . . . is anticipated. Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. . . . Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another . . ." Observations showed the following: - 9/28/21 at 10:40 a.m., a certified nursing assistant (CNA) (#4) donned gloves, performed perineal care for Resident #7, removed the gloves, assisted an unidentified CNA with a transfer, and exited the room without performing hand hygiene. - 09/28/21 at 11:06 a.m., two CNAs (#9 and #11) assisted Resident #5 to the bathroom utilizing the sit-to-stand lift. The CNA (#9) donned gloves and performed perineal care. Without removing her gloves, the CNA adjusted the resident's clothing, assisted to transfer the resident to her wheelchair, placed a cloth mask on the resident's face, removed the resident's sweater, and	F 880	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 perform hand hygiene when removing gloves, after perineal cares, and before exiting a resident's room in accordance with CDC guidelines. (2) Ensure staff administering medications do not have bare hand contact with medications. (3) Ensure staff continuously wear a surgical face mask, covering both nose and mouth in accordance with guidelines from the CDC. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current 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 10/29/2021 the facility shall complete the following actions:	

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F 880	Continued From page 8 grabbed the handles of the resident's wheelchair. The CNA (#9) failed to remove her gloves and perform hand hygiene after perineal care and before completing other tasks. During an interview on 9/30/21 at 9:45 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene after glove removal and before exiting the resident's room. MEDICATION ADMINISTRATION Review of the facility policy titled "Medication Administration" occurred on 09/30/21. This policy, reviewed 2021, stated, ". . . Remove medication from source, taking care not to touch medication with bare hand. . . ." Observation on 09/29/21 at 8:29 a.m., showed a nurse (#7) punched out multiple medications from Resident #3's medication cards into a medication cup. The nurse dropped two of the medications on top of the medication cart, picked them up with her bare hands, and placed the medications into the medication cup prior to administering them to the resident. PERSONAL PROTECTIVE EQUIPMENT Review of the Centers for Disease Control and Prevention (CDC) guidance found at: https://www.cdc.gov, updated August 13, 2021, stated, "Your Guide To Masks . . . wear a mask that covers your nose and mouth . . . How not to wear a mask . . . under your nose . . ." Observations during survey showed the following:	F 880	(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 complete hand hygiene in accordance with CDC guidelines. b. Failure to ensure staff do not have bare hand contact with medications. c. Failure to wear surgical mask covering nose and mouth. 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, IP or suitable designee will ensure the following: a. All staff will receive education on proper hand hygiene after perineal care, after removing gloves and before exiting a resident's room. b. Licensed staff will receive education on bare hand contact with medications. c. All staff will receive education on the proper use of a surgical mask. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, 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 certified nursing staff to ensure performance of proper hand hygiene, when indicated, in the course of their routine duties.	

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F 880	Continued From page 9 * 09/27/21 at 5:35 p.m. a dietary staff member (#5) checked food temperatures wearing a surgical mask below her nose. * 09/28/21 at 5:25 p.m. a dietary staff member (#5) prepared resident meal trays in the kitchen wearing a surgical mask below her nose. During an interview of the morning of 09/30/21 an administrative staff (#1) stated she expected staff to wear a mask covering their nose and mouth.	F 880	(2) Observation of licensed staff passing medications. (3) Observation of all staff wearing surgical mask in accordance with guidelines for the CDC. 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. 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 10/29/2021	