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 _____	10/23/2014

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 For the standard Medicare/Medicaid recertification survey, started on 10/20/14 and completed on 10/23/14, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 3 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 observation, review of manufacturer's instructions, and staff interview, the facility failed to follow professional standards of practice to properly prime (a procedure to expel air from the needle attached to an insulin pen) an insulin pen for 1 of 1 resident (Resident #13) observed receiving insulin. Failure to follow the manufacturer's recommendation for priming an insulin pen has the potential for residents to receive an incorrect dose of insulin. Findings include: The facility provided the manufacturer's instructions for NovoLog FlexPen as they did not have a policy. Review of the NovoLog FlexPen manufacturer's instructions occurred on 10/22/14. The instructions stated, "Patient Instructions For Use NovoLog FlexPen . . . Giving the airshot before	F 281	1. Physician insulin orders for Resident #13 were reviewed as well as administration guidelines for administering insulin using a flexpen. 2. Physician insulin orders were reviewed for all residents that receive insulin with a flexpen. A facility policy "Administering Insulin with a Flexpen" was developed and reviewed with all nurses on 10/22/14. 3. All nurses will be inserviced by 11/18/14. Documentation will be available to them by the Director of Nursing to review and to educate them on the proper procedure of priming an insulin flexpen for use. 4. A QA Study will be completed monthly for six months by the Director of Nursing on various shifts to monitor the compliance with proper priming and administration of insulin with the flexpen. Results will be presented at the quarterly QA meeting. 5.	11/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Fraser
TITLE: Administrator
(X6) DATE: 11/7/14

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 each injection - Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing E. Turn the dose selector to select 2 units . . . F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge . . . G. Keep the needle pointing upward, press the push-button all the way in . . . A drop of insulin should appear at the needle tip. . ." Observation on 10/20/14 at 5:20 p.m. showed a licensed nurse (#3) prepared Resident #13's insulin injection. The nurse failed to prime the insulin pen before administering the insulin. Observation on 10/21/14 at 5:25 p.m. showed a licensed nurse (#4) prepared Resident #13's insulin injection. The nurse failed to prime the insulin pen before administering the insulin. During an interview on 10/22/14 at 1:30 p.m., an administrative nurse (#1) confirmed staff are expected to prime an insulin pen before administering insulin.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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	1. Resident #1 received an OT evaluation for transferring on 10/23/14. Resident #1 is now using a Hoyer lift for all transfers and toileting. 2. All residents who utilize the stand-aide for transfers were reviewed and assessed for appropriateness and correct posture. 3. The Director of Nursing will continue to review all residents that utilize quarterly, and with any change/decline in health status for appropriateness of the stand-aide. Any resident found not able to transfer per "E-Z	

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, manufacturer's recommendations, and staff interview, the facility failed to ensure safe transfers and re-evaluate the appropriateness of an assistive device for 1 of 2 sampled residents (Resident #1) observed during stand lift transfers. Failure to properly use a stand lift and re-evaluate appropriateness may result in unnecessary pain and a fall or injuries to residents. Findings include: Review of the E-Z Way stand lift Operator's Instruction manual occurred on 10/22/14. The instructions, dated 2009, stated, ". . . Patients should be able to bear some weight . . . The Seat Strap is used for additional lower body support and can be used for transferring . . ." Review of the facility policy titled "E-Z Stand Aide Policy" occurred on 10/22/14. This policy, dated 2009, stated, ". . . Purpose: To provide safe, comfortable transfers to residents. . . Patients should be able to bear some weight. . ." Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set, dated 08/12/14, identified extensive assist of two or more persons for transfers and severely impaired cognition. The care plan identified the problem of frozen right shoulder. The care plan stated, ". . . Approach: . . . Stand Aid Use - Continue to use stand aid with foot plate in higher position to fit resident. Position sling well under arms to prevent sliding . . . Resident refuses to use bed-side commode,	F 323	3. (continued) Stand Aide Policy" guidelines will be referred to OT for an evaluation. 4. A monthly QA will be conducted for six months by the Director of Nursing identifying all residents that utilize the stand-aide and if they are able to transfer per E-Z Stand Aide Policy guidelines appropriately. Any residents found not to be transferring appropriately will be referred to OT for an evaluation. Results will be presented and discussed at the quarterly QA meeting. 5.	11/18/14

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F 323	Continued From page 3 which was recommended by OT [Occupational Therapist]. Transfers- extensive assist of [two]. . . ." Resident #1's Therapy Services Screen identified the following: " . . . Functional skill level change observed by staff - Functional concerns of nursing staff: please eval [evaluate] for appropriateness of stand-aid use. . . . 05/07/14 Screen completed by OT. Continue with using stand aid for all transfers. 05/08/14 use bottom sling for [increased] safety [with] transfers to/from bed only. Bedside commode for toileting at all times. . . ." Observation on 10/21/14 at 1:30 p.m. showed two certified nursing assistants (CNAs) (#5 and #6) used the E-Z stand lift and transferred Resident #1 from the wheelchair to the toilet. During the transfer, the sling slid up under the resident's axilla and Resident #1's elbows raised to shoulder height causing the resident's shoulders to shrug upwards. Observation on 10/21/14 at 4:10 p.m. showed two CNA's (#7 and #8) used the E-Z stand and transferred Resident #1 off the toilet into the wheelchair. The resident grasped onto the hand grips and the sling slid up under the resident's axilla causing Resident #1 to hang in the lift with pressure under the axilla. As the licensed nurse (#9) observed the coccyx dressing, the resident stated "oh my arms." The CNA's then transferred Resident #1 into the wheelchair. When raised to a standing position to complete cares Resident #1's elbows raised to shoulder level and shoulders shrugged upwards. During a telephone interview on 10/22/14 at 2:15	F 323		

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F 323	Continued From page 4 p.m., a consulting OT (#9) stated she had not been informed that Resident #1 refused the bedside commode and the resident should be re-evaluated to determine the most appropriate method to transfer. During an interview on 10/22/14 at 2:40 p.m., a nurse manager (#1) indicated she was unaware of any issues regarding use of the lift.	F 323		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. 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 prepare food in a manner designed to meet individual needs for 1 of 4 sampled residents (Resident #6) with physician's orders for a mechanically altered diet. Failure to prepare food at the right consistency placed Resident #6 at increased risk of choking when eating. Findings include: Review of the facility policy "Level 2 Food Lists for Dysphagia: Mechanically Altered Foods" occurred on 10/22/14. The undated policy stated, ". . . Cooking and Preparation Tips . . . Vegetables: Moist, well cooked, soft boiled, baked, or mashed potatoes. All soft, well-cooked vegetables in pieces less than 1/2 inch size. . . . Foods Not	F 365	1. Physician diet orders for Resident #6 were reviewed by all dietary staff on 10/23/14. 2. Physician diet orders were reviewed on 10/23/14 for all residents that receive mechanically altered diets and reviewed with all dietary staff on 10/23/14. Food lists were also reviewed with staff at this time. 3. The dietary manager will continue to review all residents on mechanically altered diets quarterly and those with a change/decline in health status. Any resident showing difficulty with chewing/swallowing will be referred to speech for an evaluation. 4. A QA study will be completed monthly for six months by the dietary manager on various shifts to ensure residents on mechanically altered diets are receiving correct textures at meals and snack times. Results will be presented at QA meetings. 5.	11/18/14

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F 365	Continued From page 5 Recommended . . . Meat . . . tough meats (such as bacon, sausage . . .) . . ." Resident #6's medical record, reviewed on all days of survey, identified the following: 03/30/14 at 6:09 p.m.: emesis of undigested food in the dining room 04/07/14 at 5:50 p.m.: "foody emesis" of undigested meat balls in the dining room 04/26/14 at 5:15 p.m.: spit out tortellini and meat sauce at supper after choking on it 04/26/14 at 7:01 p.m.: staff sent a fax to the physician requesting a swallow evaluation to determine if the consistency of the food was causing the resident's coughing and choking episodes 05/10/14 at 12:20 p.m.: resident coughing and gagging on chicken at lunch - staff noted resident had whole chicken breast rather than ground meat An "Outreach Therapy Services Dysphagia Plan of Treatment," onset date 04/30/14, stated, "Patient seen for clinical dysphagia evaluation . . . pt [patient] does demonstrate [increased] mastication [chewing] [with] cut-up meats as well as whole kernel corn as still chewing & [and] had food remnants on tongue (skins of corn). . . ." A "Dysphagia Communication Note," dated 04/30/14, identified the Occupational Therapist recommended a regular diet with ground meat and level 2 vegetables. A physician's order, dated 05/10/14, stated, "Diet Level 4 Regular, Ground meats. Level 2 vegetables. Can have bread Thin/Regular liquids. No straws." Observations of Resident #6 during meals showed the following:	F 365		

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F 365	Continued From page 6 10/21/14 at 11:45 a.m.: received chicken on the bone (not ground), oven baked potatoes cut in approximately 3/4 inch chunks, and mixed vegetables with beans approximately two inches long. The resident consumed none of the chicken, potatoes, or vegetables. 10/22/14 at 7:33 a.m.: received oatmeal and a sausage link. The resident consumed the oatmeal and one bite of the sausage link. 10/22/14 at 11:40 a.m.: received ground beef and gravy with mashed potatoes and cooked carrots approximately two inches long. During an interview on 10/21/14 at 3:10 p.m. a dietary manager (#2) provided the dysphagia policy and stated staff should provide Level 2 vegetables cut in 1/2 inches pieces. When interviewed on 10/22/14 at 4:15 p.m. the manager (#2) stated the chicken Resident #6 received at noon on 10/21/14 may have been meant for another resident and agreed staff should have cut the potatoes served on 10/21/14 into smaller pieces and cut up the sausage link served on 10/22/14.	F 365		