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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 12/07/15 and completed on 12/09/15, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping services to maintain a clean/sanitary, comfortable, and odor free environment during 3 of 3 days of survey (December 07 - 09, 2015). Failure to prevent odors and maintain a clean/sanitary environment placed residents and staff in an uncomfortable and unpleasant environment. Findings include: The initial tour of the facility occurred on 12/07/15 at approximately 2:55 p.m. Observation showed the following: * an unpleasant odor on hallway B * a garbage cart containing soiled briefs in the middle of hallway B * the plastic kick guards bent and/or chipped on the doors to room 40, 41, and 43 (potential for	F 252	1. All dirty carts have been removed from the hallway on 01/13/2016. All soiled briefs and garbage will be taken to the soiled utility room when exiting rooms after providing cares. The plastic kick guards in room 40, 41 and 43 were replaced prior to survey team leaving the building. An air freshner was immediately placed in bathroom 43 and 44 and is checked daily and replaced when empty. The floor strips in 44 were replaced. The floor mat in room 40 was replaced. Two ceiling vents were cleaned immediately and the ceiling in room 38 and 40 was repaired. All of this was completed the day of the survey. 2. A walk-thru of the building was completed on December 23rd, 2015. No	1/13/16

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

Electronically Signed | 12/23/2015

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1 skin tears) * a strong urine odor in the bathroom between room 43 and 44 * the gripper strip in front of bed A in room 44 peeling away from the floor (accident/trip hazard) * a torn fall mat in room 40 (potential for skin tear and trip hazard) * the wallpaper/plaster hanging from the bathroom ceiling in room 38 and 40 * dust/debris on two ceiling air exchange vents in the B hallway Observation on all days of survey showed a garbage cart containing soiled briefs on hallway B and a unpleasant odor on hallway B. The environmental tour of the facility occurred on 12/09/15 at 1:00 p.m. with two administrative staff members (#3 and #4). Observation showed all the above issues present with the expection of the garbage cart which had been removed from hallway B. The staff members were not aware of the issues and stated housekeeping and direct care staff are expected to fill out a work order and provide it to the maintenance department when they identify things that need to be repaired, replaced, or cleaned. During an interview on 12/09/15 at 2:30 p.m., an administrative staff member (#6) stated the CNAs are expected to remove the garbage cart from hallway B after they have completed morning cares with the residents.	F 252	other areas in the building were identified. 3. Dirty carts will no longer be stored in the hallway. Staff will utilize the dirty utility room. A monthly maintenance inspection will be completed to monitor for needed environmental corrections for 6 months. Areas needing repair will be logged in the maintenance log and front desk for repair. Housekeeping staff will continue to clean all bathrooms daily and as needed. Rooms with odor problems will have appropriate air freshners put in place. Staff will be in-serviced on or before January 13th, 2016 on the procedure for reporting housekeeping/maintenance issues in log book at front desk. A binder will be kept at front desk for all staff to log needed tasks in. The binder will be checked multiple times per day by housekeeping/maintenance staff and corrections made. 4. January 13th, 2016 5. A monthly QA will be completed to address environmental hazards and odors in the building. The QA will be completed monthly for 6 months. Results will be reported to the QA team to ensure compliance has been achieved. The DON/Administrator will be responsible for ensuring compliance has been achieved in cooperation with the Housekeeping/Maintenance Supervisor.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		1/13/16

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 2 A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #5) after a significant change in the resident's condition. This limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one	F 274	1. Resident #5 care plan, nurse's progress notes and CNA documentation were reviewed by DON and MDS Coordinator on 12/23/2015 from resident's quarterly MDS submission dated 11/24/2015. The need for a significant change was identified and scheduled to be completed the week of 12/28/2015. 2. All of MDS submissions from this quarter were reviewed on 12/14/2015 by the DON and MDS Coordinator for all resident's triggering for decline in ADL's as per QM indicator. No other inconsistencies were observed. 3. Resident MDS dated 11/24/2015 will be corrected the week of 12/28/2015 and	

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 3 area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement), . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and bursitis of left hip. Resident #5's annual Minimum Data Set (MDS), dated 08/26/15, identified supervision of one person with bed mobility, transfers, walk in room, locomotion on and off unit, personal hygiene, and bathing. Resident #5's quarterly MDS, dated 11/24/15, identified extensive one person assistance with bed mobility, transfers, walk in room, locomotion on and off unit, personal hygiene, and bathing. The medical record lacked evidence staff completed a SCSA following Resident #5's decline in ADL's. During an interview on 12/09/15 at 10:45 a.m., an administrative nurse (#1) confirmed a SCSA should have been done.	F 274	correction request submitted to CMS/State after completion the week of 12/28/2015. All care plan team staff will be in-serviced on 01/13/2016 by the DON on the need for significant change MDS and when they are required to be completed. 4. January 13th, 2016 5. A QA study will be completed monthly for 6 moths of all MDS submissions that are triggering for decline in ADL's by the DON. QM reportes will be utilized to identify all residents who may be showing decline in ADL function. Results will be reviewed directly with the MDS Coordinator and presented at the quarterly QA meeting.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		1/13/16

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDS) accurately reflected the residents' status for 4 of 9 sampled residents (Resident #1, #3, #5, and #9). Failure to code the MDS correctly for delusions (Resident #9), wandering (Resident #3), falls (Resident #5), and bathing (Resident #1) does not provide an	F 278	1. Resident #1, #3, #5 care plans, nurse's progress notes and CNA documentation were reviewed by the DON and MDS Coordinator on 12/10/2015 for accuracy and consistency. All MDS corrections were made on 12/10/2015 and submitted to CMS/State. Resident #9 MDS was corrected on 12/23/2015 and correction request submitted to CMS/State	

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5 accurate assessment of the residents' current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, stated the following: * Page E-2 and E-3, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. . . . If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion." * Page E-18, "E0900: Wandering . . . Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period." * Page G-23, "G0120: Bathing . . . Code 4, total dependence: if the resident is unable to participate in any of the bathing activity. . . ." * Pages J-29, 30, and 31, "J1800: Any Falls Since . . . Prior Assessment . . . Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since . . . Prior Assessment . . . J1900 . . ."	F 278	2. All MDS submissions from the last quarter were reviewed by the DON and MDS coordinator for accuracy and consistency on 12/14/2015. No other MDS's were identified with having accuracy issues and all correlate to care plan, progress notes and CNA documentation. 3. The DON/Administrator will monitor the accuracy of each MDS prior to signing the MDS as complete. If changes need to occur they will be communicated with the MDS Coordinator for discussion on completion variances prior to submission. The DON will provide staff education on wandering, delusions, falls and bathing to the care plan team on 01/13/2016. 4. January 13th 2016 5. A QA study will be completed monthly for 6 months by the DON on various MDS submissions for accuracy in all entries, as provided from information provided from care plans, progress notes and CNA documentation. Results will be reviewed with the MDS Coordinator and also quarterly at the QA meeting.	

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 - Review of Resident #9's medical record occurred on 12/09/15. Diagnoses included Alzheimer's disease and delirium. The admission MDS, dated 09/27/15, identified the presence of delusional thoughts during the assessment period. Resident #9's progress note, dated 09/21/15, stated, "8:30 p.m. . . . Stated that 'you girls don't care, why are you holding me here like a prisoner'. States that she wants to go home and that noone [sic] knows where she is. . . ." A progress note, dated 09/22/15 at 1:24 p.m., stated, ". . . Res [resident] irritable & paranoid when she woke up, told CNA [certified nursing assistant] 'why are you in here watching me? You all are up to no good' . . ." The facility failed to identify if Resident #9 would accept a reasonable alternative explanation to her thought of being held prisoner and the staff up to no good. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The quarterly MDS, dated 09/30/15, identified both long and short term memory problems, required extensive assistance for locomotion and transfers, and presence of wandering four to six days during the assessment period. The medical record lacked evidence Resident #3 wandered during the assessment period in September 2015. - Review of Resident #1's medical record	F 278		

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 occurred on all days of survey. Diagnoses included left sided hemiplegia (paralysis). The quarterly MDS, dated 10/18/15, identified total assistance of one staff member for bathing. During an interview on 12/09/15 at 10:09 a.m., a CNA (#5) stated Resident #1 is always "very involved with her bath." The CNA stated the resident utilized her right hand to wash her face and upper body. - Review of Resident #5's medical record occurred on all days of survey. The fall event reports identified the following: * 06/05/15: Fall without injury * 06/08/15: Fall without injury * 07/08/15: Fall and hit head * 07/26/15: Fall and abrasion to head Facility staff failed to code the falls on the annual MDS, dated 08/26/15. During an interview on 12/09/15 at 10:45 a.m. an administrative nurse (#1) verified Resident #5's falls were not coded on the MDS.	F 278		
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		1/13/16

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: FALLS 1. Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure staff implemented fall interventions for 2 of 4 residents (Resident #6 and #8) care planned for a tab alarm when in their wheelchair or recliner. Failure to follow care plan interventions may result in residents experiencing falls and/or injury. Findings include: Review of the facility policy titled "Falls and Fall Risk, Managing" occurred on 12/09/15. This policy, revised December 2007, stated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . . . Prioritizing Approaches to Managing Falls and Fall Risk . . . 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls . . ." - Review of Resident #6's medical record occurred on December 07-08, 2015 and diagnoses included osteoarthritis. The current care plan stated, "Problem . . . ADLS [activities of daily living] . . . Approach . . . Safety Devices . . . TABS alarm to wheelchair and recliner . . ." Review of the progress notes identified Resident #6's most recent fall occurred on 09/06/15 while self-transferring.	F 323	1. Resident #6 and #8 care plans were reviewed on 12/10/2015. Resident #8 had TABS alarm replaced 12/10/2015 with a silent chair pad alarm. Resident #6 TABS alarm was discontinued on 12/10/2015. Care plans were updated to reflect changes on 12/10/2015. The mattresses in room 34A and 34B were replaced during the survey with appropriate mattresses. 2. All residents who utilize TABS alarm or chair alarm were reviewed on 12/10/2015, as well as all resident's who have triggered for falls per QM indicator to ensure all safety measures are appropriate and in place. All mattresses in the building were inspected on 12/10/2015 and no other mattresses of concerns were identified. 3. All staff will be in-serviced on the importance of safety devices and following the plan of care by 01/13/2016. Residents that currently utilize safety alarms will also be reviewed by 01/13/2016. An updated safety alarm device log is kept in the care plan binder. All staff were in-serviced on 01/13/2016 on the requirement of mattress sizes on resident beds and the potential for entrapment. Prior to new mattresses being placed on beds the DON will ok the appropriate size mattress is being placed on each bed and keep a log to show documentation after each replacement.	

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 Observation of Resident #6 identified staff failed to place the tab alarm onto the resident's wheelchair or recliner during the following times: *12/07/15 at 4:53 p.m. - resident in her wheelchair in the lounge *12/08/15 at 7:42 a.m. - resident in her wheelchair in the dining room *12/08/15 at 10:33 a.m. - resident in her wheelchair in the activity room *12/08/15 at 11:52 a.m. - resident in her wheelchair in the dining room *12/08/15 3:10 p.m. - resident in her recliner in her room *12/08/15 at 5:40 p.m. - resident in her wheelchair in the dining room During an interview on 12/08/15 at 5:40 p.m., a nurse (#9) stated staff should clip the tab alarm to Resident #6 when she sat in her wheelchair or recliner. - Review of Resident #8's medical record occurred on December 08-09, 2015 and diagnoses included right lower leg amputation and dementia. The current care plan stated, "Problem . . . At risk for falls . . . Approach . . . tab alert on w/c [wheelchair] [and] recliner . . ." Review of the progress notes identified Resident #8's most recent fall occurred on 06/26/15 while self-transferring. Observation on 12/09/15 at 10:28 a.m. identified two certified nursing assistants (#7 and #8) assisted Resident #8 with toileting and transferred him back into his wheelchair. The CNAs (#7 and #8) failed to clip the wheelchair	F 323	4. January 13th, 2016 5. A bi-monthly QA study will be conducted for 6 months and quarterly for one year thereafter by the DON on all residents that utilize safety alarms on various shifts to monitor the compliance of care plans and safety devices. A bi-monthly QA study will also be conducted for 6 months and quarterly for one year therafter by the DON on the proper size mattresses on all beds. Results will be reviewed at the quarterly QA meeting.	

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 tab alarm onto the resident's clothing prior to exiting the room. ENTRAPMENT RISK 2. Based on observation, review of professional reference, and staff interview, the facility failed to ensure resident beds were equipped with proper fitting mattresses on 3 of 3 days of survey. Failure to provide proper fitting mattresses may result in entrapment and injury to residents. Findings include: Review of the document "Guidance for Industry and FDA [Food and Drug Administration] Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" occurred on 08/05/15. This document, dated 2006, page 19, stated, "Zones 5, 6, and 7: Although seven potential zones of entrapment have been identified . . . FDA is recommending dimensional limits for zones 1-4 because these zones were most frequently reported as having entrapments. . . . Zone 7 remains a potential for entrapment. . . ." Page 20, stated, "Zone 7 - Between the Head or Foot Board and the End of the Mattress: Zone 7 is the space between the inside surface of the head board or foot board and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot boards . . ." During the initial tour of the facility on 12/07/15 at 2:55 p.m., observation revealed a gap between the mattress and bed frames in room 34A and	F 323		

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 _____	12/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 34B. The environmental tour occurred on 12/09/15 at 1:00 p.m. with two administrative staff members (#3 and #4). Observation showed a seven and a half inch gap between the mattress and foot board in room 34A and a five and a half inch gap between the mattress and foot board in room 34B. The staff members (#3 and #4) agreed the gaps were potential entrapment hazards.	F 323		