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 _____	11/03/2016

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 October 31, 2016 and completed on November 3, 2016, 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 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy, record review, and staff interview, the facility failed to provide an ongoing activity program designed to meet the interests and the physical, mental, and psychosocial well being for 1 of 1 sampled resident (Resident #8) dependent on staff for activities. Failure to provide activities that met the resident's individual needs and interests, including one-to-one activities, limited the resident's ability to reach their highest practicable level of physical, mental and psychosocial well-being. Findings include: Review of the facility's policy titled "Individual Activities and Room Visit Program" occurred on 11/3/16. This policy, revised January 2011, stated, "Policy Statement: Individual activities will be provided for those residents whose situation	F 248	1. Resident #8's care plan was reviewed on October 31st, 2016, which shows resident is to receive a minimum of three one on one visits initiated by staff a week. Resident #8 is receiving three one on one visits in accordance with her care plan and documentation is being completed showing compliance. 2. All care plans will be reviewed for all resident activity programs to ensure proper documentation is being completed reflecting adequate programs by December 1st, 2016. Residents will be screened to determine if they need to be on one on one program and proper care planning and documentation is present to reflect the current programs. The review of all resident activity care planning will be	12/8/16

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

Electronically Signed | 11/15/2016

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F 248	Continued From page 1 or condition prevents participation in other types of activities . . . The activities offered are reflective of the resident's individual activity interests as identified . . . in the . . . progress notes and the resident's Comprehensive Care Plan . . . It is recommended that residents on a full room visit program receive, at a minimum, three room visits per week. Typically a room visit is ten to fifteen minutes in length . . ." - Review of Residents #8's medical record occurred on 11/3/16. Diagnoses included multiple scleroses. The annual Minimum Data Set (MDS), dated 5/10/16, identified total assist of one person for all Activities of Daily Living (ADL's), both long and short term memory difficulties, rarely/never makes self understood or has the ability to understand others, and severely impaired daily decision making. The MDS identified the activities most important to Resident #8 were religion, music, animals, reading, and outdoors. Current care plan stated, "Problem . . . Category: Activities . . . Goal . . . Resident cannot verbalize words. She can only listen . . . Resident will participate in 3 one/one [one-on-one] activities per week . . . Approach . . . Offer resident 3 one/one activities per week . . ." Review of Resident #8's individual activity record for August 1, 2016 through October 31, 2016 showed the following: * August 1-31, 2016: 1-1 Visit/Sensory/Manicure and hand massage: 1 day 1-1 Visit/Sensory/Read from Ideals: 1 day 1-1 Visit/Sensory/Looked at pictures: 1 day The log showed no activity participation on 28 out of 31	F 248	completed by December 1st, 2016. 3. One on one activity forms and resident daily documentation forms were reviewed and revised to include time in and time out spent with all one on one activities and the type of activity performed. These forms were revised on November 7th, 2016. Activity charting will be updated and the activity staff will be trained by December 1st, 2016 on adequate care planning and charting procedures. Staffing hours were reviewed with the Activity Department outlining more than enough hours budgeted per week to allow completion of all resident activity programs. 4. The Director of Nursing/Administrator will conduct a QA study weekly for one month, followed by twice a month for 3 months and and monthly for 6 months after to determine if records are being kept and Activity care plans are being implemented for all residents. Activity Logs will be turned in monthly to the Director of Nursing on the 1st day of the following month and reviewed for compliance for 1 year. 5. December 8th, 2016	

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F 248	Continued From page 2 days. * September 1-30, 2016: 1-1 Visit/Sensory/Looked at horse pictures: 1 day 1-1 Visit/Sensory/Manicure: 1 day 1-1 Visit/Sensory/Read from Ideals: 1 day 1-1 Visit/Sensory/Read the Mountaineer: 1 day The log showed no activity participation on 26 out of 30 days. * October 1-31, 2016: 1-1 Visit/Sensory/Read to resident: 4 days 1-1 Visit/Sensory/Manicures: 1 day The log showed no activity participation on 26 out of 31 days. Review of the progress notes identified on 08/12/16 at 5:20 p.m. " . . . Resident received 3 one-to-one visits per week to include music, reading, looking at pictures, manicures and massaging hands . . ." This progress note conflicted with the above activity log. During an interview on 11/03/16 at 11:25 a.m., an activity staff member (#4) stated the following: * There is an activity log in a binder located in the activity room for Resident #8. * This activity log should include individual activity of one-on-one visits three times a week with notes regarding the visit. * When the resident is sleeping, they are not woke up and therefore, lose their one-on-one time. Sometimes we go back but don't always have the time due to other scheduled activities. * Staff members should do the one-on-one time.	F 248		

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F 248	Continued From page 3 During an interview on 11/03/16 at 11:55 a.m., an administrative nurse (#1) stated the one-on-one interactions with Resident #8 should be completed by a staff member. The facility failed to ensure staff provided a meaningful activity program to Resident #8, who was totally dependent on staff, per careplan to meet her individual needs.	F 248		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. 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	F 278		12/8/16

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F 278	Continued From page 4 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument 3.0 (RAI) User's Manual (Version 1.13), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 4 of 9 sampled residents (Resident #3, #4, #7 and #9). Failure to accurately complete portions of the MDS, Section E (Behaviors) (Resident #4 and #7), Section H (Bladder and Bowel) (Resident #3) and Section N (Medications) (Resident #3 and #9) does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to these residents. Findings include: MEDICATIONS The Long-Term Care Facility RAI Manual, revised October 2015, Chapter 3 page N-5 stated, ". . . N0410: Medications Received . . . 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home . . . N0410B, Antianxiety. . ."	F 278	1. Care plans, progress notes, physician notes, CNA documentation and MDS's for residents 3, 4,7 and 9 were reviewed by the DON and MDS coordinator on 11/15/2016. MDS corrections were made prior to December 8th, 2016 and submitted to CMS and the state of North Dakota. 2. All MDS submissions for the last quarter were reviewed by the DON and MDS coordinator for proper completion on 11/15/2016. No other MDS's were identified during the review. 3. The DON and RN-Administrator will monitor proper MDS completion prior to signing the MDS as complete. If changes need to occur they will be communicated with the MDS Coordinator prior to submission. The DON will provide staff training on drug classifications and behaviors to the care plan team on 11/15/2016. 4. A QA study will be completed monthly for 6 months by the DON on various MDS submissions for proper completion. Results will be reviewed with the MDS Coordinator and also quarterly at the QA meeting. 5. December 8th, 2016	

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F 278	Continued From page 5 - Review of Resident #9's medical record occurred on November 2-3, 2016 and diagnoses included anxiety disorder. The physician orders identified Clonazepam (an antianxiety medication) administered daily since 10/11/2016. An admission MDS, dated 10/18/16, and a quarterly MDS, dated 10/24/16, failed to identify Resident #9 received an antianxiety medication each day of the 7-day look-back period. - Review of Resident #3's medical record occurred on all days of survey. Current physician orders identified Clonazepam administered daily since 11/25/15. An annual MDS, dated 02/24/16, and a quarterly MDS, dated 10/20/16, failed to identify Resident #3 received an antianxiety medication each day of the seven-day look-back period. BEHAVIORS The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 page E-1, stated, "Section E: BEHAVIOR Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident . . . may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. . . Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. . . ." - Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 09/13/16, identified other behavior symptoms occurred during the seven-day	F 278		

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F 278	Continued From page 6	F 278		

look-back period. A progress note, dated 09/14/16 (after the assessment period), described the resident's behavior.

- Review of Resident #7's medical record occurred on November 2-3, 2016. The quarterly MDS, dated 07/05/16, identified other behavior symptoms occurred during the seven-day look-back period. The medical record lacked evidence of Resident #7's other behavioral symptoms.

BLADDER AND BOWEL
The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 page H-1-2, stated, "The intent of the items in this section is to gather information on the use of bowel and bladder appliances, . . . ostomy (including urostomy, ileostomy, and colostomy). . ."

- Review of Resident #3's medical record occurred on all days of survey. The current physician order report stated, "Change colostomy bag weekly and prn [as needed] . . ." An annual MDS, dated 02/24/16, failed to identify the use of a colostomy.

During an interview on the morning of 11/03/16, an administrative nurse (#1), a MDS nurse (#2) and a social service staff member (#3), confirmed the documentation for behaviors occurred outside the MDS seven-day look-back period, and failed to code antianxiety medication and a colostomy.