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 _____	11/16/2017

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 11/13/17 and completed on 11/15/17, 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 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		12/8/17

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

Electronically Signed | 11/28/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1 Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 6 sampled residents (Resident #2, #3, and #6) who required assistance with transfers using a gait belt. Failure to utilize a gait belt for assisted transfers, including proper use, during transfers placed the residents at risk of accidents and injury. Findings include: Review of the facility policy titled "Safe Lifting and Movement of Residents" occurred on 11/15/17. This policy, revised July 2017, stated, "In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. . . . 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) . . ." Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice,"10th edition, Pearson Education, Inc., New Jersey, page 1054, stated, "Assisting a Client to Ambulate . . . If the client is a low safety risk . . . use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ." - Observation on 11/14/17 at 3:52 p.m. showed two certified nursing assistants (CNAs) (#1 and #2) transferred Resident #6 from her wheelchair to the toilet. After loosely applying a gait belt	F 323	1. Resident #2,#3 and #6 care plans were reviewed on 11/15/17 with all CNA staff. Policy titled "Safe Lifting and Movement of Residents" was also reviewed at this time and staff voiced understanding. OT demonstrated safe and proper transfer technique using a gait belt at 2:00 pm on 11/15/17. 2. All evening CNA staff did return demonstration of safe and proper transfer techniques using a gait belt per OT evaluation on 11/15/17. All CNA staff were notified on 11/28/17 and updated on the current policy regarding the use of gait belts and the proper technique. 3. A QA study will be conducted monthly by the DON for 6 months, during various shifts, on proper use of gait belts during transfers. Results will be communicated at our quarterly QA meeting and monthly with staff. 4. Annual training will be provided to our CNA staff to ensure proper transfer techniques continue to be used when using a gait belt for transfer. 5. December 8th, 2017	

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F 323	Continued From page 2 around the resident's waist, the CNAs (#1 and #2) placed one hand under Resident #6's axilla, and one CNA (#1) used her other hand to grab the back of the resident's pants. When Resident #6 had completed toileting, both CNAs transferred the resident back to her wheelchair holding under the resident's axilla with one hand and holding the gait belt with the other. - Observation on 11/14/17 at 5:05 p.m. showed two CNAs (#2 and #3) transferred Resident #2 from his recliner to wheelchair. After applying the gait belt, one CNA (#2) held onto the gait belt, while the other CNA (#3) positioned the wheelchair. The CNA (3#) then placed her hand on back of the residents pants to pull the resident into the wheelchair and failed to utilize the gait belt. - Observation on 11/14/17 at 6:10 p.m. showed two CNAs (#1 and #3) applied a gait belt loosely around Resident #3's waist. The gait belt slid up the resident's back and under her axilla as the CNAs transferred the resident from her wheelchair to a recliner. The CNAs then re-positioned Resident #3 further back in the recliner by lifting under her axilla and pulling up on the back of her pants. The CNAs (#1 and #3) failed to utilize the gait belt correctly. During an interview on 11/15/17 at 12:30 p.m., two administrative staff members (#4 and #5) stated they expected facility staff to utilize gait belts correctly.	F 323		