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 _____	11/28/2018

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 11/26/18 and concluded 11/28/18.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) 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, staff interview, review of the facility policy, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled residents (Resident #12) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include:	F 637	1. The care plan, progress notes, physician notes, CNA documentation and MDS assessments for resident #12 were reviewed by the DON/MDS Coordinator/RN Administrator on 12/06/18. A significant change assessment was opened with an ARD of 12/06/2018 and submitted to CMS and the state of North Dakota. 2. All resident's ADL/BIMS scores were reviewed for the past quarter by the DON/Social Service Designee on 12/06/18 for areas with two or more changes. No other residents were identified to have a change in two or more areas during the review.	12/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/11/2018

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F 637	Continued From page 1 Review of the facility policy titled "Resident Assessment Instrument" occurred on 11/29/18. This undated policy stated, "The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessment and reviews according to the following schedule: . . . b. When there has been a significant change in the resident's condition . . ." The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are 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., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." - Review of Resident #12's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 06/08/18, identified the resident as independent with bed mobility, transfers, toileting, walking in the room and corridor, and locomotion on and off the unit. The medical record identified Resident #12 was hospitalized on 08/20/18 until 08/21/18. A quarterly MDS, dated 09/06/18, identified the resident required extensive assistance with bed mobility, toileting, and locomotion on and off the unit. The record lacked rationale for staff failure	F 637	3. The care plan team will review all resident's that have had an improvement or decline in condition during each weekly meeting to determine if a significant change may be warranted. The care plan team will also receive eduation regarding significant change recommendations and regulations, as stated in the RAI 3/0 User's Manual by December 31st, 2018. 4. A QA study will be completed monthly for 6 months by the DON on all ADL and BIMS scores of resident population to determine if there has been an improvement or decline in 2 or more care areas. QA will continue quarterly thereafter and all results will be discussed at each quarterly QA meeting. 5. December 31st, 2018	

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F 637	Continued From page 2 to complete a SCSA following Resident #12's hospitalization. During an interview on 11/28/18 at 11:50 a.m., an administrative staff member (#2) stated staff was waiting until the December MDS to do a SCSA.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 13 sampled residents (Resident #16) and 1 supplemental resident (Resident #23). Failure to accurately complete Section I (Active Diagnoses) and Section N (Medications) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2017, page I-8 stated, ". . . Item I2300 Urinary tract infections (UTI): The UTI has a look-back period of 30 days for active disease . . ."	F 641	1. The care plans, progress notes, physician notes, CNA documentation and MDS's for residents #16 and #23 were reviewed by the DON/MDS Coordinator on 12/06/2018. MDS corrections were completed on both assessments. 2. All MDS submissions for the last quarter were reviewed by the DON/MDS Coordinator for proper completion on 12/06/2018. No other MDS's were identified in the review. 3. The DON/RN Administrator will monitor proper MDS completion prior to signing the MDS as complete. If changes need to occur, they will be done prior to submission. The MDS Coordinator and care plan team will receive training on medication classifications and active diagnosis. 4. A QA study will be completed monthly for 6 months by the DON/RN Administrator on various MDS submissions for proper completion. Results will be reviewed quarterly at the	12/31/18

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F 641	Continued From page 3 - Review of Resident #16's medical record occurred on all days of survey and identified the resident was hospitalized on 08/21/18 with a diagnosis of urinary tract infection (UTI). A quarterly MDS, dated 09/05/18, identified staff failed to code section I2300 for a UTI in the last 30 days. During an interview on 11/28/18 at 11:20 a.m., an administrative staff nurse (#2) confirmed she failed to code a UTI on Resident #16's MDS dated 09/05/18. SECTION N: MEDICATIONS The Long-Term Care Facility RAI Manual, revised October 2018, page N-7, stated, ". . . N0410E, Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. . . ." - Review of Resident #23's medical record occurred on all days of survey. The current physician's orders identified Plavix (clopidogrel) 75 milligrams (mg) daily (QD). The quarterly MDS, dated 10/11/18, identified the use of an anticoagulant 7 times during the 7-day look back period. During an interview on 11/28/18 at 11:40 a.m., an administrative staff member (#2) confirmed she incorrectly coded an anticoagulant on Resident	F 641	QA meetings. 5. December 31st, 2018	

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F 641	Continued From page 4 #23's 10/11/18 MDS.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 2 sampled residents (Resident #21 and #28) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs.	F 644	1. The level 1 screening for resident #21 and #28 were reviewed by the Social Service designee on 12/06/2018. Updated Level 1 screenings were completed by 12/31/2018. 2. All PASARR screenings will be reviewed for accuracy. The Social Service Designee along with the DON will review diagnosis, significant changes in resident conditions, medication changes, behavior logs and psychiatry consults and PASARR screenings with be completed accurately.	12/31/18

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F 644	Continued From page 5 Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred. . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #21's medical record occurred on all days of survey. The record showed an initial PASARR completed on 11/14/16 with no mental illness identified. The screening, dated 11/14/16, identified the Level I screen conducted for the individual determined there was no evidence to suggest presence or known conditions of mental illness, mental retardation, or a condition related to mental retardation. Resident #21's medical record identified the following current diagnoses: unspecified psychosis not due to a substance or known physiological condition 01/22/16, other specified mental disorder due to known physiological condition 03/09/17, and hallucinations 03/07/18. The record lacked evidence the facility identified Resident #21's diagnoses of psychosis on the	F 644	3. The Social Service designee/DON will monitor all required documentation from psychiatry after each visit for changes in diagnosis, significant change in resident conditions, medication changes, behavior logs and psychiatry consults to ensure proper screenings have been completed. The DON will be provide training to the SSD on accurate completion of the PASARR screening prior to 12/31/2018. 4. A QA study will be completed monthly for 6 months by the Social Service designee on all PASARR screenings to determine accuracy of screenings. 5. December 31st, 2018	

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F 644	Continued From page 6 11/14/16 PASARR. During an interview on the afternoon of 11/27/18, a social service staff member (#3) confirmed the facility failed to identify psychosis on recent PASARR completed 11/14/16 for Resident #21. - Review of Resident #28's record occurred on all days of survey. The record showed an initial PASARR completed on 11/15/16 with no major mental illness identified. Resident #28's medical record identified a psychiatric note dated 07/10/18 that identified diagnoses of major depression, and a psychiatric note dated 10/10/18 that identified diagnoses of major depression and psychosis. The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses. During an interview on 11/28/18 at 9:46 a.m., a social service staff member (#3) confirmed a new PASARR Level I should have been completed on resident #28 following the new diagnoses.	F 644		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		12/31/18

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F 755	Continued From page 7 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to establish a system to account for controlled medications in 1 of 1 medication room refrigerator containing facility stock narcotics. Failure to assure all controlled medications are accounted for has the potential for medication loss and/or diversion. Findings include: Review of facility policy titled "Procedure for Counting Narcotics" occurred on 11/28/18. This policy, dated April 2004, stated ". . . A complete narcotic count of all Schedule II-IV (2 to 4)	F 755	1. The narcotic log was reviewed on 12/07/2018. Nursing staff verify the contents of narcotics in the E-kit including the refrigerated locked box and document amounts at each shift change which is twice per day. Nursing staff verify the content amounts and sign off in the narcotic log twice per day. 2. All narcotics were reviewed by the DON in the log book on 12/07/2018 for accuracy. No signatures were missing on the review. 3. The DON will monitor the narcotic log count weekly for 6 months to ensure all	

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F 755	Continued From page 8 medications will be done in the afternoon by one on duty charge nurse and another licensed nurse. Each count will be signed off on the Controlled Drug Daily Accountability Log indicating that either the count was right or noting any discrepancies. . . ." Observation of the medication room refrigerator occurred on 11/28/18 at 1:47 p.m. with a staff nurse (#1), and showed a locked box contained three 2 mg (milligrams)/ml (per millilter) vials of Lorazepam designated as a facility stock medication. Review of the controlled Drug Account Log identified the Lorazepam last counted by nursing staff in March 2018. During an interview on the afternoon of 11/28/18, an administrative nurse (#2) confirmed facility nurses should have counted and documented the Lorazepam. The facility failed to verify all controlled medication per their policy.	F 755	required signatures are present. Nursing staff will be educated on the management and use of the narcotic log for all scheduled, prn and e-kit narcotics by 12/31/2018. 4. A QA study will be completed weekly for 3 months, then monthly for 1 year to ensure requirements for the narcotic log are being followed and documented appropriately. Pharmacy will also check the log for signatures and accuracies with each monthly visit. 5. December 31st, 2018	