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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembilier Nursing Center	500 Delano Ave Walhalla, ND 58282

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to maintain a sanitary kitchen environment for 1 of 1 facility kitchen. Failure to ensure the sanitizer test strips used to test the concentration of sanitizing solution are not expired has the potential for inadequate sanitization and may result in foodborne illness.Findings include:Observation in the kitchen on 04/27/26 at 11:13 a.m. showed a dietary staff member (#4) tested the concentration of a premixed sanitizing solution with test strips that expired October 2025.During an interview on 04/27/26 at 11:25 a.m., a dietary staff member (#4) stated staff should not use expired test strips.

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 4 of 12 sampled residents (Residents #3, #4, #18, and #20) and 1 supplemental resident (Resident #8) observed during cares. Failure to follow infection control standards for hand hygiene and glove use during cares and while performing procedures has the potential to transmit infections to residents, staff, and visitors. Findings include: Review of the facility policy titled Handwashing/Hand Hygiene occurred on 04/29/26. This undated policy stated, . Staff will perform hand hygiene when indicated using proper technique and consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. After handling items potentially contaminated with blood, body fluids, secretions, or excretions . moving from a contaminated body site to a clean body site . Review of the facility policy titled Clean Dressing Change occurred on 04/29/26. This undated policy stated, . Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: a. If the table is soiled, wipe clean . b. Place a disposable cloth or linen saver on the overbed table . Review of facility policy titled Insulin Pen occurred on 04/29/26. This undated policy stated, . Procedure . Perform hand hygiene . [NAME] gloves . Review of facility policy titled Blood Glucose Monitoring occurred on 04/29/26. This undated policy stated, . The nurse will perform the blood glucose test utilizing the facility's glucometer [A handheld device to check blood sugar] . the nurse will abide by the infection control practices . Procedure . Perform hand hygiene and don gloves . collect blood sample . discard the lancet [disposable needle] in a puncture resistant sharps container. Remove the strip and dispose of it in sharps container. remove and discard gloves and perform hand hygiene. - Observation on 04/27/26 at 9:30 a.m. showed Resident #4 seated in a wheelchair. Two certified nurse aides (CNAs) (#6 and #7) completed hand hygiene, applied gloves, and entered the room. The CNAs assisted Resident #4 to stand with a mechanical sit-to-stand lift. The CNA (#6) completed perineal cares, and without removing the soiled gloves and completing hand hygiene, placed a clean brief on the resident. The CNA (#6) removed the soiled gloves, and without completing hand hygiene, repositioned the resident's pants, and transferred the resident into the wheelchair. Both CNAs completed hand hygiene and exited the room. The CNA (#6) failed to perform hand hygiene after removing soiled gloves and before touching other items. Observation on 04/28/26 at 10:15 a.m. showed a nurse (#3) performed hand hygiene, applied a gown and gloves, and entered Resident #18's room with colostomy supplies. The nurse placed the colostomy supplies on the resident's overbed table without establishing a clean field. The nurse removed the soiled colostomy bag, disposed of the bag, removed the soiled gloves, and without performing hand hygiene, applied clean gloves. The nurse cleansed and dried the stoma with cleansing spray and gauze, removed the soiled gloves, and without performing hand hygiene, applied (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clean gloves. The nurse cut the colostomy bag seal to size, applied a colostomy barrier seal, applied the new colostomy bag, and without removing the soiled gloves or performing hand hygiene, the nurse sanitized the scissors and overbed table. The nurse removed the soiled gown and gloves, performed hand hygiene and exited the room with the garbage bag. The nurse (#3) failed to establish a clean field before placing the clean ostomy supplies on the table and failed to perform hand hygiene between glove changes and prior to sanitizing medical supplies. - Observation on 04/28/26 at 11:10 a.m. showed a nurse (#3) completed hand hygiene, applied a gown and gloves, and entered Resident #20's room to perform a dressing change. The nurse moved a juice glass and other items to the side of the overbed table. Without sanitizing the overbed table or placing a barrier, the nurse placed the clean dressing supplies on the overbed table and completed the dressing change. The nurse (#3) failed to establish a clean field before placing clean dressing supplies on the overbed table. - Observation on 04/28/26 at 11:41 a.m. showed a nurse (#3) prepared an insulin pen for Resident #8. The nurse performed hand hygiene, and without applying gloves, administered the insulin to Resident #8, returned to the medication cart, and without performing hand hygiene, prepared medication for another resident. The nurse (#3) failed to follow standard infection control protocols while administering insulin and failed to perform hand hygiene prior to preparing medications for another resident. - Observation on 04/28/26 at 5:03 p.m., showed a nurse (#3) entered Resident #20's room, performed hand hygiene, applied gloves, and checked the resident's blood glucose by poking the finger with a lancet. The nurse placed the soiled lancet on the resident's bedside table and obtained a drop of blood on the test strip. The nurse removed the soiled gloves, and with a bare hand, disposed of the lancet and test strip in a sharp's container. The nurse (#3) failed to wear gloves when disposing of a contaminated lancet and test strip and failed to sanitize the resident's overbed table after exposure to the contaminated lancet. - Observation on 04/29/26 at 9:38 a.m. showed CNAs (#6 and #9) performed hand hygiene, applied gowns and gloves and entered Resident #3's room which required enhanced barrier precautions (EBP). The CNAs transferred the resident from the wheelchair to the bed utilizing a mechanical body lift. The CNA (#6) removed the soiled brief, cleansed the resident's rectal area, repositioned the resident, and the CNA (#9) completed perineal care. The CNA (#6) removed the soiled gloves, and without completing hand hygiene or applying clean gloves, placed a clean brief on the resident. The CNA (#9), still wearing soiled gloves, assisted with placing the clean brief then removed the soiled gloves. Both CNAs completed hand hygiene. The CNA (#6), without applying clean gloves, positioned heel boots and blankets on the resident. Both CNAs removed their gowns and completed hand hygiene prior to exiting room. The CNA (#6) failed to perform hand hygiene after removing soiled gloves and before touching other direct care items. The CNA (#9) failed to remove soiled gloves and perform hand hygiene before applying a clean brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/29/26 at 5:55 p.m., an administrative staff member (#2) stated she expected staff to follow infection prevention policies and procedures related to infection control.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, review of facility policy, and staff interview, the facility failed to promote privacy and confidentiality of the electronic medication administration record (eMAR) on 1 of 1 medication cart. Failure to promote resident privacy and lock computer screens may result in unauthorized viewing of the residents' private health information records by other residents, visitors, or unlicensed staff. Findings include: Review of the facility policy titled Safeguarding of Resident Identifiable Information occurred on 04/29/26. This undated policy stated, . Facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information . Computer screens showing clinical record information may not be left unattended and readily observable or accessible by other residents or visitors. Observation on 04/28/26 at 11:41 a.m. showed a nurse (#3) at the medication cart. The nurse left the medication cart with prepared insulin and removed Resident #8 from the dining room to administer medication in a private area down the hallway. The nurse (#3) failed to lock the unattended cart and computer screen. During that time, two visitors walked in front of the unlocked medication cart with the computer screen and eMAR clearly visible.During an interview on 04/29/26 at 5:55 p.m., an administrative staff member (#2) confirmed staff are expected to lock the computer screen and medication cart when unattended.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, review of manufacturer's guidelines, and staff interview, the facility failed to ensure accurate labeling and storage for 1 of 1 resident (Resident #15) observed for eye drop administration. Failure to properly label and dispose of medications may result in residents receiving an incorrect dose of medication, reduced medication efficacy, and has the potential to cause an eye infection.Findings include: Review of prescribing information for Systane Ultra Preservative-Free [PF] single-use vials (eye drops), found at https://systane.myalcon.com/products/systane-complete-preservative-free/, occurred on 04/29/26, and stated . Systane Ultra Preservative-Free [PF] single-use vials. must be discarded after each use . After opening the vial of our Preservative-Free product, the risk of product contamination increases .Observation on 04/29/26 at 8:53 a.m. showed a nurse (#5) administered Systane Ultra PF single-use eye drops, one drop in each eye, to Resident #15. After administration, the nurse (#5) capped the single-use vial, placed it in the medication cart and stated, There is enough medication in there for another use .Review of the electronic medication administration record (eMAR) identified Systane Ultra PF eye drops, one drop into both eyes two times daily. The Systane Ultra PF pharmacy label, stated, Give 2-4 times a day as needed.The nurse failed to ensure the medication label matched the current physician's order and failed to appropriately discard the single use vial after use. During an interview on 04/29/26 at 5:55 p.m., an administrative staff member (#2) confirmed she expected staff to discard single use medication vials and medication labels to match Physician's orders.