STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

(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 The standard Medicare/Medicaid recertification survey started on 07/16/18 and concluded 07/19/18.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident interview, the facility failed to ensure 2 of 3 sampled residents (Resident #5 and #20) reviewed for restorative nursing programs received the services developed by the facility's therapy staff. Failure to consistently provide restorative nursing services may adversely affect the residents' abilities to maintain their range of motion (ROM), balance, strength, and mobility.	F 688	1. On 8/1/18 , Physical Therapy assessed resident #5 and #20 for range of motion and neither resident had any decline in ROM. Care plans for resident #5 and #20 were updated to reflect new orders for restorative therapy. 2. All residents requiring restorative therapy at Rolette Community Care Center have the potential to be affected.	8/23/18

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

Electronically Signed | 08/08/2018

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F 688	Continued From page 1 Findings include: Review of the facility policy titled "Restorative Nursing Policy" occurred on 07/19/18. This undated policy stated, ". . . 5. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for such services (Level II services). . . . 7. A resident's Level II Restorative Nursing plan will include: a. The type of activities to be performed. b. Frequency of activities. c. Duration of activities. . . . 9. Restorative aides will implement the plan for a designated period of time, performing the activities, and documenting on the Restorative Aide Activity Worksheet. . . ." - Review of Resident #5's medical record occurred on all days of survey. The current care plan stated, ". . . Resident has limited strength and range of motion in his lower extremities and his upper extremities have functional range of motion with decreased coordination in his hands and fingers. . . . APPROACH: . . . R.A. [restorative activity] program 5 x's [times] ROM per week for strengthening/ stretching exercises. . . ." The restorative nursing documentation, dated 05/21/18 - 07/15/18, showed staff provided passive range of motion (PROM) on 26 of 40 days in an eight week period. Staff failed to provide therapy on 14 days as per the restorative program care plan. - Review of Resident #20's medical record occurred on all days of survey. The current care plan stated, ". . . Behavioral Symptoms . . .	F 688	3. A Mandatory In-service for Licensed/Certified Nursing staff including restorative aides was held on August 8, 2018 to review policy titled, “Restorative Nursing”. Education and training will be provided by Physical Therapist and Director of Nursing regarding importance of following recommended restorative therapy exercises and proper documentation in resident’s electronic health record. 4. An audit was created to monitor restorative therapy exercises and documentation to ensure they are accurate and reflect the current care plan. These audits will be performed twice weekly x 12 weeks then monthly x 3 months. These audits will be taken to QAPI committee and reviewed for compliance.	

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F 688	Continued From page 2 Resident will often refuse R/A. . . . RA Goals: 1. The resident to maintain strength to participate with transfers and participate with ADL's [activities of daily living]. 2. The resident to maintain AROM [active range of motion] to prevent contractures. 3. The resident to maintain ambulation with FWW [front-wheeled walker] or in parallel bars 20-30 feet or as tolerates. . . . Encourage Resident to participate in her recommended RA program 5x/week for AROM including nu-step and strengthening exercise using light weights and bands to all extremities, and ambulation with assist of 1 using FWW, 20-30 feet or as tolerates. . . ." The quarterly Minimum Data Set, dated 06/02/18, indicated Resident #20 received passive and active range of motion on two days of the seven day look-back period, and no ambulation. The staff failed to provide the restorative nursing program on five days as ordered. The restorative nursing documentation, dated 06/11/18 - 07/15/18, showed staff offered ROM and ambulation on eight days (the resident refused on four of the eight days) of 25 days in a five week period. Staff failed to offer therapy on 17 days as per the restorative program care plan. During an interview on 07/16/18 at 5:12 p.m., Resident #20 stated, "They don't offer much exercise here, once in awhile someone will walk me or help me on the exercise bike."	F 688		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate	F 700		8/23/18

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F 700	Continued From page 3 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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to attempt appropriate alternatives to bed rails and assess resident safety with the use of bed rails prior to installation for 4 of 4 sampled residents (Resident #4, #5, #20, and #24) assessed for side/bed rail use. These failures may contribute to unnecessary use of bed rails and increased the residents' risk of injuries from the bed rails. Findings include: On all days of survey, observation showed Resident #4, #5, #20, and #24's beds with bed rails attached to and elevated on one or both sides of the head of the bed.	F 700	1. On 8/1/18. Assessments were completed for residents #4, #5, #20, #24 for the use of side rails. Side rails were removed for all 4 residents. 2. All residents have the potential to be affected. 3. A mandatory In-Service for all Licensed/Certified Nursing staff was held on 8/08/2018. Review of policy titled, “Proper Use of Side Rails”, review of forms, “Consent for Side Rail Use” and “Evaluation for Use of Side Rail” . With emphasis on education with risk for entrapment, alternative methods used	

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F 700	Continued From page 4 Review of the above listed residents' medical records occurred on all days of survey. The records showed Resident #4, #5, and #24's current care plans included the use of the bed rails as grab/transfer bars. The facility failed to address bed rails in Resident #20's care plan. The facility's "Consent for Side Rail Use" listed the possible risks and benefits of using the rails. The risks included "possible fall over the rail with attempts to get out of bed, possible strangulations if head or body should get caught in the rail, possible fractures if a body part is caught in the rail, bruising of skin if bumping rails, and feelings of confinement and loss of independence." Facility staff completed an evaluation for the use of bed rails for each resident prior to implementation. Staff completed the evaluations in 2014 or 2015. The evaluation addressed the reason staff instituted the bed rails, how the rails assisted the resident, continence, medications, cognitive status, and whether or not the rails impeded the resident's freedom of movement or obstructed their view. The evaluation failed to include an assessment of safety issues/risk of entrapment related to the use of rails. The residents' records failed to show evidence staff attempted alternatives to the use of bed rails, completed an assessment for safety, including a risk of entrapment, prior to the use of the side/bed rails, or re-evaluated the resident's use of rails with changes in status. During an interview on 07/19/18 at 11:12 a.m., an	F 700	prior to installation and consent for side rail use. 4. An audit was created to monitor for side rail assessment, alternative methods and consent for side rail use. These audits will be performed weekly x 12 weeks then monthly x 3 months. These audits will be taken to QAPI committee and reviewed for compliance.	

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F 700	Continued From page 5 administrative nurse (#1) stated the facility had not attempted alternatives to the bed rails and she was unable to locate a facility policy regarding bed rails.	F 700		
F 770 SS=B	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the laboratory (lab) collection tubes (vacutainers) available for use by the facility staff in 1 of 1 storage area (medication room) had not expired. Use of expired vacutainers when obtaining blood samples from residents may result in inaccurate lab results. Findings include: Observation of the medication room occurred on 07/19/18 at 10:52 a.m. with a licensed staff member (#3). Observation identified the following expired laboratory supplies: 5 blue top vacutainers expired on 05/31/18 2 green top vacutainers expired on 05/31/18 1 yellow top vacutainer expired on 02/28/18 During the observation, the licensed staff member (#3) confirmed the above items should	F 770	1. All expired laboratory vacutainers were discarded on 07/19/2018. 2. All residents have the potential to be affected. 3. A Mandatory in-service for License Nursing staff was held on 08/08/2018. Agreement was set in place that laboratory vacutainers would be ordered “as needed” through local vendor. 4. An audit will be created to monitor for expired laboratory supplies. These audits will be performed weekly x 12 weeks then monthly x 3 months. These audits will be taken to QAPI committee and reviewed for compliance.	8/23/18

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F 770	Continued From page 6 be discarded.	F 770		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to accommodate resident preferences and/or offer an alternative menu item of similar nutritive value during 3 of 5 meals observed (evening meal on 07/16/18, noon meal on 07/17/18, noon meal on 07/18/18). Failure to follow residents' care plans regarding food preferences or offer substitutes may result in inadequate nutrition and weight loss. Findings include: Review of the facility policy titled "Resident Food Preferences" occurred on 07/19/18. This policy, revised November 2015, stated, ". . . Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. . . . Nursing staff will document the resident's food and eating preferences in the care plan. . . . The Food Services Department will offer a variety of foods	F 806	1. On 07/20/2018, Resident #10 diet card was updated for resident preferences and proper substitution. 2. All Residents have the potential to be affected. 3. A mandatory In- Service for All Staff was held on 08/08/2018. Review of policy titled, “Resident Food Preferences”, with emphasis on proper substitutions with equal nutritional value and monitoring diet cards for updates. 4. An audit was created to monitor residents’ preferences, proper substitutions and diet cards. These audits will be performed daily x 4 weeks, then weekly x 8 weeks, then monthly x 3 months. These audits will be taken to QAPI committee and reviewed for compliance	8/23/18

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F 806	Continued From page 7 at each scheduled meal . . ." Review of Resident #10's medical record occurred on all days of survey. Diagnoses included adult failure to thrive and dementia. Resident #10's current care plan stated, ". . . Therapeutic diet. Resident take [sic] diuretic at risk for fluid imbalance. . . . Approach . . . Monitor chewing ability- teeth in poor condition. Favorite foods may be bought in by family and given as snacks. Resident likes wheat toast with every meal. . . ." Resident #10's dietary tray card failed to identify the resident's preference of toast with meals. Observation of the evening meal on 07/16/18 showed Resident #10 refused most of her meal, and staff failed to offer a substitute or toast with her meal. Observation of the noon meal on 07/17/18 showed Resident #10 refused most of her meal, and staff failed to offer a substitute or toast with her meal. Observation of the noon meal on 07/18/18 showed Resident #10 refused most of her meal, and staff failed to offer a substitute or toast with her meal. During an interview on the morning of 07/19/18, an administrative nurse (#1) stated staff should follow the resident's care plan regarding food preferences.	F 806		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/23/18

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F 880	Continued From page 8 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 9 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to follow infection control practices for 2 of 5 sampled residents (Resident #16 and #19) observed during personal cares. Failure to follow infection control practices of hand hygiene during toileting/personal care (Resident #16), and catheter bag placement (Resident #19) has the potential to spread infection to other residents, personnel, and visitors.	F 880	1. Resident #16 and #19 have been assessed and show no signs or symptom of infection. 2. All residents have the potential to be affected. 3. A mandatory in-service was held on 08/08/2018 for all staff to review policy	

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F 880	Continued From page 10 Findings include: Review of the facility policy titled "Handwashing/Hygiene" occurred on 07/19/18. This undated policy, stated, ". . . Use an alcohol-based hand rub . . . or soap and water for the following situations: . . . j. After contact with blood or bodily fluids . . . m. After removing gloves . . ." - Review of Resident #19's medical record occurred on all days of survey. Diagnoses included urethral stricture with retention of urine. The current physician's orders identified a suprapubic catheter. Observation showed the following: 07/16/18 at 3:03 p.m. Resident #19 in his wheelchair with his catheter drainage bag in a cloth covered bag dragging on the floor along with the uncovered tubing as the resident wheeled himself around and outside of the facility. 07/17/18 at 9:00 a.m. Resident #19 walking with restorative staff as his cloth covered catheter bag and uncovered tubing dragged on the floor. 07/17/18 at 3:35 p.m. a CNA (#2) assisted the resident from the bed to the wheelchair. While assisting the resident, the CNA dragged the uncovered catheter bag on the floor and placed the bag on the floor to untangle the tubing. - Observation on 07/17/18 at 9:41 a.m. showed a CNA (#2) assisted Resident #16 off the toilet after the resident voided and had a bowel movement. The CNA performed perineal care, removed her gloves, applied a gait belt and assisted the	F 880	titled, “Handwashing/Hygiene” with emphasis on handwashing after glove removal. All Licensed/Certified Nursing staff reviewed policy titled, “Catheter Care”. Education was provided on proper placement of catheter bag during catheter cares. 4. An audit was created to monitor for hand hygiene and catheter care. These audits will be performed daily x 2 weeks then weekly x 10 weeks then monthly x 3 months. These audits will be taken to QAPI committee and reviewed for compliance.	

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F 880	Continued From page 11 resident to the bed. Without performing hand hygiene, the CNA removed the resident's shoes and glasses, adjusted the blankets, raised the head of bed, gave the resident a drink of water, lowered the head of bed, and gave the resident her call light. The CNA (#2) failed to perform hand hygiene after ensuring the resident's safety prior to doing other tasks. During an interview on 07/19/18 at 11:46 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene after removing gloves and ensuring resident's safety.	F 880		