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 _____	C 06/09/2022

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 and complaint investigation started on 06/06/22 and concluded on 06/09/22.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		7/14/22

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

Electronically Signed | 07/11/2022

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to honor a resident's rights for 1 of 1 sampled residents (Resident #3) observed using a power mobility chair, in a manner and environment that maintained, enhanced, and respected the resident's dignity and individuality. Failure to honor residents' wishes, does not preserve the residents' personal dignity, or enhance their quality of life. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included aphasia (inability to speak). The current care plan stated, . . ."Resident has a power mobility chair that [resident] uses for independent mobility. [Resident #3] demonstrates good safety awareness and power mobility control to use the device in the facility. The resident has been educated on the safety [sic] use of the chair. . . . staff to monitor for concerns, if concerns remind resident of the safety [sic] use of the chair. . . ." Observations showed the following: * 06/08/22 at 11:50 a.m., a staff nurse (#4) gave Resident #3 medications and the resident wrote a note requesting to go outside. The nurse (#4)	F 550	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this plan of correction does not constitute admission or agreement by Rolette Community Care Center of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. 1. Corrective Action a. The facility does not have a policy in which COVID restrictions do not allow for outdoor time unsupervised. The staff nurses #4 and #1 quoted during the survey were immediately educated regarding this misconception. Resident #3 is allowed to go outdoors alone and was educated on the safety considerations and the need to sign in and out with nursing staff as per policy for residents	

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F 550	Continued From page 2 told Resident #3 they'd have to find someone to go with, stating, "Remember since covid you can't go outside by yourself." Resident #3 kept shaking his head no, and again wrote a note wanting to go outside now, and alone. When asked what Covid had to do with a resident going outside alone, Nurse (#4) replied the policy is residents need a staff member with them so that they do not encounter visitors coming into the facility. The nurse also stated [Resident #3] could go out back (of the building) alone but dislikes going out back, stating, "It's rough and uneven back there." The nurse (#4) reiterated it was not due to the resident being unsafe going out front alone, but due to Covid. * 06/08/22 at 12:30 p.m., Resident #3 wrote a note asking an unidentified staff member to go outside. The unidentified staff stated they would check if the social worker could take him outside. Resident #3 paced back and forth in the hallway using his power mobility chair for approximately 45 minutes waiting to go outside. During an interview on 06/08/22 at 2:40 p.m., an administrative nurse (#1) stated, "We haven't updated our policy for outdoor time. We implemented a facility policy due to Covid and we haven't updated it yet, [Resident #3] could go out the back door but that's uneven so not the best for his wheelchair." During an interview on 06/08/22 at 3:30 p.m., two administrative staff members (#9 and #13) stated Covid had nothing to do with Resident #3 not being able to go outside alone using his power mobility chair and they don't know where staff got that from. The administrative staff members	F 550	that are not an elopement risk. 2.Identification of Others a. All residents have the potential to be affected by this alleged deficient practice. 3. System Changes a. DON or designee will provide all staff education regarding Resident Rights/Exercise of Rights, CFR(s): 483.10(a)(1)(2)(b)(1)(2) and policy titled, Unsupervised Outdoor Time on or before 07/14/22 or before next scheduled shift if after this date. 4. Monitoring a. DON, Social Worker, or Designee will complete interviews with residents that are able to go outdoors unsupervised to ensure that their wishes and dignity are being honored. Interviews will be completed with a sample of 3 residents per week for 12 weeks. b. Findings of the interviews will be reported to QAPI committee for review and recommendations. The need for extending the interview process will be determined based on the results of interviews completed and on QAPI committee review and recommendations. 5. Correction Date: a. 07/14/2022	

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F 550	Continued From page 3 stated Resident #3 is unsafe out front due to cars coming and going in the parking lot but had not discussed the risk with Resident #3. They also said Resident #3 is allowed to go outside alone in the back, but agreed it is unsafe there due to the ground/pavement being uneven. The facility failed to honor the resident's right to go outdoors alone.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		7/14/22

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F 583	Continued From page 4 provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to provide privacy and confidentiality of medication administration records (MAR) for 4 of 4 residents (Resident #2, #16, #22, and #23) observed during administration of insulin. Failure to close the MAR may result in unauthorized viewing of resident records by other residents, unlicensed staff, and/or visitors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 234, stated, ". . . ensure the privacy and confidentiality of client information stored in computers. . . . Do not leave client information displayed on the monitor where others may see it. . . ." Observations on 06/07/22 showed the medication cart located outside of the physical therapy room. The nurse (#1) prepared insulin at the cart and administered insulin to residents in the physical therapy room as follows: *At 5:09 p.m. Resident #23 *At 5:13 p.m. Resident #16 *At 5:17 p.m. Resident #22	F 583	1. Corrective Action a. The facility will implement re-education of the facility policies consistent with the requirements of 483.10(h)(1)-(3)(i)(ii). Nurse #1 was re-educated on the regulation immediately when administration was aware of the occurrence. 2. Identification of Others a. The facility has determined that all residents have the potential to be affected. 3. System Changes a. DON or designee will provide education/review of CFR(s): 483.10(h)(1)-(3)(i)(ii) and on policy entitled, "Computer Terminals/Workstations" to all staff that handle PHI. Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. 4. Monitoring a. DON or Designee will complete observation audits of computer terminals/workstations to ensure PHI is not visible and closed out when not attended by nursing staff. Audits will be	

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F 583	Continued From page 5 *At 5:20 p.m. Resident #2 The nurse (#1) returned to the cart after each resident's insulin injection and failed to close the computer screen prior to returning to the physical therapy room for the next injection with the MAR visible. During an interview on 06/09/22, administrative staff (#1, #9, and #13) agreed nursing staff should to close the computer screen when the medication cart was left unattended.	F 583	completed at least 3 times weekly for 12 weeks across all shifts. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and recommendations. 5. Correction Date: a. 07/14/2022	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		7/14/22

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F 604	Continued From page 6 purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview the facility failed to assess the use of a seatbelt as a possible restraint for 1 of 2 sampled residents (Resident #4) observed with a seat belt while in a wheelchair. Failure to assess the seatbelt as a possible restraint, monitor its use, and evaluate the need for continued use placed Resident #4 at risk for an unnecessary restraint and injury related to its use. Findings include: The facility policy titled "Use of Restraints" occurred on 06/09/22. This undated policy stated, ". . . Restraints shall only be used . . . and never for . . . the prevention of falls. . . . Prior to placing a restraint, there shall be a pre-restraining assessment and review to determine the need for restraints. . . . The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions . . ." Review of Resident #4's medical record occurred on all days of survey and included a diagnosis of dementia. The current care plan failed to address the seat belt use.	F 604	1. Corrective Action a. Restraint Need Assessment completed for Resident #4. Seat belt has been removed. To help prevent sliding forward in chair, staff were instructed to use split leg sling with Hoyer lift. Dycem pad to be placed under wheelchair cushion and on top of wheelchair cushion. Sling is to be removed when resident is in the wheelchair. 2. Identification of Others a. The facility has determined that all residents have the potential to be affected. 3. System Changes a. DON or Designee will provide education to all staff on the survey regulations and interpretive guidelines for F604, 483.10 (e) (1), 483.12 (a)(2). Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. b. Education includes review of policy Use of Restraints. 4. Monitoring a. DON or designee will complete audits	

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F 604	Continued From page 7 Nursing progress notes identified the following: 12/28/21 at 8:35 p.m.: ". . . Resident was sitting next to nurses station and fell out of wheelchair. POA (power of attorney) notified, POA thinks resident might need a seat belt so she is safe in her chair, POA was told maybe he would have to talk to the social worker about that concern. DON (director of nursing)/ADMIN, (administrator) SW, (social worker) MDS (minimum data set staff) notified through email . . ." Observation during all days of survey showed Resident #4 seated in her wheelchair with the seat belt across her lap. During an observation on 06/09/22 at 8:50 a.m., a licensed social worker (LSW) (#2) and a nurse (#3) asked Resident #4 to remove her seat belt. The resident removed her top dentures and handed them to the nurse. The nurse and LSW asked the resident several times to remove her seat belt and at one point placed the residents left hand on the seat belt. The resident still did not remove the seat belt. The resident mumbled a few non-sensical words and looked around the room. The record lacked evidence of an assessment regarding the use of the seatbelt as a possible restraint, as well as ongoing monitoring and evaluation of its continued indications for use. The record also lacked evidence of education provided to the resident/her representative regarding the risks and benefits of seatbelt use. During an interview on 06/09/22 at 08:24 a.m., an administrative nurse (#1) confirmed the record lacked a physician's order and the initial	F 604	on all residents for use of restraints weekly for 12 weeks. b. Findings will be reported to QAPI committee for review and recommendations. The need for extending audits will be determined based on results of audits and QAPI committee review and recommendations. 5. Correction Date a. 07/14/2022	

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F 604	Continued From page 8 assessment or ongoing evaluation and monitoring of Resident #4's continued use of the seat belt.	F 604		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		7/14/22

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F 655	Continued From page 9 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview the facility failed to accurately develop a baseline care plan within 48 hours of admission and revise the baseline care plan with changes in resident care needs for 2 of 2 residents (Residents #76 and #77) admitted in the past 30 days. Failure to reflect the resident's immediate needs on the baseline care plan upon admission and then revise the baseline care plan to reflect the resident's needs/changes until staff completed the comprehensive care plan limits the staff's ability to provide safe, effective, and person-centered care for each resident. Findings include: Review of the facility policy titled "Baseline Care Plan Policy" occurred on 06/09/22. This undated policy stated, ". . . Rolette Community Care Center will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. . . . The baseline care plan will: Be developed within 48	F 655	1. Corrective Action a. A copy of the baseline care plan summary signed by facility representative was placed in the medical record for resident #77 and #76. 2. Identification of Others a. The facility has determined that all new admission residents have the potential to be affected. 3. System Changes a. All interdisciplinary care plan team members responsible for writing baseline care plans will be reeducated on the facility's policy and procedure for developing Baseline Care Plans, which includes procedures for providing a resident a written summary of their baseline care plan. Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. 4. Monitoring a. The DON or designee will complete audits of all new admission baseline care	

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F 655	Continued From page 10 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident . . . Interventions shall be initiated that address the resident's current needs including: Any health and safety concerns to prevent decline or injury, such as elopement, fall . . . any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. . . ." - Review of Resident #76's medical record occurred on all days of survey and identified an admission date of 06/02/22. Diagnoses included dementia with behaviors, Parkinson's disease, reduced mobility, and restlessness and agitation. An admission fall risk assessment completed on 06/02/22 identified Resident #76 as a high fall risk and an admission elopement assessment stated, ". . . is a high elopement risk . . . wanderguard placed on resident. bed and chair alarm placed for res. [resident] also. . . ." Review of Resident #76's progress notes on 06/02/22 showed the following: * At 11:48 a.m., ". . . totally dependent on 1 person for all ADL's [activities of daily living]. . . ." * At 12:54 p.m., ". . . Took 2 staff and gait belt to transfer [Resident's name] out [of] a car and into his w/c [wheelchair] to bring him into the facility . . . fall at home 1 week ago. . . . Res. [resident] can only bear wt [weight] on Rt [right] leg and he shakes when pivot transfers and grabs out, scared he is going to fall. . . . family states he is continent of bowel and bladder. uses the urinal and a bed pan. . . ." * At 4:46 p.m., "Res got up out of bed. fell to Lt knee, onto fall mat, on floor by bed. . . ."	F 655	plans weekly for 12 weeks. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and recommendations. 5. Correction Date a. 07/14/2022	

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F 655	Continued From page 11 * At 7:56 p.m., "at approx. [approximately] 1630 [4:30 p.m.] res was so anxious. . . . he tried to go out [the] Locker room door [staff] caught him and redirected [him]. Wander guard put on him. . . ." Additional progress notes for Resident #76 showed the following: * On 06/03/22 at 8:23 p.m., ". . . Is total patient care with ADLs. . . . Is transferred with pivot transferred [sic] with assist of 2 [staff]. Does have a bed and chair alarm . . . Can become physically aggressive and cannot be redirected. Does have episodes of increase [sic] anxiety, Does propel self in w/c on unit." * On 06/04/22 at 6:54 p.m., ". . . 2 assist with gait belt and pivot transfer. he shakes and is very scared he is going to fall whenever he is being transferred. . . ." * On 06/06/22 at 2:46 p.m., " . . . Resident is an assist with two with EZ stand [a sit-to-stand mechanical lift]. . . ."; at 6:11 p.m., "seroquel [antipsychotic] 25 mg [milligrams] administered per charge nurse delegation for anxiety/agitation/exit seeking behavior. Resident hard to redirect . . ."; and 8:26 p.m., ". . . requires total patient [assistance] with ADL's. Does feed self after tray has been set up. . . ." * 06/07/22 at 1:24 p.m., ". . . Becomes very anxious when attempting to pivot transfer him into wheelchair. . ."; and at 1:44 p.m., ". . . Resident tolerated 2 person pivot lift [transfer]. Does have severe spasms in left leg, PT [physical therapy] in tomorrow to assess transfers. . . ." Review of Resident #76's care plan from 06/02/22 (date of admission) through 06/07/22 indicated the following problems/interventions:	F 655		

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F 655	Continued From page 12 * Problem Start Date: 06/03/22, Category: Behavioral Symptoms stated, "Resident experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). . . . Approach Start Date 06/03/22 stated, "Equip resident with a device that alarms when wanders. Check for proper functioning of device every [blank] (frequency)." * Problem Start Date: 06/06/22, Category: ADL Functional / Rehabilitation Potential stated, "Resident's ability to transfer extensive, walk in room (not attempted, walk in corridor (not attempted, dress extensive assist) eat assist of one, toilet extensive assist maintain personal hygiene extensive assist. . . . Approach Start Date: 06/06/22 stated, "Provide extensive assist with ADLs. Uses W/C . . ." Observation on 06/06/22 at 2:38 p.m. and 06/07/22 at 9:53 a.m. showed Resident #76 anxious, had difficulty with transfers, unable to bear weight to his left leg, and very fearful of falling during transfers. See F689. Observations throughout survey showed a wanderguard, a bed alarm, a chair alarm, a fall mat in his room, and Resident #76 around the facility in his wheelchair. The facility failed to address the ADL care needs and the amount of assistance Resident #76 required within two days of admission, failed to identify the resident's risk for falls/elopement, and failed to update the care plan as his need for increased assistance with a mechanical lift developed. The facility also failed to identify Resident #76's	F 655		

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elopement attempt, use of a bed and chair alarms, use of a fall mat, address the frequency of wanderguard function tests, and develop a problem, goal, and interventions related to the resident's fall incident.

- Review of Resident #77's medical record occurred on all days of survey and identified an admission date of 05/26/22. Diagnoses included dementia with behaviors, Alzheimer's disease, urinary incontinence, and restlessness and agitation.

An admission fall risk assessment, completed on 05/26/22, identified Resident #77 as a high fall risk. An admission elopement assessment stated, ". . . Wander guard was placed by nurse due to the risk for elopement . . ." A nursing order, dated 05/26/22, stated, "Check wander guard activation daily . . . Wander guard on wheelchair. . . ."

Review of Resident #77's progress notes showed the following:
* On 05/26/22 at 10:40 a.m., ". . . uses a rolling walker with 1 assist and a gait belt for ambulating. is independent with bed [mobility]. . ."
* On 05/26/22 at 6:00 p.m., "Res was walked to DR [dining room] with 1 assist and a gait belt and his rolling walker. . . ."
* 05/27/22 at 10:01 p.m., ". . . walked to breakfast using his rolling walker, 1 assist and gait belt. does bend knees and leans forward when walking, with a shuffle gait. . . ."
* On 05/28/22 at 11:26 a.m., "Per [provider's name] due to high fall risk add bed alarm. Resident has tried to transfer self x 2 [twice] today. He has an unsteady gait . . . He is an

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assist of 1 with dressing and toileting . . . Has been walking with walker, assist of 1 with gait belt."
* 05/29/22 at 1:22 p.m., ". . . resident is an extensive assist of 1 with dressing and morning ADL's . . . assist of 1 with gait belt and walker for transfers and walking throughout the building. Resident also used a w/c [wheelchair] as needed today. . . . Needs assistance in the bathroom . . . Bed alarm in place to mattress as resident is high fall risk and attempts to transfer self throughout the day. . . ."
* 05/31/22 at 8:59 a.m., "Resident was found sitting on [the] floor by bedside stand by CNA [certified nursing assistant], resident's wheelchair alarm was going off . . ."
* 05/31/22 at 3:19 p.m., ". . . Resident is an assist of 1 with ADL's and transfers, resident uses w/c for mobility/can self propel. Resident has unsteady gait/ chair and bed alarm to alert staff when attempting to self transfer. . . ."
* 06/01/22 at 12:55 p.m., "Initial PT [physical therapy] Assessment . . . Functional Assessment: . . . a high fall risk when he walks with flexed knees and shuffling gait. . . . Recommend . . . Ambulation with FWW [front wheeled walker], gait belt and assist of 1 with w/c follow as tolerated. . . ."

Review of Resident #77's care plan from 05/26/22 (date of admission) through 06/07/22 indicated the following problems/interventions:
* Problem Date: 05/26/22, Category: Falls, stated, "Resident at risk for falls. . . . Approach Start Date: 05/26/22 Call light within reach. Bed in lowest position. . . ."

Observation on 06/08/22 at 9:40 a.m., showed

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F 655	Continued From page 15 the resident seated in a recliner with a chair alarm underneath him in the lounge area. Observations throughout survey showed Resident #77 had a wanderguard in place, a bed alarm on his mattress, and a chair alarm in his wheelchair. During an interview on 06/09/22 at 11:40 a.m., administrative staff members (#1, #9, and #13) agreed the 48 hour baseline care plan should reflect a resident's care needs and amount of assistance required and the care plan should be updated when care needs/changes are identified. The facility failed to: * Address the ADL care needs and amount of assistance Resident #77 required within two days of admission. * Identify the resident's risk for elopement. * Update the care plan as his need for increased assistance with use of a wheelchair. * Identify Resident #77's use of bed and chair alarms, and use of a wanderguard. * Develop problems, goals, and interventions related to the resident's ADL care/assistance needs. * Update the care plan to reflect the physical therapist's recommendations after their initial assessment.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		7/14/22

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F 657	Continued From page 16 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 3 of 11 sampled residents (Resident #13, #15, and #20). Failure to revise the care plans may limit staff"s ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans Comprehensive" occurred on 06/09/22. This undated policy stated, "Policy Statement . . .	F 657	1. Corrective Action a. A review has been completed of all care plans to ensure accuracy. 2. Identification of Others a. The facility has determined that all residents have the potential to be affected. 3. Systematic Changes a. Education has been completed with the individuals on the Interdisciplinary Team that are responsible for making updates to the care plan.	

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F 657	Continued From page 17 Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. . . ." - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, borderline personality disorder-aggression, restlessness and agitation, and wandering. Physician's orders included: * 08/09/21 Ativan (an anti-anxiety) 0.5 mg (milligrams) by mouth every bedtime. * 08/10/21 Seroquel (an anti-psychotic) 100 mg, 1.5 tablets; Special Instructions: give 150 mg Seroquel by mouth every bedtime. * 12/06/21 Seroquel 100 mg 1 tablet; oral Once A Day 04:00 PM * 01/08/22 Seroquel 50 mg 1 tablet; oral; Special Instructions: give one 50mg tablet by mouth before ADLs (Acitivities of Daily Living) in the morning Resident #13's current care plan stated, ". . . Resident can get upset and display disruptive behavioral symptoms . . . Resident experiences wandering . . . Resident has behavioral symptoms not directed to others . . . Resident has socially inappropriate/disruptive behavioral symptoms . . . Resident has impaired decision making R/T [related to] cognitive loss. . . ." Nursing staff failed to care plan Resident #13's use of anti-psychotic and anti-anxiety medications as it relates to behaviors. - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included major depressive disorder.	F 657	4. Monitoring a. A chart review audit for one sampled resident will be completed to ensure the facility has accurate and up to date care plans and that the above corrective actions and changes are being followed. This will be completed weekly for six weeks, then monthly for three months. Any areas identified through this audit will be immediately corrected. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and recommendations. 5. Correction Date a. 07/14/2022	

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Physician's orders included the following:
* 06/01/22 Namenda (a medication used for dementia) 10 mg by mouth twice a day.
* 04/29/22 Seroquel 150 mg by mouth every bedtime.
* 03/08/22 Seroquel 25 mg 1 tablet; oral twice a day.
* 01/31/22 Mirtazapine (an anti-depressant and anti-anxiety) 15 mg 1 tablet once a day.

Progress notes included the following:
* 04/14/22 12:04 p.m., Dr. [Doctor's name] was notified of residents behaviors. Orders to increase seroquel to 100 mg at HS [bedtime] . . ."
* 04/29/22 12:05 p.m., ". . . Resident was hollering out at staff yelling that he was not going to eat. Staff encouraged him to come eat in the dining room. He continued to holler out and yelled at staff, writer asked him to go sit in the dining room. Resident would throw his feet down staff was unable to assist him with placing his foot pedals on. . . . He was also disgruntled while going into the shower this AM yelling that staff was going to choke him. . . ."

Nursing staff failed to care plan Resident #15's behaviors, use of anti-psychotic, anti-depressant, and anti-anxiety medications.

- Review of Resident #20's medical record occurred on all days of survey. Diagnoses include hemiplegia and hemiparesis affecting left non-dominant side and memory deficit.

Resident #20's progress notes showed the following:
* 05/10/22 11:28 p.m. ". . .Found on floor in

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F 657	Continued From page 19 bathroom, stated he was self transferring from toilet to WC [wheelchair], missed and sat self down on floor. . . ." * 05/29/22 06:08 p.m. ". . .Resident was found sitting on floor at bedside by aid [certified nursing assistant]. . . . Resident reports that he was trying to scoot himself back into his w/c, didn't lock his breaks while using the hand rail on bed to pull himself up, his w/c slid back and he reports he went to the floor. . . ." * 05/30/22 10:29 p.m. "Auto breaks [sic] and anti-tipper devices are on order for resident's wheelchair as a fall prevention measure. To be installed when delivery received." In an interview on 06/07/22 at 4:10 p.m., two administrative staff (#1 and #13) confirmed staff have installed the anti-tip bars. The automatic locking brakes have yet to arrive. Resident #20's current care plan states, ". . . Resident has diagnosis of Hemiparesis and is S/P [status post] CVA [cerebral vascular accident]. [Resident #20] also takes psychotropic medications and is at risk for falls. Staff will provide ADL assistance as needed. Staff will be sure [Resident #20] call light is within his reach and will answer [Resident #20] call light promptly. Staff will encourage [Resident #20] to participate in R.A. [Restorative Aide] program to maintain/improve [Resident #20] strength." Nursing failed to revise the care plan to include the addition of the anti-tipping device to the resident's wheelchair. During an interview on the morning of 06/09/22, administrative staff (#1, #9, and #13) agreed the	F 657		

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F 657	Continued From page 20 residents' care plans should include the use of psychotropic medications, behaviors, and wheelchair safety devices.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: WEIGHTS 1. Based on record review, review of facility policy, and staff interview the facility failed to provide care in accordance with professional standards for 2 of 2 sampled residents (Resident #13 and #24) with a weight discrepancy. Failure to weigh residents as ordered and/or reweigh residents per facility policy may delay needed treatment for weight loss or gain and alter the resident's ability to maintain a sufficient health/nutritional status. Findings include: Review of the facility policy titled "Weight Assessment and Intervention" occurred on 06/09/2022. This undated policy showed ". . . Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian. . . ." - Review of Resident #13's medical record occurred on all days of survey. Diagnoses	F 658	WEIGHTS 1. Corrective Action a. Resident #13 has been reweighed and weight was verified to be correct as of 06/15/2022. b. Resident #24 has been reweighed and weight was verified to be correct as of 06/10/2022. 2. Identification of Others a. The facility has determined that all residents have the potential to be affected. 3. System Changes a. DON or Designee will provide education to all staff verbally on importance of weight tracking. Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. b. Education includes review of updated policy on Weight Assessment and Intervention.	7/14/22

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F 658	Continued From page 21 included dementia with behavioral disturbance. A physician's note, dated 04/05/2022 states: ". . . 2. History of failure to thrive, currently some weight gain. . . ." A physician's order, dated 08/03/2021, shows "Monthly Weight Once a Day on the 6th of the Month" Review of Resident #13's weights from 01/05/2022 through 06/06/2022 showed the following: * 01/06/2022 124 lbs (pounds) * 02/06/2022 no weight recorded * 03/06/2022 130.5 lbs * 04/06/2022 131 lbs * 05/06/2022 139.5 lbs (6% gain in one month) * 06/06/2022 182 lbs (30% gain in one month) A dietary note, dated 04/05/22 stated, ". . .Intake has improved slightly since last review. Current wt of 130.5# [pounds] is below IBW [Ideal Body Weight] of 148-180#. Goal for resident is to increase wt to nearer IBW. A wt gain of 5# in 90 days is noted. Resident #13's care plan, edited on 04/06/2022, stated, ". . .Offer a high calorie high protein supplement indicated with poor intake. Goal for resident is to increase wt [weight] to nearer [sic] 140 lbs [pounds] . . ." During an interview on 06/08/22 at 2:16 p.m., an administrative nurse (#1) agreed staff failed to weigh the resident on 02/06/22 and agreed the 06/06/2022 weight of 182 pounds appeared incorrect and should have flagged for a reweigh when documented.	F 658	4. Monitoring a. DON or designee will complete audits on all resident weights weekly for 12 weeks. b. Findings will be reported to QAPI committee for review and recommendations. The need for extending audits will be determined based on results of audits and QAPI committee review and recommendations. 5. Correction Date a. 07/14/2022 NEUROLOGICAL ASSESSMENT 1. Corrective Action a. Policy was updated to include the frequency that nursing staff are to perform a neurological assessment after a fall. b. Nurse that triggered the neurological checks for Resident #76 on 06/02/2022 has been educated on the updated policy. c. Resident #77s Neurologic Assessment Form (on paper) was located and scanned to chart. Nurses educated as to importance of placing completed (paper) Neurologic Assessment Form in Medical Records mailbox to be scanned into Matrix. 2. Identification of Others a. The facility has determined that all residents have the potential to be affected if a fall occurs. 3. Systematic Changes a. DON or Designee will provide education to nurses on Neurological	

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F 658	Continued From page 22 During an interview on 6/08/22 at 3:37 p.m., the administrative staff (#9) confirmed the dietitian performs a quarterly weight assessment and the discrepancy should trigger as a concern needing a correction or confirmation of weight. The staff (#9) was unsure why the 30% weight gain on 06/06/22 (42.5 lbs) did not trigger for a reweigh when documented in the medical record. Failure to follow the physician's orders and obtain monthly and accurate weights may contribute to incorrect assessment of weight changes and failure to initiate nutritional interventions. - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included weight loss and failure to thrive. Review of the Resident #24's weights from 12/10/21 through 05/10/22 identified the following: 12/10/2021 147.5 lbs 01/10/2022 139.5 lbs (5% loss in one month) 02/10/2022 140 lbs 03/05/2022 149.5 lbs (7% gain in one month) 03/10/2022 134.5 lbs (10% loss in one month) 04/10/2022 136 lbs 05/10/2022 147 lbs (8% gain in one month) The facility failed to reweighed Resident #24 when they identified a 5% or more change from the previous weight assessment. Provider's notes indicated the following for Resident #24: *03/08/22, ". . . weight 149 pounds . . ." *04/28/22, ". . . weight is 136 pounds which is	F 658	Assessment policy. Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. 4. Monitoring a. DON or designee will audit to review completion of Neurological Check after falls. Audits for every fall will be completed weekly x 12 weeks. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and recommendations. 5. Correction Date a. 07/14/2022	

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	355081	A. BUILDING _____ B. WING _____	C 06/09/2022

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

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F 658	Continued From page 23 down 13 pounds from last rounds [on 03/08/22]. . . ." A dietary note, dated 05/16/22, stated, ". . . a current weight of 147# which is above her IBW of 102-124#. [Resident's name] has experienced a significant wt increase in the past 30 days of 8.1%. During an interview on 06/09/2022 at 2:48 p.m., administrative staff members (#1 and #9) agreed staff failed to reweigh Resident #24 per facility policy and may result in inaccurate recommendations/orders by the dietician and the provider. NEUROLOGICAL ASSESSMENT 2. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 13 sampled residents (Resident #76 and #77) who experienced an unwitnessed fall. Failure to perform/accurately complete neurological assessments following a fall may result in delayed identification and treatment of signs/symptoms of a closed head injury. Findings include: Review of the facility policy titled "Neurological Assessment" occurred on 06/09/22. This undated policy stated, ". . . Neurological assessments are indicated . . . following an unwitnessed fall . . . Perform neurological checks with the frequency as ordered or per falls protocol. . . . The following information should be recorded in the resident's	F 658		

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F 658	Continued From page 24	F 658		

medical record: The date and time the procedure was performed. . . . All assessment data obtained during the procedure. . . . Report other information in accordance with the facility policy and professional standards."

The facility's policy lacked the frequency nursing staff are to perform neurological assessments after a fall.

- Review of Resident #76's medical record occurred on all days of survey and identified a diagnoses of Parkinson's disease, reduced mobility, restlessness, and agitation.

A nursing progress note, dated 06/02/22 at 4:26 p.m., indicated Resident #76 experienced a fall out of bed. The progress note failed to identify if the fall was witnessed or unwitnessed.

Review of a neurological assessment form completed for Resident #76 showed assessment data entered on the following dates and times:
* 06/02/22 at 11:00 a.m., 2:45 p.m., 3:00 p.m., 4:15, p.m., and 5:45 p.m.
* 06/03/22 no entries recorded
* 06/04/22 at 10:00 a.m., and 4:00 p.m.
* 06/05/22 at 8:00 a.m., 3:00 p.m., 4:30 p.m., and 9:00 p.m.
* 06/06/22 no entries recorded
* 06/07/22 1:00 p.m. and 8:00 p.m.

A handwritten note at the bottom of this form stated, "Timeframe: Initial, then every 30 minutes x 4 [four times], then every 8 hours x 3 days [for three days]."

During an interview on the morning of 06/09/22, an administrative staff member (#9) confirmed

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F 658	Continued From page 25 the handwritten note on the bottom of Resident #76's neurological assessment form as the facility's protocol for frequency of nursing staff to perform and document a resident's neurological assessment data. During an interview on the morning of 06/09/22, administrative staff members (#1 and #9) agreed nursing staff failed to perform Resident #76's neurological assessments at the frequency listed on the assessment form and confirmed the form lacked any data entries for 06/03/22. - Review of Resident #77's medical record occurred on all days of survey and identified diagnoses of Alzheimer's disease, dementia, restlessness, and agitation. A nursing progress note, dated 05/31/2022 at 8:59 a.m., stated, "Resident was found sitting on floor by bedside stand by CNA [certified nursing assistant], residents wheel chair alarm was going off . . ." The progress note failed to identify if the fall was witnessed or unwitnessed. Resident #77's medical record lacked evidence staff initiated a neurological assessment after the fall on 05/31/22 and the facility failed to provide a fall assessment/investigation report related to this fall. During an interview on the morning of 06/09/22, administrative staff members (#1 and #9) confirmed Resident #77 had an unwitnessed fall on 05/31/22 and agreed nursing staff failed to initiate neurological assessments after the fall occurred.	F 658		
F 677	ADL Care Provided for Dependent Residents	F 677		7/14/22

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F 677 SS=D	Continued From page 26 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on information received from the complainant, observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary services for 3 of 13 sampled residents (Resident #6, #15, and #24) who required activities of daily living (ADL) assistance. Failure to provide assistance for hygiene and repositioning of residents may result in low self esteem, skin breakdown, and/or pressure ulcers. Findings include: Information received by the department from an anonymous complainant identified concerns with staff not providing necessary activities of daily living (ADL) cares to dependent residents. PERSONAL CARES Review of the facility policy titled "Activities of Daily Living, supporting" occurred on 06/09/22. This undated policy stated, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal hygiene . . ." - Review of Resident #6's medical record occurred on all days of survey.	F 677	1. Corrective Action a. Resident #6 was provided with a razor to trim any visible facial hair daily or as needed. b. Staff educated residents are to be toileted upon request. c. Facility policy Repositioning was updated to reflect every 2 hour repositioning for residents in chairs. d. Resident #24 has been placed on a q2h turning/repositioning schedule 2. Identification of Others a. The facility has determined that all dependent residents have the potential to be affected. 3. System Changes a. DON or Designee will provide education to all staff on the survey regulations and interpretive guidelines for F677, 483.24(a)(2). Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. b. Education includes review of policy Activities of Daily Living, Supporting, Repositioning, and Shaving the Resident. 4. Monitoring a. DON or designee will complete audits	

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F 677	Continued From page 27 Resident #6's current care plan stated, ". . . Personal Hygiene Extensive with 1 assist . . ." Observations on all days of survey showed Resident #32 with visible facial hair. During an interview on 06/08/22 at 9:54 a.m., Resident #6 stated, "They usually only shave me when I get a haircut, I need it more than that." During an interview on 06/09/22 at 11:55 a.m., administrative nurse (#13) stated she expected staff to shave both male and female residents. - Review of Resident #15's medical record occurred on all days of survey and included the diagnosis of weakness. The Minimum Data Set (MDS), dated 04/05/22 identified extensive assist for toileting. Resident #15's current care plan stated, ". . . Self Care Deficit - Requires staff intervention or assistance to remain clean, neat and free of body odors. Will be clean, dry, odor free . . . Give prompt assistance to Resident when he asks to go to the bathroom. . . ." Observations on 06/06/22 showed the following: * 04:37 p.m., Resident #15 was seated in the recliner in the lounge area and as a certified nursing assistant (CNA) (#6) walked past him, he requested her assistance with going to the bathroom. The CNA stated, "Give me a minute." The CNA (#6) did not go back to assist Resident #15 with toileting. * 04:43 p.m., Resident #15 requested assistance to the bathroom a second time. A nurse (#7)	F 677	on a sample of 5 residents weekly x 12 weeks that commonly are seated in commons areas that require assistance with repositioning and or toileting. b. Observation audits will be completed on residents (both male and female) to ensure they are well groomed/shaved weekly x 12 weeks. c. Findings will be reported to QAPI committee for review and recommendations. The need for extending audits will be determined based on results of audits and QAPI committee review and recommendations. 5. Correction Date a. 07/14/2022	

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F 677	Continued From page 28	F 677		

acknowledged the resident and stated, "Yes ok".
* 04:49 p.m., Resident #15 requested assistance to the bathroom a third time.
* 04:51 p.m., the nurse (#7) assisted Resident #15 from the recliner to the wheelchair.
* 04:52 p.m., the CNA (#6) assisted Resident #15 in his wheelchair to his room.
* 04:53 p.m., the CNA (#6) assisted Resident #15 to the bathroom. Observation showed the resident's incontinent product and pants soaked with urine.

During an interview on 06/09/22 at 11:50 a.m., administrative staff (#1, #9 and #13) confirmed they expected nursing staff to take all residents to the bathroom immediately upon the resident's request.

REPOSITIONING

Review of facility policy titled "REPOSITIONING" occurred on 06/08/22. This undated policy stated, ". . . Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. . . . Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. . . . Residents who are in a chair should be on an every one hour (q1 hour) repositioning schedule. . . . Assist the resident to change his or her position in chair. Monitor the need for toileting or incontinence care when changing position. . . ."

- Review of Resident #24's medical record occurred on all days of survey and identified diagnoses of limited range of motion and failure to thrive. The resident's quarterly Minimum Data

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F 677	Continued From page 29 Set (MDS), dated 05/17/22, identified total dependence and required assistance of two for bed mobility and transfers. The care plan indicated Resident #24 is at risk for pressure ulcers. Observations showed Resident #24 seated in her wheelchair in the same position and location on the following days/times: * 06/06/22 from 2:29 p.m. to 4:15 p.m. * 06/07/22 from 9:22 a.m. to 11:14 a.m. * 06/08/22 from 1:21 p.m. to 3:43 p.m. * 06/09/22 from 8:41 a.m. to 10:49 a.m. During an interview on 06/08/22 at 01:34 p.m., when asked if staff have a toileting or repositioning schedule for Resident #24, the CNA (#15) stated the nurses charted repositioning in the medication administration record (MAR)/treatment administration record (TAR) and staff charted toileting in the vitals section in the medical record. Review of Resident #24's April-June 2022 MAR/TAR showed no documentation for repositioning and review of the May-June 2022 toileting schedule showed limited documentation for Resident #24. During an interview on 06/09/22 at 11:48 a.m., the administrative staff (#1, #9, and #13) agreed staff should reposition Resident #24 every hour while in her wheelchair per facility policy.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		7/14/22

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F 689	Continued From page 30 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide assistance and/or assistive devices necessary to ensure safety and prevent accidents or injury for 4 of 13 sampled residents (Residents #2, #3, #15 and #76) who required staff assistance for transfers and repositioning. Failure to assess a resident for transfer ability and assistance needs, use a gait belt during transfers, and ensure resident safety during repositioning placed the residents at risk for injury/falls and impaired skin integrity. Findings include: TRANSFER FOR RESIDENT WITH LEFT-SIDED WEAKNESS Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Massachusetts, pages 1116-1120, stated, "Before transferring any client . . . the nurse must determine the client's physical and mental capabilities to participate in the transfer technique. Gait belts are not appropriate for all clients . . . They are suitable for clients who can bear weight and require only minimal assistance. . . . before transferring a client, assess the following: . . . ability to bear weight	F 689	1. Corrective Action a. Resident #76s transfer method was clarified and updated in care plan and on CNA care cards per recommendations from Physical Therapy evaluation. b. Staff are receiving education with demonstration on gait belt use and proper transfer/reposition methods, including transfer of a resident with one-sided weakness and use of mechanical lifts. c. Resident #15s care plan and CNA care card do reflect that resident is to have assist of 1 using a gait belt and walker. Staff re-educated that gait belt must be used. d. Staff were re-educated not to lift Resident #3 under the arms during repositioning. 2. Identification of Others a. The facility has determined that all residents requiring transfer assistance have the potential to be affected. 3. System Changes a. DON or Designee will provide education to all staff on the survey regulations and interpretive guidelines for F689, 483.25(d)(1)(2). Staff must be educated on or before 07/14/22 or before	

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F 689	Continued From page 31 (full, partial, or none). Ability to position feet on the floor. . . . muscle strength . . . position equipment appropriately. . . . Place the wheelchair parallel to the bed and as close to the bed as possible. Put the wheelchair on the side of the bed that allows the clients to move toward the stronger side. . . . Transferring a Client with an Injured Lower Extremity [limited or non-weight bearing to the extremity] movement should always occur toward the client's unaffected (strong) side. . . ." Review of Resident #76's medical record occurred on all days of survey and identified an admission date of 06/02/22. Diagnoses included dementia, Parkinson's disease, and reduced mobility. Review of Resident #76's progress notes showed the following: * 06/02/22 at 11:48 a.m., ". . . totally dependent on 1 person for all ADL's [activities of daily living]. . . ." * 06/02/22 at 12:54 p.m., ". . . Took 2 staff and gait belt to transfer [Resident's name] out [of] a car and into his w/c [wheelchair] to bring him into the facility . . . Res. [resident] can only bear wt [weight] on Rt [right] leg and he shakes when pivot transfers and grabs out, scared he is going to fall. . . ." * 06/03/22 at 8:23 p.m., ". . . Is total patient care with ADLs. . . . Is transferred with pivot transferred [sic] with assist of 2 [staff]. . . ." * 06/04/22 at 6:54 p.m., ". . . 2 assist with gait belt and pivot transfer. he shakes and is very scared he is going to fall whenever he is being transferred. . . ." * 06/06/22 at 2:46 p.m., " . . . Resident is an	F 689	next scheduled shift if after this date. b. Education includes review of policies for Use of Gait Belt, and Safe Lift and Movement of Residents, Repositioning. 1. Monitoring a. DON or designee will complete observation audits of staff performing transfers or repositioning on a sample of 5 residents per week for 12 weeks. b. Audits of CNA care cards will be completed at least weekly to ensure transfer method is accurate for each resident. c. Findings will be reported to QAPI committee for review and recommendations. The need for extending audits will be determined based on results of audits and QAPI committee review and recommendations. 2. Correction Date a. 07/14/2022	

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F 689	Continued From page 32 assist with two with EZ stand [a sit-to-stand mechanical lift]. . . ." * 06/07/22 at 1:44 p.m., ". . . Resident tolerated 2 person pivot lift. Does have severe spasms in left leg . . ." Resident #76's care plan stated, "Problem Start Date: 06/06/22 . . . Resident's ability to transfer extensive . . . toilet extensive assist. . . ." The care plan lacked adequate instruction for staff to safely transfer Resident #76. See F655 Observations of Resident #76 showed the following: * 06/06/22 at 2:38 p.m., a certified nursing assistant (CNA) (#10) placed a gait belt on Resident #76 while sitting at the edge of the bed and then placed a wheelchair diagonal to the bed on the resident's weak side (left side). The CNA (#10) and a nurse (#8) (one on each side of the resident) held the gait belt with both of their hands, raised Resident #76 to a semi-standing position while the resident leaned towards the wheelchair with his left leg bent at the knee and off the floor and bore only partial weight on the right leg. The resident verbally expressed fear of falling. While still holding onto the gait belt, the two staff manually turned the resident and placed him into the wheelchair. * 06/07/22 at 9:53 a.m., Resident #76 seated sideways on the toilet and a gait belt around his waist. After toileting, a CNA (#14) positioned a wheelchair facing the front of the toilet. With the resident's weak leg (left leg) at the front of the toilet and adjacent to the wheelchair, two CNAs (#11 and #14) held the gait belt with both of their hands and manually lifted/maneuvered the resident off the toilet and into his wheelchair. The	F 689		

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resident did not bear weight on the left leg and was unable to assist with his right leg. The resident again expressed fear of falling.

During an interview on 06/08/22 at 9:40 a.m., when asked how facility staff know what type of assistance a resident requires for transfers, a CNA (#15) pulled a sheet of paper from her pocket, and identified the paper as a resident care card. Observation showed all boxes meant to identify Resident #76's current ADL care needs and assistance were blank. The CNA (#15) stated Resident #76 is a pivot transfer, "But I feel he should be a hoyer [a mechanical assistive device used to transfer residents]." When asked how she knew Resident #76 was a pivot transfer, the CNA (#15) stated, "from his wife when he came here [upon admission on 06/02/22]."

The facility failed to assess Resident #76's ability to safely transfer and failed to ensure staff were competent to transfer a resident who was unable to bear weight safely.

GAIT BELTS

Review of the facility policy titled "Use of Gait Belt Policy" occurred on 06/09/22. This undated policy stated, ". . . It is the policy of the Rolette Community Care Center to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. . . ."

- Review of Resident #15's medical record occurred on all days of survey and included a diagnosis of weakness. The current care plan stated, ". . . Resident is limited in ability to balance self while standing . . . Resident will

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F 689	Continued From page 34 stand upright with assistance of one with gait belt . . ." Observations showed the following: * 06/06/22 at 2:35 p.m., a CNA (#12) assisted Resident #15 from his wheelchair to stand in the bathroom without using a gait belt and by lifting under his left arm. * 06/06/22 at 4:51 p.m., a nurse (#7) transferred Resident #15 from the recliner to his wheelchair without using a gait belt by lifting under his arms. * 06/06/22 at 4:54 p.m., a CNA (#6) assisted Resident #15 from the wheelchair to stand in the bathroom without using a gait belt by lifting under the resident's arms. * 06/08/22 at 12:10 p.m., a CNA (#14) transferred Resident #15 from the recliner to his wheelchair without using a gait belt by lifting under both his arms. During an interview on 06/09/22 at 11:58 a.m., administrative staff (#1, #9 and #13) indicated they expected staff to use a gait belt with Resident #15. SAFE LIFT/REPOSITIONING OF RESIDENTS Review of the facility policy titled "Safe Lift and Movement of Residents" occurred on 06/09/22. This undated policy stated, ". . . Manual lifting of residents shall be eliminated when feasible. . . . Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. . . ." Review of the facility policy titled "Repositioning" occurred on 06/09/22. This undated policy stated,	F 689		

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F 689	Continued From page 35 ". . . Repositioning the Resident in Bed . . . Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed. . . ." - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, ". . . Resident requires extensive asst [assistance] x 1 [of one staff] with some ADL's [activities of daily living]. . . . Resident uses wheelchair. . . ." Observation on 06/06/22 at 4:41 p.m. showed a CNA (#10) assisted Resident #2 from a laying position in bed to a seated position by lifting under the resident's neck with her arm. The CNA (#10) applied a gait belt to the resident, lifted under the resident's right arm, and assisted him to a standing position. The CNA (#10) then used the gait belt to pivot the resident into the wheelchair. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included paraplegia. The current care plan stated, ". . . Resident requires assistance with ADL's. Is non-ambulatory. . . . Resident uses total lift for all surface to surface transfers with 2 person staff assist. . . ." Observation on 06/06/22 at 4:28 p.m. showed two CNAs (#10 and #12) transferred Resident #3 to bed using a full-body mechanical lift. The CNAs attempted to position the resident higher in the bed by placing their arms under the resident's axillae and lifting under the resident's arms. Resident #3 then motioned to be moved to the other side of the bed. The CNA's lifted under the	F 689		

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F 689	Continued From page 36 resident's arms, however, the resident's lower body did not move. Resident again motioned a request to be farther over in the bed and the CNAs again lifted under the resident's arms. The resident moved minimally but didn't request to be moved again. During an interview on 06/09/22 at 11:30 a.m., administrative staff (#1, #9 and #13) agreed residents should not be lifted behind the neck or under the arms.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		7/14/22

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F 726	Continued From page 37 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 1 nursing staff (#3) observed using the suction machine knew the location of equipment required to care for the needs of the residents. Failure to ensure nursing staff are knowledgeable regarding the location of the suction machine may result in poor resident care and/or outcome. Findings include: Observation on 06/09/22 at 9:32 a.m. showed a staff nurse (#3) located the suction machine and the tubing in a cupboard at the nurses' station, and stated she needed a canister to connect the tubing. The nurse failed to locate a canister in two different store rooms. At 9:40 a.m., the staff nurse asked an administrative nurse (#1) if the facility had canisters for the suction machine. The administrative nurse went to one of the two store rooms and found a canister. At 9:44 a.m., the staff nurse had all the supplies necessary to suction and demonstrated the use of the suction machine. During an interview on 06/09/22 at 11:55 a.m., administrative staff (#1, #9 and #13) stated nursing staff should know how to use the suction machine and have the proper supplies available and ready in case of emergencies.	F 726	1. Corrective Action a. Administrative nurse (#1) assisted Nurse #3 in locating suction equipment and educated her immediately on the location of the supplies. 2. Identification of Others a. The facility has determined that all residents that require suctioning have the potential to be affected. 1. System Changes a. DON or Designee will provide education to all staff on location of suction machine supplies, so they are readily available to care for the needs of the residents. Staff must be educated on or before 07/14/22 or before next scheduled shift if after this date. 2. Monitoring a. DON or Designee will monitor suction machine supply location and quantity weekly for 12 weeks to ensure availability. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and	

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F 726	Continued From page 38	F 726	recommendations. 3. Correction Date: a. 07/14/2022	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 1 medication cart. Failure to lock the medication	F 761	1. Corrective Action a. The facility will implement re-education of the facility policies consistent with the requirements of 483.45(g)(h)(1)(2).	7/14/22

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F 761	Continued From page 39 cart when unattended may result in unauthorized access to medications. Findings include: The facility failed to provide a policy for medication administration or medication storage upon request. Observations on 06/07/22 showed the medication cart located outside the physical therapy room. The nurse (#1) prepared and administered insulin to fourt residents in the physical therapy room at 5:09 p.m., 5:13 p.m., 5:17 p.m., and 5:20 p.m. The nurse (#1) left the medication cart unlocked each time she entered the physical therapy room to administer insulin. During an interview on 06/09/22, administrative staff (#1, #9 and #13) agreed nursing staff should lock the medication cart when it is left unattended.	F 761	Nurse #1 was re-educated on the regulation immediately when administration was aware of the occurrence. 2. Identification of Others a. The facility has determined that all residents have the potential to be affected. 3. System Changes a. DON or designee will provide education directly from State Operations Manual F761 page 513 and complete a policy review for Storage of Medications and Medication Storage Policy to all nurses on or before 07/14/22 or before next scheduled shift if after this date. 4. Monitoring a. DON or Designee will complete observation audits of the Medication and Treatment Carts to ensure they are locked when not attended by nursing staff. Audits will be completed at least 3 times weekly for 12 weeks. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and recommendations. 5. Correction Date: a. 07/14/2022	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/14/22

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F 880	Continued From page 40 §483.80 Infection Control 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;	F 880		

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F 880	Continued From page 41 (iv)When and how isolation should be used for a resident; including but not limited to: (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: THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS STANDARD SURVEY CONDUCTED ON 04/27/21. Based on observation, review of facility policy, professional reference, and staff interview, the facility failed to follow infection control practices for 7 of 13 sampled residents (Residents #3, #4,	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of 483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency.	

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F 880	Continued From page 42 #9, #12, #13, #15, and #24) observed during cares. Failure to follow infection control practices has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: PERSONAL PROTECTIVE EQUIPMENT (PPE) Review of the facility policy titled "Infection Prevention and Control Program" occurred on 06/09/22. This policy, revised April 2022, stated, "Policy: This facility has established and maintains 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. . . . Standard Precautions: . . . All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. . . ." A CDC (Centers for Disease Control) publication with content source from the National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, dated January 28, 2022, states, "Procedure Masks . . . Wear procedure masks with "A proper fit over your nose, mouth and chin to prevent leaks . . ." Observations showed the following: * 06/06/22 at 4:40 p.m., a certified nursing assistant (CNA) (#6) entered Resident #3's room with a face mask on her chin, then pulled it over her mouth and nose. * 06/07/22 at 3:41 p.m., a CNA (#6) assisted	F 880	The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff provide catheter cares/emptying of urinary drainage bags consistent with facility policy and in accordance with CDC guidelines for catheter maintenance. (2) Ensuring staff have adequate knowledge of hygienic cleaning practices of resident care items and equipment to correctly disinfect mechanical lifts between resident use. (3) Ensuring staff correctly wear a facemask, over chin, mouth, and nose, in accordance with guidelines from the CDC. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate staff on correct catheter cares and emptying of urinary catheter bags. (2) Educate all staff on correct disinfecting practices for all reusable equipment. To verify this/these staff understands correct disinfection, this/these staff will perform a successful return demonstration of identifying the need and correct procedure for disinfecting of reusable equipment. (3) Educate clinical staff on correct positioning of a face mask.	

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F 880	Continued From page 43 Resident #12 with cares with her surgical mask positioned on her chin, not covering her mouth and nose. * 06/07/22 at 4:53 p.m., a CNA (#6) assisted Resident #4 with cares with her surgical mask positioned on her chin, not covering her mouth and nose. * 06/07/22 at 5:11 p.m., a CNA (#6) assisted Resident #15 with cares with her surgical mask positioned on her chin, not covering her mouth and nose. FOLEY CATHETER CARES Review of the facility policy titled "Emptying a Urinary Drainage Bag" occurred on 06/09/22. This undated policy stated, ". . . General Guidelines . . . Do not allow the drain spout to come into contact with the measuring container, hands, or any other object. (Note: If accidental contamination occurs, wipe the drain spout with an alcohol sponge or swab.) . . . Steps in the Procedure . . . Place a paper towel on the floor beneath the drainage bag. . . . Pour urine down the commode. . . . Rinse out the measuring container and return to its designated storage area. . . ." - Observation on 06/06/22 at 4:28 p.m. showed a CNA (#10) emptied Resident #3's catheter bag into a urinal. Without putting a paper towel on the floor, the CNA placed the urinal on the floor, opened two alcohol swab packets, setting one on the floor and using the other to cleanse the catheter drain spout. The CNA put the drain spout into the urinal and proceeded to shake the drain spout back and forth. "Sometimes there's mucus in the tube and it can take forever to drain	F 880	2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for catheter care, disinfecting of equipment and positioning of face masks from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 07/14/2022 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to complete catheter cares correctly. b. Failure to ensure cleaning of reusable equipment was completed in a hygienic manner with appropriate dwell times to achieve disinfection in accordance with CDC guidelines and cleaning product manufacturer instructions. c. Failure to ensure proper face mask placement. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff whose normal duties	

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F 880	Continued From page 44 it. The CNA shook and "milked" the drain spout against the sides of the urinal. The CNA removed the alcohol swab from the open packet on the floor, used it to cleanse the drain spout and placed the drain spout back into its holder. The CNA emptied the urinal into the toilet, failed to rinse the urinal, and hung it on the grab bar beside the toilet. During an interview on 06/09/22 at 11:45 a.m., administrative staff (#1, #9, and #13) agreed the catheter drain spout should not intentionally touch the sides of the measuring container when being emptied and a protective barrier should be placed on the floor. CLEANING AND DISINFECTING OF EQUIPMENT Review of the facility policy titled "Cleaning and Disinfection of Resident-Care Items and Equipment" occurred on 06/09/22. This undated policy stated, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC [Centers for Disease Control] recommendations for disinfection . . . Reusable resident care equipment will be decontaminated and/or sterilized between residents . . ." Observations showed the following: * 06/06/22 at 1:12 p.m., two CNAs (#12 and an unidentified CNA) transferred Resident #9 with a full body lift. Upon completion of the transfer, a CNA (#12) failed to clean the lift, removed the lift from the room, and placed it in the shower room down the hall.	F 880	include catheter cares. b. Educate all staff whose job duties include hygienic cleaning procedures including effective contact or dwell times for disinfectants used on reusable equipment. This education will include the CDC's lesson on cleaning available at https://youtu.be/t7OH8ORr5Ig. c. Educate all staff whose normal duties include direct interaction with residents on the correct usage and positioning of face masks. This education will include the CDC's lesson on personal protective equipment developed for nursing home staff available at https://youtu.be/YYTATw9yav4. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of staff types to ensure performance of proper catheter care, in the course of their duties. (2) Observations of staff types to ensure	

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F 880	Continued From page 45 * 06/06/22 at 2:29 p.m., two CNAs (#12 and #17) transferred Resident #24 with a sit to stand lift. Upon completion of the transfer, a CNA (#12) failed to clean the lift, removed the lift from the room, and placed it in the shower room down the hall. * 06/06/22 at 4:28 p.m., two CNAs (#10 and #12) transferred Resident #3 with a full body lift. Upon completion of the transfer, a CNA (#10) failed to clean the lift, removed the lift from the room, and placed it in the shower room across the hall. * 06/07/22 at 10:42 a.m., two CNAs (#11 and #14) transferred Resident #13 with a full body lift. Upon completion of the transfer, a CNA (#11) failed to clean the lift, removed the lift from the room, and placed it in the shower room across the hall. During an interview on 06/09/22 at 11:45 a.m., administrative staff, (#1, #9, and #13) agreed the lifts should be cleaned with disinfecting wipes after use and before removing the lift from the resident's room.	F 880	performance of proper equipment disinfection, in the course of their duties. (3) Observations of all staff types to ensure performance of proper face mask positioning, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 07/14/2022	
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and	F 888		7/14/22

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	355081	A. BUILDING _____ B. WING _____	C 06/09/2022

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F 888	Continued From page 46	F 888		

procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in

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F 888	Continued From page 47 paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical	F 888		

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F 888	Continued From page 48 exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the	F 888		

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F 888	Continued From page 49 CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on review of employee COVID-19 vaccination records, review of facility policy, and staff interview, the facility failed to ensure a 100% COVID-19 vaccination rate for 1 of 5 staff records reviewed (Staff A). Failure to ensure staff completed all recommended doses of the vaccination series for COVID-19 or obtained an exemption may have allowed staff to work while unvaccinated without proper precautions which placed residents and staff at risk for COVID-19 infection. Finding include: Review of the facility policy titled "Determination of Employee COVID-19 Vaccination Status" occurred on 06/09/22. This policy, revised 01/01/22, stated, "Purpose: Rolette Community Care Center (RCCC) is responsible for providing a safe and healthy workplace. Determination of an employees' COVID-19 vaccination status is part of a workplace hazard assessment used to identify potential hazards related to COVID-19. The information will be used for the purpose of national and state facility reporting as well as providing guidance with physical distancing, personal protective equipment use and physical barriers necessary for the workplace. Policy: RCCC will request from all new employees their status of COVID-19 vaccination and request copy of vaccination card. If provided, this will be kept in their confidential medical file. If unable or unwilling to provide proof of COVID-19 vaccination, they will be considered	F 888	1. Corrective Action a. Staff A received his 2nd dose of the Moderna vaccine on 06/15/2022. This brings the facility into compliance with a 100% vaccination rate for staff with primary vaccination series. 2. Identification of Others a. Any new staff starting at the facility have the potential to be affected. b. The facility has determined that all residents have the potential to be affected. 3. Systematic Changes a. Education has been completed with the infection control team and with Staff A regarding the vaccine requirement. Policy Determination of Employee COVID-19 Vaccination Status is updated to reflect the requirements. 4. Monitoring a. An audit of the staff vaccination matrix will be completed weekly for 12 weeks. Any negative findings will be corrected with the staff member not in compliance prior to their next work shift. b. Findings of the audits will be reported to QAPI committee for review and recommendations. The need for extending the audits will be determined based on the results of audits and on QAPI committee review and	

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F 888	Continued From page 50 un-vaccinated for our purposes as described above." The policy failed to address the vaccine requirements. Review of the facility's employee COVID-19 vaccination records occurred on 06/08/22. The record lacked evidence whether Staff A received the COVID-19 vaccine or obtained an exemption. During an interview on 06/09/22 at 9:55 a.m., an infection control nurse (#9) confirmed Staff A failed to provide the facility proof of vaccinations status or exemption. The facility had a 98.4% vaccination rate due to the facility's lack of proof of Staff A's Covid-19 vaccination status or exemption.	F 888	recommendations. 5. Correction Date a. 07/14/2022	