STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	07/18/2019

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 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey began on 07/16/19 and concluded on 07/18/19.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #15) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: Review of Resident #15's medical record occurred on all days of survey.	F 637	1. Resident # 15- An MDS-SCSA was completed on 7/25/19. The resident□s status was assessed, areas of significant change were identified, and it was determined that these areas of decline will not normally resolve without further intervention from staff. His care plan was reviewed and revised with appropriate interventions implemented. 2. All MDS's were reviewed to assess for possible areas of significant change. All residents of the Rolette Community Care Center have the potential to be affected by this practice.	8/22/19

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

Electronically Signed | 08/09/2019

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F 637	Continued From page 1 The quarterly Minimum Data Set (MDS) dated, 02/12/19, identified the resident as requiring limited assist with bed mobility and locomotion off unit, supervision with locomotion on unit, occasional bladder incontinence, and cognition moderately impaired. The quarterly MDS dated, 05/12/19, identified the resident as requiring extensive assist with bed mobility, locomotion off unit and locomotion on unit, always incontinent of bladder and severely impaired cognition. Observation on all days of survey showed Resident #15 in a wheelchair and dependent on staff for mobility. During an interview on 07/18/19 at 12:05 p.m., an administrative nurse (#1) confirmed a significant change in status assessment should have been completed for Resident #15. The facility failed to complete a significant change status assessment for the quarterly MDS dated 05/12/19 in response to Resident #15's decline in functional, incontinence, and cognitive status.	F 637	3. A mandatory inservice for all Licensed and certified personnel will be held on 8/14/19 and 8/15/19 to provide education with emphasis on accurate coding and documentation to ensure that all SCSA are identified and completed as required. Information from the RAI manual and F-tag 637 will be used as educational reference materials. 4. An audit has been developed to monitor every MDS that is done to identify changes that would require a SCSA to be completed. This audit will be completed weekly for three months, then monthly for no less than three months until 100% compliance is maintained for two consecutive months. The results of the audits will be reported to the QI committee for review and recommendations. This audit will be completed by the MDS coordinator or designee.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F 640		8/22/19

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F 640	Continued From page 2 (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and	F 640		

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F 640	Continued From page 3 approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), the facility failed to ensure timely electronic data submission of required Minimum Data Sets (MDS) assessment for 1 of 1 sampled resident (Resident #1) whose MDS did not get transmitted. Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-32 stated, ". . . The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days). . ." Review of Resident #1's MDS occurred on 07/18/19. The most current MDS dated 06/07/19, showed the MDS in "production batch" and not "accepted" as all previous MDS showed. Staff completed the current MDS on 06/11/19 and failed to send it for transmission until 07/18/19 (37 days after completion). During an interview on 07/18/19 at 9:40 a.m., an administrative nurse (#1) confirmed staff failed to transmit the MDS.	F 640	1. Resident # 1-MDS dated as completed on 6/11/19 was transmitted on 7/17/19. 2. Transmittal records of all MDS's have been reviewed. All MDS's have been transmitted timely and within CMS regulations. All residents of the Rolette Community Care Center have the potential to be affected by this deficient practice. 3. A mandatory in-service for the interdisciplinary MDS/care planning team and the receptionist/ward clerk (s), will be held on 8/14/19 and 8/15/19 to provide education with emphasis on the importance of the timely transmittal of all MDS assessment data to the CMS system no later than 14 days after the MDS completion date as required. Information from the RAI manual and F-tag 640 will be used as educational reference materials. 4. An audit has been developed to monitor that every MDS that has been done and completed, meets the transmittal requirements as identified in the CMS regulation F-640. This audit will be completed weekly for three months, then monthly for three months until 100% compliance has been achieved. The results of the audits will be reported to the QI committee for review and recommendations. This audit will be	

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F 640	Continued From page 4	F 640	completed by the MDS coordinator or designee.	
F 657 SS=E	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. (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 observation, record review, and family and staff interview, the facility failed to ensure staff reviewed and revised comprehensive care plan to reflect the residents' current status for 6 of	F 657	1. Care Plans and CNA cards have been reviewed and updated to reflect the individual's needs as follows:	8/22/19

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F 657	Continued From page 5 12 sampled residents (Resident #2, #14, #15, #18, #21, and #29) and one closed record (#30). Failure to review and revise the care plans to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbance and major depressive disorder. Physician's orders included oxygen at 2-4 liters as needed (PRN) for shortness of breath or oxygen saturation less than 88% and Seroquel (an antipsychotic medication) 12.5 mg at 8:00 p.m. Observations during survey showed an oxygen cylinder on the back of Resident #2's wheelchair and an oxygen concentrator next to her bed. During an interview on 07/16/19 at 2:58 p.m., Resident #2's family member stated the resident occasionally wears oxygen and staff check her oxygen saturation every day. Resident #2's current care plan stated, "Resident has a Diagnosis of Depression . . . Resident also takes Seroquel. At risk for falls and/or unwanted side effects". The interventions/approaches identified side effects of the Seroquel but failed to identify behaviors Resident #2 may display or interventions, including non-pharmacological interventions, which may decrease and/or eliminate the behaviors. The residents care plan also failed to identify his/her use of oxygen. - Review of Resident #14's medical record	F 657	Resident #2's care plan and CNA care card have been reviewed and updated to reflect her individual need for the use of oxygen. The care plan stating use of Seroquel had been updated to reflect the scheduled dose of 12.5 mg dose of Seroquel being changed to 12.5 mg PRN for restlessness, agitation and insomnia per MD order. Prior to giving PRN Seroquel, non pharmacological interventions will be attempted and documented on. Interventions including but not limited to address needs of toileting, hunger, and thirst; distraction in the form of activity such as coloring as she enjoys doing. Resident #14's care plan and CNA care card have been reviewed and updated to reflect her individual needs for oxygen therapy. Resident #15's care plan and CNA care card have been reviewed and updated to reflect his individual needs for oxygen, wheelchair locomotion and episodes of incontinence. Resident #18's care planned and CNA care card have been reviewed and updated to reflect his individual needs regarding behaviors. Resident #21's care plan and CNA care card have been reviewed and updated to reflect her individual needs regarding behaviors.	

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F 657	Continued From page 6 occurred on all days of survey. A physician's order identified continuous oxygen by nasal cannula at 2 liters. Observations showed Resident #14 used oxygen on all days of survey. The current care plan failed to identify Resident #14's need for continuous oxygen. - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease and dependent on supplemental oxygen. Physician's orders included continuous oxygen at 2 liters. The quarterly Minimum Data Set (MDS), dated 05/12/19, identified oxygen therapy 7 days a week, extensive assistance with wheelchair locomotion on/off the unit, and always incontinent of bladder. Observations on all days of survey showed Resident #15 used continuous oxygen and requiring staff assistance with wheelchair locomotion. Resident #15's current care plan stated, ". . . Uses w/c [wheelchair] without assistance for locomotion . . . Resident has occasional urinary incontinence. . . ." The facility failed to update Resident #15's care plan to identify assistance with wheelchair locomotion and his/her increased incontinence. The care plan also failed to identify oxygen use. - Review of Resident #18's medical record occurred on all days of survey. Physician's orders included Seroquel (an antipsychotic medication) 50 milligrams (mg) at 8:00 a.m., 25 mg at 2:00 p.m., 150 mg at 8:00 p.m., and PRN, Depakote	F 657	Resident #29's care plan and CNA care card have been reviewed and updated to reflect her individual needs regarding concerns over wandering/elopement. Resident #30 (closed record) was discharged from facility prior to state survey, however, her care plan has been reviewed and updated to reflect her need for dialysis while residing in our facility. 2. All residents of the Rolette Community Care Center have the potential to be affected by this practice. 3. The care plans have been updated to reflect the individual needs of all the residents. A mandatory in-service will be held for the care plan team members on 8/9/2019. 4. An audit has been developed to monitor every Care Plan that is done to identify changes. This audit will be completed weekly for three months, then monthly for three months until 100% compliance. The results of the audits will be reported to the QI Committee for review and recommendations. This audit will be completed by MDS Coordinator or designee.	

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F 657	Continued From page 7 Sprinkles (an anticonvulsant medication) 250 mg at 8:00 a.m. and 125 mg at 8:00 a.m., and Lexapro (an antidepressant) 20 mg daily. Resident #18's current care plan stated, "Takes psychotropic medications. Is at risk for unwanted side effects from these medications." The interventions/approaches identified side effects of the medications listed above but failed to identify Resident #18's behaviors and interventions, including non-pharmacological interventions, which may decrease and/or eliminate the behaviors. During an interview on the afternoon of 07/18/19, an administrative nurse (#2) confirmed she expected oxygen use and behaviors to be on the resident's care plans. - Review of Resident #21's medical record occurred on all days of survey. The current care plan stated, ". . . Psychotropic Medication Use: Resident has diagnosis of Psychosis and major depressive disorder. Takes Abilify, Seroquel and Prozac. At risk for unwanted side effects from psychotropic medications. . . ." The interventions/approaches identified side effects of the medications listed above but failed to identify Resident #21's behaviors and interventions, including non-pharmacological interventions, which may decrease and/or eliminate the behaviors. - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and delusional disorder. The "Wander/Elopement Risk Assessment," dated 12/13/18, identified staff	F 657		

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F 657	Continued From page 8 placed a wanderguard due to Resident #29's history of wandering/elopement. The progress notes identified Resident #29 cut the wander guard off multiple times but staff failed to identify wandering/elopement as a concern on his/her care plan. During an interview on the afternoon of 07/18/19, an administrative nurse (#2) confirmed she expects wandering/elopement to be on the resident's care plan. - Review of Resident #30's medical record occurred on 07/18/19. Diagnoses included chronic kidney disease stage 5 and end stage renal disease. Physician's order included dialysis once a week on Wednesday. The care plan failed to address Resident #30's need for dialysis.	F 657		
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 - §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, and staff interview, the facility failed to provide consistent transfer methods to prevent accidents for 1 of 5 sampled residents (Resident #15) who required staff assistance with transfers. Failure to ensure	F 689	1. For Resident #15, notifications was provided to staff on July 19, 2019 regarding appropriate transfer techniques based on physical therapy recommendations. Care plan and care	8/22/19

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F 689	Continued From page 9 staff transfer residents in a consistent manner may result in falls and/or injuries. Findings include: Review of #15's medical record occurred on all days of survey. Diagnoses included dementia, hemiplegia and hemiparesis. The resident's current care plan identified extensive assist of one staff for transfers. Resident #15's physical therapy note, dated 06/19/19, stated, ". . . The nursing staff reports the resident has been having increased difficulty completing standing pivot transfers and is not consistently able to complete safely. The resident transfers w/c [wheelchair] to/from bed and w/c to/from toilet with standing pivot transfer with assist of 2. At times however this is difficult for the resident and is unsafe. He then transferred using the sit to stand mechanical (EZ stand) lift. He is able to follow instructions and hold onto the handle grips and WB [weight bear] through his LE [lower extremity] with reminders to use his legs. The resident is comfortable using he EZ stand lift and has no c/o [complaints of] during transfer assessment. Recommend the resident to transfer with the EZ stand lift and nursing staff to monitor. . . ." Observations on 07/17/19 were as follows: * 10:23 a.m., showed one certified nursing assistant (CNA) (#5) transferred Resident #15 on and off the toilet using a gait belt. The resident was unsteady, shaky and almost fell while transferring off the toilet. * 3:18 p.m., showed two CNAs (#6 and #7) transferred Resident #15 on and and off the toilet	F 689	card were reviewed and current. 2. All residents of the Rolette Community Care Center have the potential to be affected by this practice. 3. A Mandatory in-service for all Licensed/Certified Nursing staff including Restorative aides on August 14,15 2019 will be given to staff regarding safe transfer methods for all residents. Care cards and care plans for all residents include required safe transfer methods and will be reinforced to all staff to ensure this deficient practice does not recur. Resident will be reevaluated by PT\OT during assessment period and more often as needed if change in condition of resident occurs to ensure safe transfers. Any changes in transfer method for any resident will be posted in a memo to inform all staff to ensure immediate knowledge exists while care cards are being updated. 4. Audits will be done on care cards and care plans and monitored by the DON or designee and will be monitored for compliance. Audit reports will be given to the QI committee weekly for 3 months, then monthly for 3 months until 100% compliance is achieved.	

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F 689	Continued From page 10 using a gait belt. During an interview on 07/17/19 at 3:30 p.m., a CNA (#7) stated ". . . We usually use two staff to transfer resident, sometimes only one, depending on how he is standing. . . ." During an interview on the afternoon of 07/18/19 an administrative nurse (#2) agreed staff should be consistent with transfers and follow physical therapy recommendations. Failure to ensure staff transferred Resident #15 as recommended by physical therapy resulted in an incorrect transfer method and may result in falls and/or injuries.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary care and services for 1 of 2 sampled resident (Resident #15) with orders for continuous oxygen. Failure to provide oxygen as ordered may result in increased shortness of breath and complicate a resident's respiratory status.	F 695	1. For Resident #15, notification was provided to staff on July 19th, 2019 regarding necessity to be monitoring 02 tanks on resident wheelchairs and to ensure that the nasal cannula is in place. Care plan and care card reviewed and current.	8/22/19

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F 695	Continued From page 11 Findings include: Review of Resident #15's medical record occurred on all days of the survey. Diagnoses included chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. A physician's order stated, "Continuous O2 [oxygen] at 2L [liters]". Observations on 07/16/19 as follows: * 11:27 a.m., showed Resident #15 seated in his wheelchair in the hallway, oxygen on at two liters per nasal cannula. Oxygen tank refill level noted to be on empty. * 3:33 p.m., showed Resident #15 seated in his wheelchair in the hallway without his oxygen on. Oxygen tank refill level remained on empty. * 4:59 p.m., showed Resident #15 seated in his wheelchair in the dining room without his oxygen on. Facility staff failed to to ensure Resident #15 had oxygen on as ordered and/or oxygen tank contained oxygen. During an interview on the afternoon of 07/18/19 an administrative nurse (#2) confirmed Resident #15's oxygen should have been on continuously.	F 695	2. All residents of the Rolette Community Care Center have the potential to be affected by this practice. 3. Education will be provided to staff on August 14,15 2019 regarding oxygen use. A laminated oxygen usage card will be placed on wheelchair of residents requiring oxygen to inform staff of oxygen order and method of delivery. Care cards for all residents include required oxygen usage as well. 4. Audits will be done and monitored by the Director of Nursing or Designee and will be monitored for compliance. Audit reports will be given to the QI committee weekly for 3 months, then monthly for 3 months until 100% compliance is achieved.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).	F 730		8/22/19

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F 730	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on review of education records and staff interview, the facility failed to ensure certified nursing assistants (CNAs) received dementia care education for 2 of 3 staff (CNA A and B) education records reviewed. Failure to provide or ensure staff attendance at mandatory staff educational inservices may result in lack of knowledge/skills to provide the care and services necessary to meet the residents needs. Findings include: Review of education records occurred on 07/18/19. CNA A and B's education records lacked evidence they received the mandatory education training on dementia care. During an interview on 07/18/19 at 1:20 p.m., an administrative nurse (#3) confirmed the facility failed to ensure all CNAs received the mandatory dementia care education/training.	F 730	1. CNA A & B will attend regular in-service education, including dementia care training. Also, the facility will complete a performance review of all nursing staff at least once every 12 months. 2. All residents of the Rolette Community Care Center have the potential to be affected by this practice. 3. Education has been provided to the specific staff (CNA A & B) identified in the statement of deficiencies on Dementia Care Education. CNA A completed training on 8/8/2019 and CNA B completed training on 8/7/2019. In addition, all staff will attend one session of a mandatory meeting utilizing the Hand in Hand Dementia Training set for August 14th (Session 1) and August 15th (Session 2). All new nursing staff will be required to complete dementia care training prior to orientation on the floor. Additional in-service education will be provided at least quarterly based on the outcome of performance reviews and audits to be completed by Nurse Educator or Designee. 4. Audits will be done and monitored by DON or Designee and will be monitored for compliance on staff training and education. Audit reports will be given to the Quality Improvement Committee Weekly for 3 months, then monthly for 3	

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F 730	Continued From page 13	F 730	months until 100% compliance is achieved.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the residents' medication regimen was free of unnecessary medications for 1 of 1 closed record (Resident #39) of a resident who received an as needed (PRN) medication on comfort cares. Failure to ensure the resident received the appropriate medication for agitation and behaviors may result in the resident receiving unnecessary medication and experiencing	F 757	1. For Resident #39, nurse who administered medication (hydromorphone) and documented inappropriate indication for use (behaviors), was educated personally by the DON on ensuring that the proper medication is selected for use (e.g., Hydromorphone for pain and Lorazepam for restlessness/aggressive	8/22/19

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F 757	Continued From page 14 adverse consequences related to the medication. Findings include: Review of Resident #39's medical record occurred on 07/18/19 and identified the following physician's orders for medications: * Lorazepam (an antianxiety) .5 milligrams (mg) every six hours PRN for increased agitation, restlessness, aggressive behaviors, may give rectally * Hydromorphone (an opioid) 2 mg every six hours PRN for pain A progress note dated 07/03/19 at 9:26 p.m. showed, "PRN Hydromorphone given for resident behaviors. Resident was found naked in bed. Resident was yelling for help and sell my soul. . . . " Review of Resident #39's July 2019 Medication Administration Record (MAR) identified staff administered the Hydromorphone at 9:26 p.m. for agitation/violent behaviors/restless instead of Lorazepam. The facility failed to ensure adequate indications for the use of medication.	F 757	behaviors/agitation.) 2. All residents of the Rolette Community Care Center have the potential to be affected by this practice. 3. All licensed nursing staff will be educated on how to document to show adequate indications for medication□ use and the diagnosed condition for which it was prescribed. This will be completed during mandatory in-services on August 14th and 15th, 2019. 4. The Director of Nursing, or designee, will complete daily audits for (1) week, weekly audits for (4) consecutive weeks, then bi-weekly for (2) months and then monthly for(3) months of medication orders to ensure that appropriate indications for use of psychotropic drugs are clearly documented in the medical record. Audited records will be reviewed by the QI Committee until 100% compliance is maintained for 6 months.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		8/22/19

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F 758	Continued From page 15 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 16 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 5 sampled residents (Resident #18) reviewed for unnecessary medications. Failure evaluate Resident #18's behaviors in order to develop a behavioral plan, provide non-pharmacological interventions, and evaluate the interventions for effectivness may have resulted in Resident #18 receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility policy titled "Behavior Management Plan" occurred on 07/18/19. This undated policy stated, "Residents who exhibit behavioral concerns may require a behavior management plan to ensure they are receiving appropriate services and interventions to meet their needs. The interdisciplinary team, including the family member, should develop a behavioral plan for each resident with identified behaviors . . . The plan should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his or her highest practicable well-being. . . . Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, when interventions were utilized, and the outcomes of the interventions. Behaviors should be included	F 758	1. For Resident #18, the Care Plan was updated to include need for consistent documentation regarding behaviors and plan for non-pharmacological interventions. 2. All residents of the Rolette Community Care Center have the potential to be affected by this practice. 3. Facility policy titled Behavior Management Plan has been reviewed, dated and posted. Nursing staff has reviewed all residents that are on Seroquel and other psychotropic medications for appropriate use. All nursing staff will be educated on approaches to take, modifications and/or redirection when negative behaviors occur (i.e., self-transfers, crawling out of bed and restlessness/agitation). Non-pharmacological interventions are to be documented along with resident□s response to the intervention. The Pharmacy consultant currently, and will continue, to review all residents' medication for appropriate use, GDR and also flags any issues for nursing and or MD to address monthly or on rounds. This will ensure that all residents are protected from unnecessary psychotropic medication use. This education will be completed during mandatory in-services on August 14th and 15th, 2019.	

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F 758	Continued From page 17 in the comprehensive plan of care . . ." Review of Resident #18's medical record occurred on all days of survey. Diagnoses included unspecified dementia with behavioral disturbance, borderline personality disorder, obsessive-compulsive personality disorder, and dysthymic disorder (a mild, chronic state of depression)-anxiety/depression. Medications included: * Seroquel (an antipsychotic) 50 milligrams (mg) at 8:00 a.m., 25 mg at 2:00 p.m., 150 mg at 8:00 p.m., and PRN for dysthymic disorder, anxiety/depression * Depakote Sprinkles (an anticonvulsant medication used for behaviors) 250 mg at 8:00 a.m. and 125 mg at 8:00 a.m. * Lexapro (an antidepressant) 20 mg daily for dysthymic disorder-anxiety/depression * Trazodone (an antidepressant) 25 mg for dysthymic disorder-anxiety/depression. Resident #18's quarterly Minimum Data Set (MDS), dated 05/25/19, identified a severe cognitive impairment, moderate depression, and two falls, one with injury. Review of the MDSs, dated 02/22/19, 11/22/18, and 08/25/18, identified six additional falls, two with injury. The current care plan stated, "Problem: Takes psychotropic medications. Is at risk for unwanted side effects from these medications. Goal: He will have no unwanted side effects from psychotropic medications. He will receive the lowest dose possible to obtain & maintain the desired results . . . Approach: [a list of all the potential side effects from Seroquel, Trazodone, and Lexapro] . . . Keep M.D. [medical doctor] informed. M.D. will	F 758	PRN Seroquel for resident #18 has been discontinued as the 14-day limit on antipsychotic drugs has been reached. 4. The Director of Nursing, or designee, will complete weekly audits of the medical record to ensure that proper documentation is being completed. Audits will be completed weekly for 8 weeks and monthly for 4 months. Audit records will be reviewed by the QI Committee until 100% compliance is maintained for 6 months.	

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evaluate risks vs. [versus] benefits of continuing these medications and possibility of a gradual dose reduction." The facility failed to identify Resident #18's behaviors and non-pharmacological interventions or approaches to decrease or eliminate the behaviors. (Refer to F657)

Review of Resident #18's certified nursing assistant (CNA) behavior charting showed no behaviors documented from May 2019 to July 17, 2019.

A physician's progress note, dated 05/07/19, stated, ". . . continued falling, increased as of late. He has advanced dementia, all efforts to encourage him to not get up without assistance for the most part unsuccessful. . . . we did make a slight reduction in his Seroquel regimen [on 03/30/19, the 2:00 p.m. dose reduced from 50 mg to 25 mg]. In the past, decrease in his psychiatric medication regimen led to increased falling, will need to discuss this with nursing . . . Nursing voicing no other concerns . . . A/P [assessment/plan] Continue current medications . . . Further discussion with nursing regarding status of behaviors after last downward adjustment of Seroquel . . ."

A physician's progress note, dated 07/02/19, stated, ". . . He has . . . longstanding history of falling, previous psychiatric care with an extensive psychiatric medication regimen. Slight decrease in his Seroquel regimen [03/20/19] . . . A/P: Advanced dementia with behaviors, history of falling, ongoing psychiatric medication regimen . . ." The medical record showed on 07/02/19 the physician decreased Resident #18's 8:00 a.m.

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F 758	Continued From page 19 Seroquel dose from 50 mg to 25 mg. The physician's progress notes identified advanced dementia with behaviors, standing without assistance, and a history of falling but failed to identify specific behaviors that require psychotropic medications. During an interview on the afternoon on 07/18/19, when asked about Resident #18's behaviors, an administrative nurse (#2) provided the following nurse's notes: * 07/02/19 at 3:49 a.m.: Resident bed alarm sounded and he writer [sic] responded to alarm and resident was attempting to self transfer. Assisted resident to bathroom and back to bed. Resident reminded to use call light for transfers to avoid a fall and or injury." * 07/03/19 at 11:26 p.m.: Resident has already been up to the bathroom three times this shift. He is attempting to self transfer and staff are responding to bed alarm." * 07/04/19 at 4:53 a.m.: "Resident up and trying to self transfer. Staff member had to stay with him as he kept tying to get up from Wheelchair." * 07/04/19 at 2:48 p.m.: "resident found lying on fall mat next to bed, appears that resident crawled out of bed, resident first stated to writer that he crawled out of bed but then he told CNA that he fell out of bed, he had removed his blanket, call light was within reach, no injuries noted, . . ." * 07/04/19 at 8:10 p.m.: resident has been continuously trying to crawl in and out of bed this shift. setting off bed alarm, resident has also been attempting to crawl out of recliners, resident appears to be very restless, md [medical doctor] ordered to increase am seroquel back to where it	F 758		

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F 758	Continued From page 20 was at 50 mg daily 8 am" * 07/08/19 at 2:08 p.m.: Resident has been very restless and agitated this shift. Resident has been up and down all shift. Writer contacted MD and gave update on resident behavior. MD gave order for prn seroquel 50 mg q [every] 6 hours. MD states if resident behaviors continue to notify him." During an interview on the afternoon of 07/18/19, when asked about behaviors, a staff member (#4) stated Resident is "up and down" all day. The facility failed to evaluate Resident #18's behaviors (self transfers, crawls out of bed, and is restless/agitated), attempt non-pharmacological interventions, and document the residents response to the intervention prior to increasing the Seroquel on 07/04/19 and initiating PRN Seroquel on 07/08/19.	F 758		