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 _____	R-C 11/26/2024

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 An on-site revisit survey was concluded on 11/26/24 to determine compliance with deficiencies identified during the recertification and complaint survey completed on 09/19/24.	{F 000}		
{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. (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.	{F 640}		12/16/24

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

Electronically Signed | 12/16/2024

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{F 640}	Continued From page 1 (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 approved by CMS. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON NOVEMBER 26, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 09/19/24 CMS-2567. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, the facility failed to ensure timely completion of required Minimum Data Set (MDS) assessments for 2 of 6 sampled residents (Resident #6 and #14). Failure to complete the MDS timely does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.19.1), pages 2-23 and 2-24	{F 640}	F640 MDS Encoding/Transmitting Resident Assessments 1. Residents #6 and #14 were affected by this deficiency. Both MDS have been submitted and no further action needs to be taken. 2. All residents have the potential to be affected by this deficient practice 3.The MDS Coordinator will provide the facility with a CMS Validation report weekly. The education provided was reviewed by the MDS Coordinator, DON, Business Office Manager and HIM Director on timely MDS submission for all types of MDS on 12-10-24. 4. Audits will be done by the DON or Business Office Manager from the MDS schedule given to them from the MDS Coordinator. Validation reports and timely	

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{F 640}	Continued From page 2 stated, . . . Annual Assessment (A0310A = 03): The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA [significant change in status assessment] or an SCPA [significant correction to prior assessment] has been completed since the most recent comprehensive assessment was completed. . . . The ARD [assessment reference date] (item A2300) must be set within 366 days after the ARD of the previous OBRA [Omnibus Budget Reconciliation Act] comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) Page 2-35 stated, "Quarterly Assessment . . . The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). -Review of Resident #6's medical record occurred on 11/26/24 and identified an annual MDS with an ARD date of 10/29/24. The previous annual MDS ARD was 10/28/23 (368 days). - Review of Resident #14's medical record occurred on 11/26/24 and identified a quarterly MDS with an ARD date of 10/27/24 and a completion date of 11/12/24 (16 days).	{F 640}	completion dates of MDS assessments will be reviewed to ensure that submissions are made on time. These will be completed weekly for 6 weeks, monthly for 2 months and then quarterly for 2 quarters. The audit will then be brought to QAPI for further discussion and recommendations. 5. Corrective Date: 12-16-24	
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON NOVEMBER 26, 2024, EVIDENCE	{F 641}	F641 Accuracy of MDS 1. The MDS for resident #17 was	12/16/24

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{F 641}	Continued From page 3 SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 09/19/24 CMS-2567. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 7 sampled residents (Resident #17). Failure to accurately code the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION N: MEDICATIONS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2024, pages N-6 through N-8, stated, ". . . N0415: High-Risk Drug Classes: . . . Coding Instructions . . . N0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period . . ." - Review of Resident #17's medical record occurred on all days of survey. Review of current physician orders identified Fiasp FlexTouch U-100 Insulin pen (fast acting insulin) 4 units subcutaneous daily at noon. The quarterly MDS, dated 11/01/24, showed staff failed to identify Resident #17 received a hypoglycemic.	{F 641}	corrected for their insulin medication. 2. All residents have the potential to be affected by this deficient practice on their MDS. 3. The education provided was reviewed by the MDS Coordinator, DON, Business Office Manager and HIM Director on accuracy of the MDS and encoding it correctly. 4. Audits will be done by the DON or Business Office Manager from the eMAR report to audit Section N for medications that the residents have received during their MDS look back period. This audit will be done for 6 weeks, then 2 months, and then 2 quarters. It will then be brought to QAPI for review and recommendations. 5. Corrective Date: 12-16-24	

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{F 658} SS=D	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: DURING THE ON-SITE REVISIT COMPLETED ON NOVEMBER 26, 2024, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 09/19/2024 CMS-2567. 1. Based on observation and review of manufacturer's guidelines, the facility failed to follow professional standards of practice for 2 of 2 sampled resident (Resident #4 and #17) observed during insulin administration. Failure to prime an insulin pen correctly may result in residents receiving an inaccurate dose. Findings include: Review of the manufacturer's guidelines titled "Fiasp insulin aspart injection. . . Instructions for use. . ." occurred on 09/11/24. This document, dated July 2023, page 8, states, ". . . Preparing your Fiasp FlexTouch Pen: . . . Step 5. Pull off the outer needle cap. Do not throw it away. Step 6: Pull off the inner needle cap and throw it away. Priming your Fiasp FlexTouch Pen: Step 7: Turn the dose selector to select 2 units. . . Step 9: Hold the pen with the needle pointing up. Press and hold in the button until the dose counter shows"0". . . . A drop of insulin should be seen at the needle tip. . . ."	{F 658}	F658 A 1. Corrective Action: a. Residents #4 and #17 have not had any adverse reactions from this deficient practice. b. Nurse #1 was educated on the proper way of priming the Fiasp FlexTouch insulin pens. 2. Identifying Others: a. All residents who receive insulin with insulin pens have the potential to be affected by this deficient practice related to insufficent amount of insulin administered. 3. System Changes: a. Education was given to nursing staff who administer insulin on the importance of proper priming of the pen prior to administering the insulin. 4. Monitoring: a. Audits will be done by the DON or her designee on the proper priming of the insulin pens Daily for 2 weeks, then weekly for 6 weeks, 2 months and then 2 quarters. The audits will then be presented to QAPI for their recommendations. F658 B	12/16/24

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{F 658}	Continued From page 5 Observation on 11/26/24 at 11:31 a.m. showed a nurse (#1) prepared Resident #4's Fiasp FlexTouch insulin pen for administration. The nurse (#1) dialed the insulin pen to 2 units and depressed the plunger to prime the pen with the inner and outer needle caps still in place. Observation on 11/26/24 at 11:42 a.m. showed a nurse (#1) prepared Resident #17's Fiasp FlexTouch insulin pen for administration. The nurse (#1) dialed the insulin pen to 2 units and depressed the plunger to prime the pen with the inner and outer needle caps still in place. 2. Based on record review, and review of facility policy, the facility failed to follow physician's orders for 1 of 1 sampled resident (Resident #9). Failure to follow physician's orders for notification of blood glucose outside of specific parameters placed the resident at risk for delayed treatment and adverse health events. Findings include: A review of the facility policy titled "Physician Services" occurred on 09/11/24. This policy, revised February 2021, stated, ". . . The medical care of each resident is supervised by a licensed physician. . . . Supervising the medical care of residents includes (but is not limited to): . . . monitoring changes in resident's medical status . . ." - Review of Resident #9's medical record occurred on all days of survey and included a diagnose of Type 2 Diabetes Mellitus. A current physician's order stated to call if blood sugar is	{F 658}	1. Corrective Action: a. Resident #9 had no lasting effect from the lack of notification to the medical director for low blood sugars. b. Nursing involved who did not notify the physician of the out of range blood sugars was educated on the order for notification. 2. Identifying Others: a. All residents have the potential to be affected by this deficient practice. 3. System Changes: a. Matrix system reports were changed to add 'blood sugar out of range' to the vital sign report. The vital report will be checked daily for 'out of range blood sugars'. b. Education to the nursing staff on the importance of reporting to the Dr all out of range blood sugars for possible changes in evaluations and orders. 4. Audits of out of blood sugars will be done by DON or her designee daily for 2 weeks, weekly for 6 weeks, 2 monthly and 2 quarters. It will then be presented to QAPI for further recommendation. 5. Corrective Date: 12/16/2024	

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{F 658}	Continued From page 6 less than 100 or greater than 450. Review of Resident #9's blood glucose checks from 10/22/24-11/26/24 showed the following: * 11/01/24 blood sugar 61 and lacked documentation of provider notification. * 11/20/24 blood sugar 71 and lacked documentation of provider notification. The medical record showed the facility failed to notify the physician of Resident #9's blood glucose levels that were less than 100. -	{F 658}		