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 _____	04/14/2011

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 For the standard Medicare/Medicaid recertification survey started on 04/11/11 and completed on 04/14/11, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	F 156 1. Resident #2 has been discharged from the facility. Resident #5 has been given the correct Medicare appeal and denial form. Resident #11 has been given the correct Medicare denial and appeal form. The power of attorney will sign. Resident #12 has been discharged. 2. All residents that have the Federal Part A benefit have the potential to be affected by this practice. 3. All residents and or their representatives that have Medicare coverage will receive a denial letter utilizing an approved form such as "Skilled Nursing Form Advanced Beneficiary Notice" or one of the five approved skilled nursing facility denial letters and "Notice of Medicare Provider Non Coverage". 4. Director of Nursing or her designee will audit all discharges from Medicare weekly for 8 weeks. The results will be taken to the QA committee for review and further action if necessary.	5-16-11
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Luther Stone — TITLE: Administrator — (X6) DATE: 5-18-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the required notice to 2 of 2 sampled residents (Resident #2 and #5) and 2 supplemental residents (Resident #11 and #12) whose Medicare coverage ended. Failure to provide denial and Medicare provider non-coverage notices to residents is an infringement of the resident's rights.	F 156		

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F 156	Continued From page 3 Findings include: Review of the Medicare billing records occurred on the afternoon of 04/13/11 and showed the Medicare Part A coverage ended for the following residents on: Resident #12 - 10/04/10 Resident #11 - 10/25/10 Resident #2 - 02/25/11 Resident #5 - 04/01/11 All of these situations required the facility to send a denial notice, to these residents or their representatives utilizing an approved Centers for Medicare and Medicaid Services (CMS) form such as "Skilled Nursing Form Advanced Beneficiary Notice - Form No. (Number) CMS-10055", or one of the five "Skilled Nursing Facility Denial Letters." Review of the above billing records identified the facility failed to issue the proper denial notices to Resident #12, #11, #2, and #5. Review of Resident #12, #11, and #2's billing records identified the facility failed to issue and notify these residents and/or their representatives of the discontinuation of Medicare Part A non-coverage benefits, utilizing the approved CMS form titled, "Medicare Provider Non-Coverage Form - No. 10123." Review of Resident #5's "Notice of Medicare Provider Non-Coverage - Form No.- 10123," dated 03/30/11, showed the facility failed to complete the form and this form lacked a signature of Resident #5 and/or his representative.	F 156		

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F 156	Continued From page 4 During interview on the afternoon of 04/13/11, these facility staff members (#1, #2, #17, and #18) confirmed the facility failed to issue the correct Medicare notices (denial and Medicare provider non-coverage) to Resident #2, #5, #11, and #12.	F 156	F275 1. Resident #7 annual assessment has been done. Resident #8 annual assessment has been done. 2. All residents have the potential to be affected by this practice. 3. The facility will complete the required comprehensive and annual assessment will be completed within 366 days. All quarterly and annual assessments will be kept on a calendar with the due dates marked. 4. Director of nursing or her designee will audit mds schedule weekly for 2 months. The results will be brought to the QA committee for further review.	5-16-11
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to conduct a comprehensive assessment at least once every 12 months for 2 of 9 sampled residents (Resident #7 and #8) who required an annual assessment. Failure to conduct a comprehensive assessment may result in the facility not addressing changes in a resident's health, psychosocial, and mental status. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, July 2010, Chapter 2, page 2-17 stated, "Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive	F 275		

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F 275	Continued From page 5 assessment is required." Page 2-18 stated, "The Assessment Reference Date (ARD) of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment." - Review of Resident #7's medical record occurred on April 13-14, 2011. Resident #7's record contained a comprehensive assessment, dated 03/27/10. The facility completed quarterly MDSs for Resident #7 on 06/26/10, 09/26/10, 01/01/11, and 04/01/11. The facility failed to complete the required comprehensive assessment by 03/28/2011 (within 366 days of 03/27/10), and instead completed a quarterly MDS, dated 04/01/11. - Review of Resident #8's medical record occurred on April 13-14, 2011. Review of Resident #8's medical record identified the facility completed an admission comprehensive MDS assessment on 12/07/09, and quarterly MDS assessments on 02/24/10, 05/26/10, 07/25/10, 09/01/10, and 01/18/11. Resident #8's medical record lacked a comprehensive annual MDS assessment completed in 2010. The facility failed to complete the required comprehensive assessment within 366 days for Resident #8. During an interview on the afternoon of 04/13/11, an administrative staff nurse (#1) confirmed she failed to complete a comprehensive MDS assessment for Resident #8 within the mandated required timeframe.	F 275		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=D	Continued From page 6 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/12/10. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument	F 278	F 278 1. Resident #1 MDS has been corrected to accurately identify the use of side rails as a restraint. Resident #6 MDS has been corrected to accurately identify a regular diet. Resident #7 MDS has been changed to accurately reflect frequently incontinent istead of occasional. 2.All residents have the potential to be affected by this practice 3 Minimum Data Set Coordinator will be inserviced on accuracy of MDS's by an experienced MDS Nurse 4. The Director of Nursing will Audit one MDS weekly for accuracy for 2 months. The results of these audits will be taken to the QA committee for further review and reccomendations.	5-16-11

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F 278	Continued From page 7	F 278		

(RAI) User's Manual, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments accurately for 3 of 9 sampled residents (Resident #7 -Section H-Bladder/Bowel Function, Resident #6 -Section K-Nutritional Status and Section M-Skin Conditions, and Resident #1 -Section P-Restraints). Failure to accurately complete the MDS for each sampled resident did not allow each resident the opportunity to received care consistent with their individualized needs, problems, and strengths and retain/maintain their maximum level of functioning.

Findings include:

The Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, July 2010, Chapter 3, page H-8 stated, ". . . Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime. Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void . . ."

Page K-9 defines mechanically altered diet as "A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. . . ." A therapeutic diet is defined as "A diet ordered to manage problematic health conditions. . . .

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F 278	Continued From page 8 Examples include calorie-specific, low-salt, low-fat, lactose free, no added sugar, and supplements during meals." Page M-33 defines "nutrition or hydration intervention to manage skin problems" as "Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions . . ." Page P-5 stated, ". . . Bed rails include any combination of partial or full rails . . . used as positioning devices. If the use of the bed rails meets the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint. . . ." - Review of Resident #1's medical record occurred April 11-14, 2011. Medical diagnosis included in part, Parkinsonism and dementia. During the initial tour of the facility with an administrative staff member (#1) on 04/11/11 at 11:55 a.m., this staff member identified Resident #1 utilized "physical restraints." When asked to identify the specific type of physical restraint Resident #1 utilized, an administrative staff member (#1) stated, "2 one-half side rails" attached to the middle of the bed frame on each side of the resident's bed. Review of a facility form titled "Side Rail Assessment" dated 08/19/10, identified the implementation of two half side rails (positioned in the middle of the bed) for Resident #1 "while the resident in bed per family request."	F 278		

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F 278	Continued From page 9 The facility completed an annual comprehensive Minimum Data Set (MDS) assessment and Resident Assessment Protocol Summary, dated 09/24/10, and quarterly MDS assessments on 12/17/10 and 03/18/11, and failed to code Section P- Restraints for Resident #1. - Review of Resident #6's medical record occurred on April 11-14, 2011. Resident #6's quarterly MDS, dated 02/17/11, contained the following coding: * Section K0500 Nutritional Approaches checked for mechanically altered diet and therapeutic diet * Section M1200 Treatments checked for nutrition or hydration intervention to manage skin problems Resident #6's current diet order stated, "Select." A dietary progress note, dated 02/14/11, stated, " . . . refuses supplementation, Regular diet, . . ." During an interview on 04/13/11 at 9:15 a.m., an administrative nurse (#1) stated the resident "selects" what he wants to eat and agreed the resident should not be coded for a mechanically altered or a therapeutic diet, and stated the resident is not on nutrition or hydration for skin issues. - Review of Resident #7's medical record occurred on April 13-14, 2011. Resident #7's quarterly MDS, dated 04/01/11, contained the following coding: * Section H0300 Urinary Continence checked for occasionally incontinent Review of Resident #7's toileting chart in the seven day look-back period (03/26/11-04/01/11)	F 278		

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F 278	Continued From page 10 for the current MDS showed the resident incontinent several times daily with episodes of continence on five of the seven days. During an interview on 04/13/11 at 5:10 p.m., an administrative nurse (#1) stated the resident should be coded frequently incontinent.	F 278	F309 1. Resident #5 pain assessment was done 4-13-2011. Medical provider evaluated on 4-20-2011. Reevaluated on 5/04/2011 and dosage was reduced. Resident #5 care plan has been reviewed and revised to include pain	5-16-11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy/procedure review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 2 of 8 sampled residents (Resident #5 and #8) currently experiencing pain and requiring frequent use of pain medications; and failed to identify and implement interventions for 1 of 4 sampled residents (Resident #3) with swallowing problems. Failure to comprehensively assess, implement interventions, and evaluate the effectiveness of interventions for residents with pain and swallowing problems does not allow them to reach their highest level of well-being, and resulted in uncontrolled pain to Resident #5.	F 309	management. Medical provider will evaaluate again on 5/10/2011. Resident #8 pain assessment has been done on 04/13/2011. Medical provider ordered a fentanyl patch. Resident # 3 Care plan has been revised to reflect the potential for a swallowing problem. 2. All residents have the potential to be affected by this practice. 3.Nursing staff will be inserviced on 05/11/2011. The inservice will cover pain assessments, proper use of pain scale and assessing for effectiveness. It will also include monitoring all residents with the potential for choking. All professional therapists will give notes and reccomendations to the Director of Nursing so that she can be sure they are implemented. 4. 5 residents will be audited for accurate pain assessments, prn usage and effective pain management weekly for 8 weeks by the Director of Nursing or her designee. The results of these audits will be brought to the QA committee for further review.	

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F 309	Continued From page 11 Findings include: Review of the facility policy titled "Pain Management" occurred on 04/14/11. This policy, revised July 2009, stated, "PURPOSE: To provide pain relief as defined by a mutually determined goal between the resident and/or family and staff for each individual resident according to their individual needs. POLICY: All staff will work toward relieving pain according to the goal determined by the resident and/or family and . . . staff. . . . Pain screening will be done at time of admission/re-entry, with monthly nursing summaries, at the onset of new pain, or at any other time the MDS [Minimum Data Set] needs to be done. . . . PROCEDURE: A. Pain Assessment Form: . . . 4. . . . a. . . . indicate on the illustration where the pain is located . . . b. Rate the intensity of the pain. . . . 7. Refer the finding to the physician, for mediation orders. . . .12. List non-pharmacological interventions on the PRN [as needed] Mar [Medication Administration Record]. (Use the section dedicated for this and record at least three interventions). 13. record date, type of non-pharmacological intervention tried, reason/location of pain, results of non-pharmacological intervention tried. . . 14. If non-pharmacological intervention ineffective, give and document use of PRN medication. . . . B. Daily Pain Assessment/Management: 1. When giving cares, observe residents for any body language that might indicate pain. Report this to the nurse. 2. Nurses observe for indications of pain when passing medications. . . . 5. Medicate as needed and monitor for effectiveness. If not effective, the MD [medical doctor] may need to be contacted and the medication evaluated and changed. 6. Complete the Pain Monitoring	F 309		

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section on the report sheets and discuss pain management (including methods of control) at change of shift with other professional nurses."

Review of the pain scale printed on the facility's PRN MARs showed the "faces" and numeric pain scale of 0-5 (0 represents "no hurt" and 5 represents "hurts worst"), while the pain scale printed on the facility's Pain Assessment Form showed a numeric pain scale of 0-10 (0 represents "no" pain and 10 represents "severe" pain).

- Review of Resident #5's medical record occurred on April 11-14, 2011. Resident #5's medical diagnoses included chronic obstructive pulmonary disease with asthma, dementia, congestive heart failure, benign prostatic hypertrophy, hypertension, Parkinson's disease, and surgical repair of a fractured right hip (03/24/11).

Physician's orders, upon Resident #5's return from the hospital on 03/28/11 included Motrin 800 milligrams (mg) one tablet every 6-8 hours as needed for pain and Tylenol 500 mg every 6 hours as needed for temperature >100 degrees Fahrenheit. An un-timed telephone order on 03/28/11, stated "oxycodone 5 mg i [one] po [by mouth] q [every] 4 h [hours] pain." Facility staff transcribed the Oxycodone order as a PRN (as needed) medication on the Medication Record.

Review of Resident #5's care plan, dated 04/05/11, identified "Problem: Right hip fracture. . . . Approach: . . . Weight bearing as tolerated. Sit up in wheel chair as tolerated. Assist of one to two staff with transfers. . . .Report to nurse

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complaints of pain." The care plan does not identify goals in regards to pain management and does not identify non-pharmacological interventions for relief of pain.

Review of the Minimum Data Set Perspective Payment System 5-Day Assessment, completed after Resident #5's return from the hospital and dated 04/01/11, identified Resident #5 experienced frequent, severe pain, which limited his day-to-day activities.

Review of Resident #5's PRN Medication Administration Record identified Resident #5 received Oxycodone 24 times and Motrin 4 times from March 29-April 12, 2011. The record identified Resident #5 rated his pain during this period from a range of "3-6" on a numeric pain scale of 0-5 (0 = no pain and 5 = severe pain). The PRN Medication Record does not identify non-pharmacological Interventions as identified in the "Pain Management" policy.

An observation at 3:05 p.m. on 04/11/11 showed Resident #5 activated his call light to notify staff of pain in his right leg. Observation showed Resident #5 grimaced with movement. A nursing staff member (#3) administered 800 milligrams (mg) Ibuprofen to Resident #5 for his leg pain.

An observation at 8:45 a.m. on 04/12/11 showed Resident #5 activated his call light to report pain in his right leg. When questioned by a nursing staff member (#4), Resident #5 stated he would rate the pain as a "6" on a scale of 0-5. The nursing staff member (#4) administered 5 mg Oxycodone to the resident for his leg pain. Observation showed Resident #5 grimaced with

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movement and verbally expressed feeling pain. At 9:00 a.m., Resident #5 stated he was in a lot of pain (he rated the pain as a "7-8") and did not want to get up for breakfast because of the pain. The nursing staff member (#4) placed a warm pack on the resident's right leg. At 10:30 a.m., when asked about his leg pain, Resident #5 stated it was "fair."

Review of the Multidisciplinary Notes on 04/12/11 identified the following:

*1:10 p.m. - ". . . Res c/o [complained of] pain in R [right] hip earlier in shift, rating pain on a pain scale 6/10, prn oxycodone given [with] no relief. Res stating 20 min [minutes] later pain is 7/10. Warm pack applied to R hip @ [at] this time et [and] was effective in alleviating pain. . . ." (In the above observation at 8:45 a.m., Resident #5 rated his pain as "6" on 0-5 pain scale; while the documentation in the Multidisciplinary Note stated the resident rated his pain on a 0-10 pain scale.)

*2:00 p.m.-10:00 p.m. - "Res c/o pain in Rt hip at 7 pm. Medicated . . . Res had call light on a few minutes stating he wanted me to call the Dr. about his leg. Explained to res that pain med needs time to work. . . ." At 8:30 p.m., the PRN MAR showed Resident #5 exhibited "no c/o's" of pain.

Observation at 9:30 a.m. on 04/13/11 showed Resident #5 sitting in his wheelchair in the lounge area. Resident #5 stated his leg hurt and he had nothing yet for pain this morning. The resident stated, "maybe that would make it (the leg pain) better" Resident #5 requested pain medication when approached by a staff member (#5).

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F 309	Continued From page 15 The multidisciplinary notes identified Resident #5 requested pain medications several times for complaints of right leg pain. Although the pain medication helped to relieve pain the majority of the time, Resident #5 continued to experience frequent pain, which he rated between moderate and severe almost 3 weeks after his surgery. The staff failed to comprehensively assess and pro-actively manage Resident #5's pain, as outlined in the facility's pain management policy. Facility staff failed to complete a "Pain Assessment Form" to determine if current interventions were meeting the goal to control Resident #5's pain. During an interview on the morning of 04/13/11, an administrative staff member (#2) confirmed a comprehensive pain assessment had not been completed since Resident #5's return from the hospital. Review of Resident #5's medical record occurred on 04/14/11 and showed facility staff completed a comprehensive pain assessment on 04/13/11. The assessment identified Resident #5's pain intensity as a 6-8 on a numeric pain scale of 0-10. The resident described the pain as "it hurts like a knife." The facility informed Resident #5's medical provider of this finding and the medical provider ordered oxycodone 5 mg one tablet twice a day for 7 days, and then re-evaluate. Failure to comprehensively assess Resident #5's hip pain impacted the resident's physical functioning and did not allow him to attain his highest practicable mental and psychosocial well-being.	F 309		

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F 309	Continued From page 16 - Review Resident #8's medical record occurred on April 13-14, 2011. The facility admitted Resident #8 in November 2009. Medical diagnoses for Resident #8 included cerebral vascular accident with left hemiparesis, insulin dependent diabetes mellitus, osteoarthritis, and peripheral vascular disease. Review of Resident #8's quarterly Minimum Data Set, dated 01/18/11, identified the resident as cognitively intact, received PRN pain medications, non-pharmacological interventions to treat pain symptoms, and frequently complained of pain which interfered with day-to-day activities during the 5-day assessment look-back period. Resident #8's care plan, dated 01/26/11, identified a "Problem: Pain/Comfort: Potential for [left] shoulder pain" with a "Goals: Maintain comfort for 4-6 hr [hours] at a time . . ." and "Approaches: Administer medications, assess pain level, assess [for] side effects [of pain medications], monitor for uncontrolled pain [and] report to MD [medical doctor] . . . Has shoulder sling for support but refuses to wear it." Review of Resident #8's "Comprehensive Pain Assessment," dated 02/19/11, identified the resident exhibited moderate, intermittent pain to her left arm and shoulder at a pain rating of 2 (on a 0-5 numeric pain scale) with a desired pain level of 0. Review of Resident #8's current physician orders occurred on 04/13/11 and lacked evidence of any scheduled around-the-clock dosing of pain medication(s) to treat the resident's left arm and shoulder pain, except for the use of PRN pain	F 309		

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F 309	Continued From page 17 medications of: - Hydrocodone 5/500 milligrams (mg) three times a day PRN - Tylenol 1000 mg every four hours PRN - Icy Hot ointment (a topical pain lotion) to painful areas as needed. Review of Resident #8's Medication Administration Records (MARs) from January-April 12, 2011 showed the resident received: PRN Tylenol 17 times and Hydrocodone 19 times in January PRN Tylenol 18 times and Hydrocodone 19 times in February PRN Tylenol 22 times and Hydrocodone 17 times in March PRN Tylenol 12 times and Hydrocodone 8 times thru April 12th. During an interview on 04/13/11 at 4:30 p.m., the surveyor informed an administrative nurse (#2) of Resident #8's frequent usage of multiple PRN pain medications over the past four months. This administrative nurse stated her unawareness of Resident #8's frequent use of PRN medications and stated she would "look into this." Review of Resident #8's medical record on the morning of 04/14/11, showed facility staff completed a comprehensive pain assessment on the afternoon of 04/13/11. The facility informed Resident #8's medical provider of the findings of this comprehensive pain assessment and the medical provider ordered a Fentanyl patch 12.5 micrograms every 72 hours. Failure of the facility to recognize Resident #8's	F 309		

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increased usage of PRN pain medications, evaluate the existing pain and potential cause(s), and implement interventions to effectively minimize Resident #8's arm and shoulder pain has the potential to interfered with the resident's day-to-day activities.

- Review of Resident #3's medical record occurred on April 11-14, 2011. Diagnoses included multiple sclerosis, paraplegia, muscle spasms, and dementia. The annual MDS, dated 01/27/11, and the quarterly MDS, dated 10/28/10, identified the resident with loss of liquids/solids from mouth when eating or drinking and with coughing or choking during meals or when swallowing medications. The careplan, dated 02/02/11, listed the problem of "mechanically altered therapeutic diet - low fat, soft, regular diet. Monitor for chewing. . . ." The physician's diet order, dated 10/11/10, listed, "low fat with ground meat - push fluids."

On 04/12/11 at 12:00 p.m., observation showed Resident #3 seated at the dining room table feeding himself. The resident frequently looked around the room, greeted and waved to other residents and staff.

An occupational therapy (OT) note, dated 07/14/10, stated, ". . . [Resident #3] referred for a swallow evaluation secondary to reports of coughing/choking during mealtime. . . . Cues made to the resident to slow down while eating, taking small bites . . ." OT note dated 07/23/10, "Resident observed again . . . During much of the meal he remains distracted. A possible change of location in which he is not able to see other large areas of the dining room may be appropriate. . . ."

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F 309	Continued From page 19 A dietary note, dated 10/04/10, stated, "Ground meat added to diet due to choking. Review last swallow evaluation on 07/14/10 - stress importance of eating slowly and limiting distractions." A monthly summary, dated 11/04/10, stated, ". . . choking spells at mealtime - choked on a grape today at lunch, doesn't chew foods well . . . choked on scrambled eggs at supper. . . ." A nursing note, dated 12/03/10 at 9:30 a.m., stated, "Resident in dining room, started coughing and turning red, resident was eating eggs with potatoes and ham. Resident coughed for five minutes then was okay." A monthly summary, dated 12/04/10, stated, ". . . frequently have coughing episodes when eating ground meat. . . ." An annual dietary summary, dated 02/01/11, stated, "History of chronic neuropathy, low fat, ground meat . . . Ground meat is tolerated well." On 04/12/11 at 3:25 p.m. during an interview, an administrative nurse (#2) stated they had discussed the results of the swallow evaluation to limit distractions, but did not feel it was feasible as the resident loves to socialize and would be detrimental to move him. This nurse agreed the careplan should include staff cueing the resident to slow down with eating. The facility failed to include Resident #3's problem with coughing/choking while eating in the careplan and interventions to reduce the coughing/choking, and failed to address this concern on the Care Area Assessment (CAA) of the latest comprehensive assessment. Failure to put measures in place to reduce the resident's	F 309		

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F 309	Continued From page 20 incidence of coughing or choking with eating has the potential for aspiration of food or liquids or blockage of the resident's airway.	F 309	F314	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of standards of practice, and staff interview, the facility failed to provide the necessary treatment to promote healing for 1 of 2 sampled residents (Resident #2) identified by the facility with a current pressure sore. Failure to provide the necessary treatment may contribute to delayed healing of Resident #2's pressure sore. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the prevention of pressure ulcers and states the facility should have a system/procedure to assure: assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes in condition are	F 314	1. Resident #2 had a pressure reducing mattress placed in her wheelchair. April 29th, 2011 Resident # 2 was discharged home. 2. All residents have the potential to be affected by this practice. 3. A Nursing Staff inservice will be held May 11, 2011. This inservice will cover our skin care clinical protocol, policy and procedures, interventions and risk factors. Policies and procedures on prevention, treatment and skin care protocols have been implemented. These include pressure ulcer assessment and care. 4. The Director of Nursing or her designee will audit 5 residents weekly for 8 weeks. The audits will look for prevention, risk factors and appropriatte treatements on the care plan. The care delivered will also be audited. The results of the audits will be taken to the QA committee for further review and action if necessary.	5-16-11

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recognized, evaluated, reported to the practitioner, and addressed. The first step in prevention is the identification of the resident at risk of developing pressure ulcers. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.

Pressure redistribution refers to the function or ability to distribute a load over a surface or contact area. Redistribution results in shifting pressure from one area to another and requires attention to all affected areas. Pressure redistribution has incorporated the concepts of both pressure reduction and pressure relief.

Appropriate support surfaces or devices should be chosen by matching a device's potential therapeutic benefits with the resident's specific situation. The effectiveness of pressure redistribution devices (e.g. 4-inch convoluted foam pads, gels, air fluidized mattresses, and low loss air mattresses) is based on their potential to address the individual resident's risk, the resident's response to the product, and the characteristics and condition of the product. Static pressure redistribution devices (e.g. sold foam, convoluted foam, gel mattress) may be indicated when a resident is at risk for pressure ulcer development or delayed healing. A specialized pressure redistribution cushion or surface might be used to extend the time a resident is sitting in a chair; however, the cushion does not eliminate the necessity for periodic repositioning.

After completing a thorough evaluation, the interdisciplinary team should develop a relevant care plan including prevention and management

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F 314	Continued From page 22 interventions with measurable goals. Many clinicians recommend evaluating skin conditions (e.g. skin color, moisture, temperature, integrity, and turgor) at least weekly, or more often if indicated. When evaluating a pressure ulcer wound, at a minimum, documentation should include the date observed and the location and staging, size (perpendicular measurements of the greatest extent of the length and width of the ulceration), depth; and the presence, location, and extend of any undermining or tunneling/sinus tract; exudate, if present: type (such as purulent/serous), color, odor, and approximate amount, pain; wound bed: color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and description of wound edges and surrounding tissue. On 04/14/11, the survey team requested a copy of the facility's current policies and procedures pertaining to pressure ulcer care and treatment from two administrative nurses (#1 and #2). These administrative nurses failed to provide any policies and/or procedures for review. - Review of Resident #2's medical record occurred on April 11-14, 2011. The facility admitted Resident #2 in February 2011. Resident #2's current medical diagnosis include decubitus ulcers to bilateral heels and buttock, insulin dependent diabetes, renal failure, and congestive heart failure. Resident #2's Braden Scale score (an assessment tool completed by the facility to identify at-risk residents needing pressure ulcer prevention interventions), completed on 02/15/11, revealed a score of "13" which placed the resident at moderate risk. Current physician	F 314		

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F 314	Continued From page 23 orders regarding treatment of Resident #2's pressure sores included wet-to-dry dressing changes daily to bilateral heels and Lantispetic ointment applied daily to buttock. Resident #2's admission Minimum Data Set (MDS), dated 02/22/11, and 14-day MDS, dated 02/28/11, identified the resident exhibited severe cognitive impairment, required extensive one person physical assistance with bed mobility, transfers, toileting, and personal hygiene, at risk for developing pressure ulcers, two Stage 2 pressure ulcers present upon admission, and the use of pressure reducing device for the bed, on a turning/repositioning program, nutritional or hydration interventions, ulcer care, and application of nonsurgical dressings and ointments/medications. Review of Resident #2's care plan, dated 02/28/11, identified pressure ulcer approaches of "Treatment as ordered . . . Upload both feet on pillow. Heel protectors to both feet. Provide Arginaid [a type of protein supplement] to promote wound healing" and urinary incontinence approaches including, ". . . at risk for skin breakdown, her skin is reddened on front peri area and she has a pressure ulcer on buttocks Stage II. clean and dry. Apply Lantispetic to open area." Random observations of Resident #2 in bed throughout all days of survey showed the resident's heel positioned directly on the mattress and the presence of bilateral soft pressure-reducing heel protectors to the resident's feet. During these observations, facility staff encouraged Resident #2 to lay on her side,	F 314		

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F 314	Continued From page 24 but the resident refused. Observation on 04/12/11 at 11:00 a.m. showed a certified nursing assistant (#14) provided physical assistance to transfer Resident #2 from her wheelchair into bed. Observation of Resident #2's wheelchair showed the seat cushion covered with a terry-cloth bath towel and the absence of any pressure-reducing cushion. Review of the facility's "Wound Assessment Record" for Resident #2's left buttock pressure sore showed the pressure sore measured 0.5 centimeters (cm) x 0.25 cm on 02/15/11 and decreased in size to 0.3 cm x 0.25 cm on 02/23/11. (The facility failed to obtain any measurements on March 2nd related to the resident out on an extended pass with family members.) On 03/16/11, Resident #2's physician observed the left buttock pressure ulcer and stated the approximate size as "< [less] 0.5 cm. The facility's weekly "Wound Assessment Record" lacked any further measurements of the size of Resident #2's buttock pressure sore. Review of the facility's "Wound Assessment Record" for Resident #2's right heel pressure sore showed the pressure sore measured 3.0 cm x 2.5 cm with a 1.0 cm redden and blacken area on February 15 and 23 and March 10. (The facility failed to obtain any measurements on March 2nd related to the resident out on an extended pass with family members.) The facility noted a left heel pressure sore on 03/10/11, and recorded measurements of 3.0 cm x 2.5 cm with a 1.0 cm redden and blacken area on the "Wound Assessment Record." On	F 314		

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F 314	Continued From page 25 03/16/11, Resident #2's physician observed the bilateral heel pressure sores. Measurements recorded on the "Wound Assessment Record," dated 03/31/11, stated, "Lt [left] 1.5 cm" and "Rt [right] .75 cm" and described the appearance as "discolored." These measurements failed to identify if this measurement is the length or width of the pressure sore. Resident #2's podiatrist manually debrided the bilateral heel pressure sores on 04/07/11. The facility failed to measure and record the specific size of the each pressure at least weekly in accordance with acceptable standards of practice. Review of Resident #2's multidisciplinary notes identified numerous entries of the resident's refusal to be repositioned on either side and the resident's preference "is to lie on her back." Review of a podiatrist progress note for Resident #2, dated 04/09/11, stated, ". . . the biggest risk is when she is in a reclined position or lying position that she needs to either have pillows under her legs or she will need to have soft pressure relief AFO [ankle foot orthotic] to help continue to heal. If the decubitus ulceration worsen, it is likely because there is not adequate off-loading. This will be important when she is in a wheelchair and in her bed." The medical record lacked evidence the facility attempted to obtain the soft pressure relief AFO in response to Resident #2's refusal to change positions when in bed. During interview on 04/12/11 at 2:00 p.m., an administrative nurse (#1) stated all of the beds in the facility contain pressure-reducing mattresses.	F 314		

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F 314	Continued From page 26 This nurse stated Resident #2 prefers to spend the majority of her time in bed, lying on her back, and only leaves her room via wheelchair for meals, church services, and restorative therapy. This nurse stated Resident #2's family took the resident out of the facility on pass from February 28 - March 03 and stated she provided Resident #2's family members with education regarding the need to wear the heel protectors and the importance of alleviating pressure to the resident's bilateral heels. This nurse confirmed Resident #2's wheelchair lacked a pressure-reducing cushion. Observation on 04/13/11 at 8:05 a.m. showed Resident #2 seated in her wheelchair in the dining room. Observation of Resident #2's wheelchair showed a pressure-reducing cushion placed on the seat of the wheelchair. Failure to consistently provide pressure-reducing interventions in accordance with recognized standards of practice creates the potential for a delay in the healing of Resident #2's buttock and heel pressure sores. The facility's failure to have a formalized system/procedure in place regarding the assessment, management, treatment, and evaluation of pressure sores has the potential to prolong the heeling process.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	Continued From page 27 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide appropriate treatment and services to maintain or restore as much normal bladder function as possible to 4 of 9 sampled residents (Resident #2, #5, #7, and #8) who are incontinent of bladder. Failure to perform bladder assessments initially and on a routine basis, develop and implement interventions, including toileting plans, and evaluate the outcome of interventions contributed to a decline or failed to maintain the level of continence of these residents. Findings include: Review of the facility policy titled "Urinary Continence and Incontinence - Assessment and Management" occurred on 04/14/11. This policy, not dated by the facility, stated, "Policy Statement: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. . . . 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function . . . . Policy Interpretation and Implementation: . . . 2. Relevant information related to urinary continence includes: . . . c. Pertinent diagnoses, including congestive heart failure, stroke, diabetes mellitus, obesity,	F 315	F315 1. Resident #2 was discharged from the facility. Resident #5 has an individualized toileting plan based upon an assessment. Resident #7 has an individualized toileting plan based upon the results of an assessment. Resident #8 has an individualized toileting plan based upon an assessment. 2. All residents have the potential to be affected by this practice. 3. An inservice will be held on May 11 to implement the new toileting plan assessment. A 3-5 day toileting assessment will be done upon admission, significant change and quarterly. Based on the outcome of the toileting assessment a toleting plan will be developed. These toileting plans will be individualized for the resident needs. 4. Director of Nursing will audit that every resident has a toileting plan, that it is being assessed for effectiveness and that it is being implemented. These audits will be done on 2 residents weekly for 8 weeks. The results of these audits will be taken to the QA committee for further review and action.	5-16-11

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F 315	Continued From page 28 neurological disorders (Parkinson's disease, multiple sclerosis) . . . d. Observations, including wet bed or clothing, . . . use of diuretics; e. Functional and/or cognitive capabilities or limitations that could affect continence, including impaired cognitive function or dementia, impaired mobility, decreased manual dexterity, decreased upper and lower extremity muscle strength, impaired vision and pain with movement; g. Environmental factors . . . distance to toilet or bedside commode, availability of urinal, and use of bed rails or restraints. 3. Periodically (as required and when there is a change in voiding), staff will define each individual's level of continence . . . 4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include: a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream, etc.); b. Associated pain or discomfort (dysuria); and c. Whether incontinence occurs in relation to coughing or sneezing . . . 6. The evaluation will include a review for medications that might affect continence . . . 7. the staff and physician will summarize an individual's continence status. for residents deemed incontinent, this includes categorizing incontinence as urge, stress, overflow, mixed, or functional . . . 17. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. a. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. . . ." During interview on the morning of 04/14/11, two administrative nurses (#1 and #2) stated the	F 315		

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F 315	Continued From page 29 facility completes bowel and bladder assessments on all residents upon admission to the facility and utilizes the information obtained to determine how the facility may maintain or improve episodes of incontinence. These staff members stated the facility utilizes a two-part form titled, "Bowel and Bladder Assessment Part A and Part B," to gather information. Instructions printed on the top of the form titled "Bowel and Bladder Assessment Part A" stated, "Complete this form after completion of the B&B [Bowel and Bladder] Assessment Part B." The facility's "Part A" form lists several questions facility staff complete to determine a resident's present bladder and bowel patterns, potential factors contributing to incontinence, and whether the resident would be a candidate for any type of a toileting program. The facility's "Part B" form provides an hourly tracking of a resident's voiding pattern for up to nine days and identifies specific codes for staff to document the results of each resident's voiding episodes such as "1. Found dry. 2. Found wet and changed. 3. Found soiled and changed. 4. Toileted and voided. 5. Toileted and BM [bowel movement]. 6. Toileted and did not void. 7. Refused. 8. Fluids offered." - Review of Resident #5's medical record occurred on April 11-14, 2011. Resident #5's medical diagnoses included chronic obstructive pulmonary disease with asthma, dementia, congestive heart failure, benign prostatic hypertrophy, hypertension, and Parkinson's disease. The annual Minimum Data Sets (MDS), dated 09/02/10, identified Resident #5 as moderately independent in decision making, required	F 315		

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F 315	Continued From page 30 extensive assistance of one person for toilet use, usually continent of urine, and not on a toileting program. The quarterly MDS, dated 11/30/10 and 02/28//11, identified Resident #5 with severe cognitive impairment on the Brief Interview for Mental Status (BIMS) test, required extensive assistance of one person for toilet use, frequently incontinent, and not on a current toileting program or trial. Current physician orders included the medication Lasix (a diuretic). Review of Resident #5's current Plan of Care, dated 04/05/11, identified "Problem: Bladder incontinence. . . . Approach: Provide privacy with cares. Encourage fluids within recommended dietary amount of 2300 cc daily. Monitor intake." The CNA care plan identified Resident #5 as independent with toileting, wears large "pull-ups", needs assistance with bathroom, offer bathroom before/after meals, encourage to use call light for help, asks if needs anything when going to room, and transfers self at times in and out of bed to w/c [wheelchair]. Review of Resident #5's Quarterly Nursing Summary, dated 12/02/10, identified ". . . has declined in this review period with needing extensive assist with ADL's [activities of daily living]. His main mode of locomotion is the wheelchair. His gait is very unsteady, says he feels weak and has had falls during this period. . . He does occasionally use his walker with guarded assist of one to two people. . . [Resident #5] is occasionally incontinent of bowel and bladder and uses the bathroom with extensive assist of one. His incontinent episodes are due to not being able to make it to the bathroom in time. . . . He does not always put his call light on for	F 315		

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assistance. Frequent room checks are done to monitor if [Resident #5] needs any assistance or at time he hollers out "Help." We continue to remind . . . to use the call system. [Resident #5] has some long and short term memory loss. He is able to communicate his needs well. . . ."

Review of Resident #5's "Bowel and Bladder Assessment - Part A," completed August 6, 2010, identified "Resident is usually continent - There have been times he has not made it to the BR [bathroom] in time. . ."

Review of Resident #5's toileting chart in the seven day look-back period (03/28/11 - 04/03/11) for the current MDS showed the resident incontinent several times daily with episodes of continence on seven of the seven days.

Review of interdisciplinary nurses notes, from 11/11/10 to 04/13/11, identified the following attempts by Resident #5 to self-transfer to the toilet:

*11/11/10 at 4:15 a.m. - "Heard res [resident] call for help - found sitting on floor [with] back up against the bed . . . Amb [ambulated] to BR [bathroom] [without] discomfort . . . Voided. . . ."

*11/12/10 at 6:00 p.m. - "Res heard hollering for help. CNA [certified nurse aide] went in to res room found res in BR lying on R [right] side [with] pants et [and] brief down to knees. Res was continent and stated "I went to BR et tried to stand up . . ."

*12/27/10 at 1:15 p.m. - "resident didn't use call light was found by CNA in bathroom, reminded resident to use call light . . ." 10:00 p.m. - "Res amb to BR . . . per self. Call light was not used. Resident was instructed on the importance of

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F 315	Continued From page 32 using the call light. . . ." *12/28/10 at 9:00 p.m. - ". . . Ambulated to br [bathroom] . . . - did not use call light." *12/30/10 at 6:30 a.m. - "Res hollering for help . . . Found sitting on bed [with] brief down to knees in a pool of urine. Assisted res to br to change brief. . . ." *01/03/11 at 9 p.m. - ". . . res uses call light at times to go to br, most often turns on light if he needs help once he has ambulated to br without assistance per walker. Reinforced the need to use call light upon ambulation to [decrease] chance of falling." *01/09/11 at 2:00 p.m. - "resident using w/c to transfer self to bathroom. States he needed to use toilet . . ." *03/02/11 at 1:00 p.m. - "Falls review - . . . will ring call light for assist if needed - will take self to bathroom by dining area at times. . . ." *04/10/11 at 8:30 a.m. - " Res found lying on floor in bathroom between toilet stool and w/c . . . Asked res what happened 'I was trying to go to the bathroom.' Asked Res why transferring without assistance, 'I needed to go to the bathroom' . . ." *04/11/11 at 1:00 p.m. - "Resident was reviewed today due to a couple of falls. He had tried to do his transfers [and] walking independently without calling for the nurse. . . . In meantime, [Resident #5] will be encouraged to use call light to ask for help, watched closely when leaving activities and heading back to room and have all falling precautions put in place. . . . will also talk to [Resident #5] about our concern for his falls and request him to use his call light." *04/13/11 at 12 midnight - "res attempting to get out of bed. Had call light on - wanting to go to the BR . . ."	F 315		

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Resident #5's urinary continence changed from usually incontinent (September 2010 MDS) to frequently incontinent (November 2010 and February 2011 MDSs) and the medical record identified several occasions where the resident sustained a fall when he attempted to get to the bathroom. Facility staff failed to complete a Bowel and Bladder Assessment to re-assess his increased bladder incontinence, determine voiding patterns and frequency to minimize self transfer, and failed to implement individualized interventions to manage, maintain, or improve Resident #5's level of incontinence.

- Review of Resident #7's medical record occurred on April 13-14, 2011. Diagnoses included bladder functional disorder, detrusor (bladder muscle) instability, osteoarthritis, and left shoulder and hip replacements. The quarterly Minimum Data Sets (MDS), dated 04/01/11 and 01/01/11, identified Resident #7 scored a 06 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) test, required extensive assistance of one person for toilet use, occasionally incontinent, and not on a current toileting program or trial. The quarterly MDS, dated 09/26/10, identified Resident #7 required limited assistance of one person for toilet use, continent of urine, and not on a toileting program. Current physician orders include the medication oxybutynin (relieves symptoms of overactive bladder).

Resident #7's current careplan included the problem "Continent of bowel and bladder" with approaches "assist with transfers and getting to bathroom, encourage to use call light when in

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bathroom, stay nearby when in bathroom, and encourage to call for help with transfers." The careplan also included the approach "offer resident to use bathroom before breakfast, early A.M. and before bed," for the problem "Limited use of left side - may contribute to falling."

A weekly summary/monthly summary form, dated 01/30/11, listed the area "Bladder and Bowel" with a checkmark by "occasionally incontinent," and "no" marked by "urinary toilet program."

On 04/13/11 at 8:51 a.m. during an interview, a certified nurse assistant (CNA) (#7) stated Resident #7 does a lot for herself, including dressing and going to the bathroom, with the CNA helping to pull up pants while the resident stands up. The CNA stated sometimes the resident gets confused and doesn't remember what she has done and needs cueing.

Review of Resident #7's toileting chart in the seven day look-back period (03/26/11-04/01/11) for the current MDS showed the resident incontinent several times daily besides episodes of continence on five of the seven days.

During an interview on 04/13/11 at 5:10 p.m., an administrative nurse (#1) stated the resident should be coded frequently incontinent.

During an interview on 04/14/11 at 9:58 a.m., an administrative nurse (#2) stated toileting should be evaluated every quarter, because things may change. Staff toilet residents with cares, such as when getting up and laying down, and during rounds, meaning every two hours.

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F 315	Continued From page 35 Facility staff failure to complete a Bowel and Bladder Assessment to determine Resident #7's overall continence performance through all shifts did not provide accurate baseline data to develop an individualized plan to allow the resident to improve/attain maximum bladder continence. - Observation of Resident #2 on 04/12/11 at 12:20 p.m. showed an administrative nurse (#2) and a nurse (#4) assisted the resident into the bathroom per the resident's request. Observation showed Resident #2's incontinent product as dry. Resident #2 voided and had a bowel movement. An administrative nurse (#2) stated Resident #2 usually informs staff when she wants to toilet. Review of Resident #2's medical record occurred on April 11-14, 2011. The facility admitted Resident #2 in February 2011. Resident #2's medical diagnoses included decubitus ulcers to bilateral heals and buttock, insulin dependent diabetes, renal failure, and congestive heart failure. Review of Resident #2's "Bowel and Bladder Assessment Form- Part B," completed from February 16-20, 2011, showed three times Resident #2 coded as "2 [found wet and changed]," one time as "3 [found soiled and changed]" and 25 times as "1 [found dry]." Review of Resident's #2's "Bowel and Bladder Assessment Form-Part A," showed the entire form as "blank" and incomplete. During interview on the afternoon 04/12/11, an administrative nurse (#1) confirmed facility staff failed to complete Part A of Resident #2's Bowel	F 315		

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F 315	Continued From page 36 and Bladder Assessment. Review of Resident #2's admission Minimum Data Set (MDS), dated 02/22/11, and 14-day MDS, dated 02/28/11, identified the resident exhibited severe cognitive impairment, required extensive one person physical assistance with toileting and frequently incontinent of urine. These MDSs identified the facility had not tried or trialed Resident #2 on any form of a toileting program (scheduled toileting, prompted toileting, or bladder training) since admission to the facility. Review of Resident #2's care plan, dated 02/28/11, identified a "Problem: Potential for complications related to urinary incontinence," a "Goal: . . . will be clean and dry with use of incontinence products and prompt care . . . ." and "Approaches: Check . . . at least every 2 hours for incontinence. Wash, rinse, and dry soiled areas. Provide . . .with adult briefs . . . Obtain and monitor lab work . . . at risk for skin breakdown, her skin is reddened on front peri area and she has a pressure ulcer on buttocks Stage II. clean and dry. Apply Lantiseptic to open area." Resident #2's February MDSs identified her as "frequently" incontinent of bladder, while the documentation from the look-back period for these assessment periods showed her as "occasionally" incontinent of bladder. Resident #2's care plan lacked specific individualized interventions to "manage," maintain, or improve the resident's level of incontinence. - Review of Resident #8's medical record occurred on April 13-14, 2011. The facility admitted Resident #8 in November 2009.	F 315		

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F 315	Continued From page 37 Resident #8's medical diagnoses included cerebral vascular accident with left hemiparesis, insulin dependent diabetes, osteoarthritis, and peripheral vascular disease. Record review identified facility staff failed to complete a "Bowel and Bladder Assessment Form- Part B," for Resident #8. Review of Resident #8's current "Bowel and Bladder Assessment-Part A," completed at the time of admission and dated 12/01/09, identified a "Present bladder pattern" of "encourage to use call light for toileting assistance." This assessment failed to identify Resident #8's normal bladder voiding pattern/habits and failed to identify whether the resident possessed the cognitive and physical ability to participate in a bladder retraining program. Resident #8's bladder assessment failed to consider possible causes (such as medical diagnosis/conditions or medications) which have the potential to impact her incontinence. Review of Resident #8's quarterly MDSs, dated 10/18/10 and 01/18/11, identified the resident as cognitively intact, required extensive one person physical assistance with toileting, and frequently incontinent of urine. These MDSs identified the facility has not tried or trialed Resident #8 on any form of a toileting program (scheduled toileting, prompted toileting, or bladder training) since admission to the facility. Review of Resident #8's care plan, dated 01/26/11, identified a "Problem: Occasional episodes of bladder incontinence," and "Approaches: Manage episodes of bladder incontinence with pull-ups [a type of incontinent	F 315		

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F 315	Continued From page 38 product]. Complete perineal cares after each incontinent episode. Monitor episodes. Provide privacy with cares." Resident #8's January 2011 MDS identified her as "frequently" incontinent of bladder which conflicts with her January 2011 care plan which states she has "occasional" episodes of bladder incontinence. The facility failed to assess and implement individualized interventions to "manage," maintain, or improve Resident #8's level of incontinence.	F 315	F323 1. Resident #5's care plan has been updated to reflect all potential cauative factors relating to falls including individualized toileting plans and effective pain management. Resident #5 has an individualized toileting plan based upon the results of an assessment. Resident # 5 has had a falls risk assessment worksheet done on April 23rd. A pain assessment has been done on April 13th and again on May 4th. Ordered routine pain medicine. 2. All residents have the potential to be affected by this practice. 3. All professional nursing staff will be insrviced on our Fall prevention policies and procedures by May 20th. This inservice will cover all policies and procedures, assessments, care plan updates and possible interventions related to fall prevention. This inservice will also cover proper lifting and gait belt usage. During incident review meeting our falls prevention and intervention procedure will be reviewed to make sure all possible causative factors are considered. 4. Director of Nursing or her designee will audit that every resident has a falls	5/20/11 Telephone Lori Martinson, RN/CM 5/24/11 @ 3:00 pm
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 policy/procedure review, the facility failed to assess and implement fall prevention measures, assess causative factors following a fall, and follow existing policy and procedures for 1 of 1 sampled resident (Resident #5) who experienced multiple falls; and failed to use assistive devices appropriately for 2 of 6 sampled residents (Resident #5 and #7) who required a gait belt while being transferred. Failure to assess for contributing factors, such as toileting needs related to falls, and implement related	F 323		

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F 323	Continued From page 39 interventions resulted in Resident #5 sustaining falls when attempting to self toilet, and failure to appropriately use gait belts during transfers has the potential to cause injury to residents. Findings include: Review of the facility policy titled "Falls Prevention and Intervention," stated, "Policy: Rolette Community Care Center maintains the responsibility to assess each resident as to the risk of injury from falling, implement an individualized interdisciplinary care plan that addresses those risks in a proactive manner and evaluates the effectiveness on a routine basis. In addition, . . . Rolette Community Care Center takes seriously it's responsibility to be at the forefront in fall prevention efforts by tracking and trending of fall incidents to identify extrinsic as well as intrinsic causes and implementing fall prevention intervention and operational action plans as necessary. Procedures: I. Proactive: To prevent the first fall. 1. All residents are assumed to have some risk of falls and staff is aware of the potential for a fall of any resident at any time and takes precautions when transferring/ambulating all residents. . . . 5. Falls - Prevention and Intervention: a. Residents that have a Score of 18 or higher on the Fall Risk Assessment, or residents that experience a fall incident, will have one or more interventions implemented immediately. The decision as to which if any measure to use will be based on history/observation and/or nurse's judgement. . . . II. Interventions to Prevent Falls . . . Interventions will be designed in relation to diagnosis and need. . . . 3. Incontinence or Issues with Toileting. a. Establish an individualized toileting plan by	F 323	risk assessment done. These risk assessments are to be done upon admission, quarterly and after any incident or signicicant change. The care plans will also be audited for appropriatte interventions developed from these risk assessments. The Director of Nursing or her designee will audit for gait belt usage and that all certified nursing assistants have access to a gait belt. These audits will be done on 5 residents weekly for 8 weeks. The results of these audits will be taken to the QA committee for further review and action.	

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F 323	Continued From page 40 implementing a 7 day Elimination Diary. . . . 5. Cognitive Impairment. c. Establish an individualized toileting plan by implementing a 7 day Elimination Diary. . . . Falls Committee. . . . b. Falling Star Program: . . . 4. Any resident who has fallen twice within 30 days or three times in 60 days is placed on this program. c. The resident will then receive: . . . 3. Individualized toileting plan . . ." - Review of Resident #5's medical record occurred on April 11-14, 2011. Resident #5's medical diagnoses included chronic obstructive pulmonary disease, dementia, asthma, Parkinson's disease, and a right hip fracture repair (03/24/11). The medical record identified Resident #5 received a diuretic medication daily. Review of Resident #5's Minimum Data Sets (MDS) identified the following: *Annual MDS 09/02/10 - Long and short term memory problems, moderate independence with daily decisions, usually continent of bladder, extensive assistance of one person with transfers and toileting, and fell in past 30 days. *Quarterly MDS 11/30/10 - Severely impaired cognitive status, frequently incontinent of bladder, not on a toileting program, and extensive assistance of one person with transfers and toileting. The MDS identified the resident had experienced more than two falls. *Quarterly MDS 02/28/11 - Severely impaired cognitive status, frequently incontinent of bladder, not on a toileting program, and extensive assistance of one person with transfers and toileting. The MDS identified the resident had experienced more that two falls.	F 323		

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F 323	Continued From page 41 Review of "Fall Risk Assessment Worksheets" from 10/23/10 to 04/05/11 identified Resident #5 with fall risk scores of 29 - 50. A score of 18 or higher is considered "at high risk." Review of Resident #5's interdisciplinary notes identified the following: *11/11/10 at 4:15 a.m. - "Heard res [resident] call for help - found sitting on floor [with] back up against the bed . . . Amb [ambulated] to BR [bathroom] [without] discomfort . . . voided. When asked what he was trying to do Res would not talk. . . ." *11/12/10 at 6:00 p.m. - "Res heard hollering for help. CNA [certified nurse aide] went in to res room found res in BR lying on R [right] side [with] pants et [and] brief down to knees. Res was continent and stated "I went to BR et tried to stand up with my w/c [wheelchair] et it got away from me." *12/27/10 at 1:15 p.m. - "resident didn't use call light was found by CNA in bathroom, reminded resident to use call light . . ." 10:00 p.m. - "Res amb to BR [with] walker per self. Call light was not used. Resident was instructed on the importance of using the call light. . . ." *12/28/10 at 9:00 p.m. - ". . . Ambulated to br [bathroom] [with] walker - did not use call light." *12/30/10 at 6:30 a.m. - "Res hollering for help from room. Found sitting on bed [with] brief down to knees in a pool of urine. Assisted res to br to change brief. . . ." *01/03/11 at 9 p.m. - ". . . res uses call light at times to go to br, most often turns on light if he needs help once he has ambulated to br without assistance per walker. Reinforced the need to use call light upon ambulation to [decrease] chance of falling."	F 323		

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F 323	Continued From page 42 *01/09/11 at 2:00 p.m. - "resident using w/c to transfer self to bathroom. States he needed to use toilet . . ." *03/02/11 at 1:00 p.m. - "Falls review - . . . will ring call light for assist if needed - will take self to bathroom by dining area at times - ambulates [with] walker short distances . . ." *04/05/11 at 9:00 a.m. - "Resident attempted to transfer self to bed from wheelchair . . . explained to Resident importance of using call light for help." *04/10/11 at 8:30 a.m. - " Res found lying on floor in bathroom between toilet stool and w/c . . . Asked res what happened 'I was trying to go to the bathroom.' Asked Res why transferring without assistance, 'I needed to go to the bathroom' . . ." *04/11/11 at 1:00 p.m. - "Resident was reviewed today due to a couple of falls. He had tried to do his transfers [and] walking independently without calling for the nurse. We will request a physical therapy consult or evaluation to see if any therapy is needed after his fracture. We will await this evaluation. In meantime, [Resident #5] will be encouraged to use call light to ask for help, watched closely when leaving activities and heading back to room and have all falling precautions put in place. . . . will also talk to [Resident #5] about our concern for his falls and request him to use his call light." *04/13/11 at 12 midnight - "res attempting to get out of bed. Had call light on - wanting to go to the BR . . ." Review of Resident #5's Quarterly Nursing Summary, dated 12/02/10, identified ". . . has declined in this review period with needing extensive assist with ADL's [activities of daily	F 323		

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living]. His main mode of locomotion is the wheelchair. His gait is very unsteady, says he feels weak and has had falls during this period. . . He does occasionally use his walker with guarded assist of one to two people. . . [Resident #5] is occasionally incontinent of bowel and bladder and uses the bathroom with extensive assist of one. His incontinent episodes are due to not being able to make it to the bathroom in time. . . . He does not always put his call light on for assistance. Frequent room checks are done to monitor if [Resident #5] needs any assistance or at time he hollers out "Help." We continue to remind . . . to use the call system. [Resident #5] has some long and short term memory loss. He is able to communicate his needs well. . . ."

Review of Resident #5's current Plan of Care, dated 04/05/11, identified "Problem: At risk for falls. Unsteady, shuffling gait has had recent falls. Dx [diagnosis] Parkinson's Disease. Goals: Falls assessments. To minimize any injury from falls. Approach: Encourage [Resident #5] to use call light for assistance . . . Monitor frequently when in bed; offer to take to the bathroom. . . Resident room checks to offer bathroom assistance. . . Ask [Resident #5] if he needs help with anything when seen propelling into room on his own. . . . Problem: Self care deficit; has unsteady gate . . . Approach: Transfers - Extensive assist of one or two staff. Uses walker with guarded assist . . ."

Review of Resident #5's Fall Evaluation Reports, completed after each fall, identified the following "New Fall Prevention Measures Implemented Following This Fall:"
*11/12/10 Fall - "pt education - encourage to use call light for assist for bathroom. PT referral."

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F 323	Continued From page 44 *12/26/10 Fall - "Resident checks - Continue with current falls interventions per care plan - medication review." *04/05/11 Fall - "resident checks, bed height adjusted/low bed, call light placed in reach." *04/10/11 Fall - "Ask [Resident #5] if needs anything when seen propelling self into room by himself. Encourage to use call light for help. Falling star: added to list." Resident #5 continued to experience falls due to self transfer attempts despite the facility's fall interventions (frequent checks, low bed, call light in reach, encourage to use call light, etc). The documentation in the medical record identified Resident #5 frequently attempted to self transfer in order to go to the bathroom to use the toilet. Resident #5 fell during several of these self-transfer attempts. The facility's lack of assessment of Resident #5's toileting needs and reliability to utilize the call light, and the lack of implementing appropriate interventions or approaches to provide necessary assistance placed Resident #5 at risk for continued falls and potential injury. - Observation on 04/11/11 at 4:20 p.m. showed two CNAs (#8 and #13) transferred Resident #5 from his wheelchair to the toilet. The CNAs applied a gait belt loosely around Resident #5, and before the transfer, one of the CNA's stated, "[Resident's name], we are going to hold you under your arms." The CNAs transferred the resident by holding him under the arms and holding the loose gait belt. Resident #5's knees buckled during the transfer. The CNA (#13) commented they have used a mechanical standing lift for this resident in the past and	F 323		

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stated, "I think they need to re-assess him" (in regards to how he is transferred).

- Observation on 04/12/11 at 12:50 p.m. showed two CNA's (#9 and #10) transferred Resident #5 from his wheelchair to his bed. The CNA's did not apply a gait belt, and observation showed Resident #5 was unsteady during the transfer.

- Review of Resident #7's medical record occurred on April 13-14, 2011. Diagnoses included osteoarthritis, left shoulder and hip replacements, and history of left humeral neck (top part of upper arm bone) fracture. The quarterly Minimum Data Sets (MDS), dated 04/01/11 and 01/01/11, identified Resident #7 makes self understood, understands others with clear comprehension, scored a 06 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) test, required limited assistance of one person for transfers, and required extensive assistance of one person for walking in the room.

Resident #7's current care plan included the problem "Self care deficit due to decreased strength and history of fractured humeral head" with approaches of "requires extensive assist for transfer. High risk for falls. Use gait/transfer belt - do not pull on arms or shoulders." The careplan also included the problem "Limited use of left side - may contribute to falling."

On 04/13/11 at 2:40 p.m., observation showed Resident #7 sitting on the edge of her bed. Two CNAs (#8 and #15) each placed one arm under the resident's axilla (arm pits) and assisted Resident #7 to a standing position, pivoted her,

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F 323	Continued From page 46 and assisted her to sit in the wheelchair. At no time during the transfer did the CNAs apply or utilize a gait belt. The resident expressed pain with the transfer, stating, "ow, ow." Failure to apply a gaitbelt and utilize it appropriately when transferring residents had the potential to cause injury and may have resulted in increased shoulder pain for Resident #7.	F 323	F371 1. A thermometer was placed in the activity room refridgerator and the 400 wing refridgerator. The temperatures are recorded 5 days a week. All opened and perishable food items will be labeled and dated. All opened and perishable food items will be removed and discarded after three days. Both of these refrigerators will be on a cleaning schedule. The rinse temperature on the dishwashing machine will be monitored and recorded daily. Our policy and procedures have been updated to reflect a high temperature rinse cycle. No sanitizer is required. The exhaust fan above the stove has been cleaned. It has been put on a cleaning schedule. 2. All residents have the potential to be affected by this practice. 3. An inservice will be held by Thursday May 11, 2011 for the dietary and activity staff. The inservice held by the certified dietary manager will cover recording refridgerator temperatures, recording dishwashing rinse temperatures, labeling perishable and opened food and discarding outdated food. The inservice will also	5-16-11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, professional literature review, and staff interview, the facility failed to store, prepare and serve food in a safe and sanitary manner in 1 of 1 kitchen, 1 of 1 activity area, and 1 of 1 kitchenette. This practice placed residents who eat food stored and prepared in these areas at risk for foodborne illness. Findings include: Review of the 2009 Food and Drug Administration Food Code, Public Health	F 371		

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F 371	Continued From page 47 Reasons, page 462, states, "the temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified . . . to ensure surfaces of multi-use utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning." Review of the facility's dietary policies and procedures occurred on 04/14/11. An un-dated policy facility policy titled "Food Storage inside/outside of kitchen area" stated, "POLICY AND PURPOSE: To assure food inside and food taken outside of the kitchen are safely and properly stored. PROCEDURE: The regulations regarding food storage that apply to items in the kitchen must also apply to food items stored in all other departments . . ." The policy titled "Storage," dated 2007, stated, "POLICY AND PURPOSE: Maintain high quality standards and regulations of food storage and refrigeration. To prevent and eliminate food contamination, food spoilage, and bacterial toxins. PROCEDURE: . . . 3. Non-food items: A. Non-food items are properly labeled and stored away from food items. B. Toxic cleaning chemicals are labeled, stored away from food areas and used in such a manner as to not contaminate foods. . . . A. Cook's and diet aide's are responsible for seeing that foods are dated and stored properly." The policy titled, "Receiving, storage, and issuing," dated 2005, stated, "POLICY AND PURPOSE: To assure all items ordered are	F 371	include a review of the cleaning schedule. 4. Certified Dietary Manager or her designee will audit dishwashing rinse temperatures, recording refridgerator temperatures, labeling and discarding outdated food and the completion of the cleaning schedule and overall cleanliness. These audits will be done weekly for 8 weeks. The results will be taken to the QA committee for further review and action if necessary. The cold packs were removed from Activity Refrigerator. The working utensils and vinegar have been removed from Activity Room cupboards. A separate refrigerator will be used to store the cold packs. per T.O. Lori Martinson DON 5/16/11 at 4 PM DL per T.O. Lori Martinson DON 5/24/11 at 3 pm CM	

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received from approved delivery sources. PROCEDURE: . . . All canned goods, staples, . . . must meet established standards for nursing home use. . . . 3. Procedure for storage of food and non-food items: A. All chemicals are stored in a separate area away from the food. . . . C. All perishable items are stored in either a walk-in refrigerator or freezer maintained at a temperature of 45 degrees or 0 degrees respectively. . . ." The temperature identified in F371 for Refrigerated Storage states, "Potentially Hazardous Foods must be maintained at or below 41 degrees F [Fahrenheit], unless otherwise specified by law."

The policy titled, "Infection Control," dated 2005, stated, "Policy: Infection Control is an important aspect in which to prevent germs, bacteria and food poisoning. . . . 5. Proper storage methods not only relate to the prevention of food poisoning, but also relate to food spoilage. This spoilage may result from storing foods under the wrong conditions of temperature and moisture . . . 6. Proper cleaning and handling of utensils, equipment and foods is very important in infection control."

The policy titled, "Dish Washing," dated 2003, stated, "POLICY: Handling sanitation and storage of dishes shall be done in a manner that will insure the highest possible sanitary standard. PURPOSE: Dishware presents an area where contamination is possible to residents, visitors, and employees. . . . PROCEDURE: . . . E. Temperature for the wash is >120 degrees F. Rinse in >120 degrees F (chemical sanitization). Final rinse > 120 degrees F. . . . G. Check temperature occasionally. H. Check detergent

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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 371	Continued From page 49 and sanitizer. . . " Observation of the kitchen, activity room, and kitchenette occurred in the afternoon of 04/13/11, starting at 1:00 p.m. An administrative dietary staff member (#6) accompanied the surveyor during the tour. The staff member stated during the tour, the automatic dish washing machine was a "low temperature" machine and used a chemical for sanitization of the dishes. An interview with a dietary staff member (#19), working in the dish room during the tour, stated she does not check the chemical sanitizer concentration, but looks at the wash temperature gauge of the machine and records the temperature on a log. Review of the equipment representative's monthly check of the machine identified it as a hot water sanitization dish machine, which sanitizes the dishes using a high temperature cycle. The facility policy does not accurately reflect the type of dishwashing machine in use. Review of the dish machine log showed staff did not check the temperature of the sanitation cycle. . The dishwashing machine was fitted with a water temperature booster. The temperature of the sanitization cycle was verified by use of a temperature indicator stripe on 04/13/11. The sanitizing cycle was determined to be within the acceptable range. Failure of staff to periodically monitor temperatures does not ensure the automatic dishwashing machine consistently reaches the correct temperature to sanitize dishes Observation in the kitchen showed a heavy build-up of dust on the vents above the stove range. The dietary staff member (#6) agreed the vents needed cleaning.	F 371		

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 _____	04/14/2011

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 371	Continued From page 50 Observation of the refrigerator in the activity room showed a bag of moist, sprouted, spoiled carrots; a carton of eggs dated November 12, 2010. The refrigerator also contained food debris and crumbs and several large cold packs (used on residents for pain relief or other use) stored along with these food products. The dietary staff member removed the carrots and eggs, and confirmed the home-canned foods should be labeled with the resident's name. Observation of a cupboard in the activity area showed cooking utensils and vinegar stored with Easy-Off oven cleaner, spray starch, and several bottles of paint. Observation of the nursing unit kitchenette showed a refrigerator temperature of 48-50 degrees. The refrigerator contained several food items, including dairy products. When asked to view the temperature log, the staff member (#6) stated staff do not record temperatures of this refrigerator or the refrigerator in the activity room.	F 371	F431 1. An inservice will be held on May 11, 2011 instructing all professional nursing staff on insulin dating and storage. 2.All residents have the potential to be affected by this practice. 3. An inservice will be heheld on May 11, 2011 instructing all professional nursing staff on proper medication storage and dating and disposal. 4. The Director of Nursing or her designee will audit all opened insulin containers have an opening date. These audits will be done weekly for 8 weeks. The results of these audits will be taken to the QA committee for further review and action if necessary.	5-16-2011
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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 _____	04/14/2011

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ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

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F 431	Continued From page 51 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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, review of professional reference, and staff interview, the facility failed to date multiple use medication vials when opened in 1 of 2 medication carts (cart A - serves the 200 wing and half of the 300 wing) for 3 of 10 insulin vials (Lantus, Humulin R, and Levemir). Failure to date the vials when opened has the potential for residents to receive insulin that has been opened and entered for more than 28 days, which may effect the potency and sterility of the medication. Findings include:	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 52 Review of the medication carts occurred on 04/13/11 at 1:15 p.m. with a nurse (#16) present. Medication cart A contained opened 100 units per milliliter vials of Lantus insulin, Humulin R insulin, and Levemir insulin. All three vials lacked an "open" date. The Centers for Disease Control and Prevention (CDC) has outlined the standards of practice for multi-dose vials. Manufacturer's label multi-dose vials as such when the medication is intended for administration of more than one dose. Typically, multi-dose vials contain an antimicrobial preservative to help prevent the growth of bacteria. The preservative does not protect against contamination caused by healthcare personnel failing to follow safe injection practices. Multi-dose vials should always be dated when they are opened or accessed, and discarded within 28 days from this date unless the manufacturer specifies a different date for the opened vial. Medication vials should always be discarded whenever the sterility is questioned or compromised. The United States Pharmacopeia (USP) General Chapter 797 recommends this practice for multi-dose vials of sterile pharmaceuticals. During an interview on 04/13/11 at 1:45 p.m., an administrative nurse (#2) agreed insulin vials should be dated when opened.	F 431		