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 _____	04/25/2012

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey stated on 04/23/12 and completed on 04/25/12, the sampled included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
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 facility policy and procedure, and staff interview, the facility failed to provide the necessary treatment and services to promote healing, for 1 of 1 sampled resident with a current pressure sore (Resident #1). Failure to monitor skin condition, and implement timely preventive/treatment measures may have resulted in Resident #1's right heel pressure ulcer. Findings include: Review of the facility policy and procedure, "Pressure Ulcers/Skin Breakdown - Clinical Protocol," occurred on 04/25/12. This document,	F314 F 314	1. Resident #1 has been assessed for the potential for skin breakdown and for the appropriate treatment of any current skin breakdown. We have continued with the treatment program that has been in place. 2. All residents have the potential to be affected by this practice. 3. All nursing staff will be in-serviced on our policies and procedures related to treatment/ services to prevent and to heal pressure sores. This in-service will also cover proper documentation and follow through on any potential or current treatments that have been initiated. These in-services will be held by our director of nursing and MDS coordinator. They will be done by May 18th.	5-30-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Father Steve | TITLE: Administrator | (X6) DATE: 5-10-2012

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 314	Continued From page 1 revised April 2011, stated "ASSESSMENT AND RECOGNITION . . . 2. . . . the nurse shall assess and document/report the following: . . . b. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue . . . CAUSE IDENTIFICATION, 1. The physician will help identify factors contributing or predisposing residents to skin breakdown . . . 2. The physician will help clarify relevant medical issues . . . TREATMENT/MANAGEMENT, 1. The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings . . . 2. The physician will help identify medical interventions related to wound management . . . 3. The physician will help staff characterize the likelihood of wound healing . . . MONITORING . . . 2. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated . . ." Review of Resident #1's medical record occurred on April 23-25, 2012. The facility admitted the resident in October 2009. Current diagnoses included dementia, status post right femur fracture (September 2011), and pressure ulcer right heel. The resident's annual Minimum Data Set (MDS), dated 04/02/12, identified severe cognitive impairment, fluctuating disorganized thinking, extensive assistance of one person for transfers and bed mobility, walking did not occur, and an unstageable pressure ulcer 1.5 centimeters (cm) long, 1.5 cm wide, and 0.5 cm deep. Resident #1 experienced a fall and fracture of the	F 314	4. All residents that are considered high risk for the development of pressure sores will be audited for the proper documentation, follow through and treatment for the prevention of and the treatment of any current pressure sores. These audits will be done weekly for 8 weeks by the Director of Nursing or her designee. The results of these audits will be taken to the QA committee for further review and to decide if further action is necessary.	

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F 314	Continued From page 2 right distal femur in the facility on approximately 09/20/11. An orthopedic physician managed the resident's fracture care. The resident was treated with a right leg immobilizer extending from the groin area to just above the foot and ankle. The physician's orders, dated 09/20/11, included ". . . 7. May check skin, but leave brace on otherwise." The physician discontinued the immobilizer on 11/01/11. Resident #1's Multidiscipline Notes identified the following: *09/27/11, 8:00 p.m. - "Res. [Resident] c/o [complains of] R) [right] heel burning. Attempted to examine heel, res. stated 'Just give me a pain pill.' " *09/28/11, 10:00 p.m. - ". . . Resident becomes agitated and demanding when experiencing pain or being moved in bed. Res. had c/o (R) heel pain during shift also. It was found that part of the brace was putting pressure on her back part of heel. Sheepskin was placed between heel and brace to provide cushion. Res. stated that if felt better." *09/29/11, no time - "Res. seen on rounds [with] [physician]. New orders obtained." Physician orders on this date were regarding pain medications. *10/27/11, 11:00 a.m. - "[Physician extender] here et [and] examined for rounds." *11/12/11, no time - "Res. had blackened area to R) heel approx. [approximately] 2.5 x [by] 3 cm. Res. c/o pain in area. Sheepskin heel protector applied. Res. also has +1-+2 edema to R) leg. [Elevated] on pillow. Res. stated "it felt better." Resident #1's physician progress notes, dated 11/23/11, stated "S [Subjective]: . . . seen today	F 314		

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F 314	Continued From page 3 for evaluation of a right heel pressure sore that appeared to be the result of the brace she was wearing related to a fracture of her right lower extremity that she has now recovered from, orthopedics has cleared her for weight bearing and unfortunately she developed a pressure sore in the right posterior heel/lower Achilles area, by phone management was started recently including regarding [sic] total protection of the heel from all pressure and weight bearing while she is in bed with a protective boot. Using minimally damp to dry dressing for now. The patient states it does hurt, but there have not been any obvious signs of infection to date by nursing staff . . . SKIN/EXTREMITIES: At the far posterior heel and distal Achilles area there is a 3 cm blackened, hard, eschar covered pressure ulcer with minimal erythema at the edge, no drainage, dry, nontender. . . . A/P [Assessment/Plan]: 1. Right pressure-related wound/ulcer, no sign of infection, thick eschar, onset seemed to correlate with prolonged use of an orthopedic device related to her right lower extremity fracture from several months ago. . . . Continue total elimination of all pressure to the right heel, continued very minimally damp to dry dressing b.i.d. [two times every day] to t.i.d. [three times every day]. . . ." The physician's orders and progress notes after 11/23/11 identified treatment of Resident #1's right heel pressure ulcer with wet to dry dressings and whirlpool. The resident was referred to a tertiary care center for surgical consultation and debridement was provided on 04/12/12. At that time, treatment was also changed to Santyl ointment (an ointment to remove necrotic	F 314		

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F 314	Continued From page 4 material) and Dakins solution (an antiseptic solution) dressing changes two times every day. Resident #1's Wound Assessment Record, initiated on 11/12/11, identified the right heel ulcer area as follows: size - 2.5 cm x 3 cm; appearance - black/eschar; drainage and odor - none; signs/symptoms of infection - induration (hardened); surrounding area - dried; pain level - "4" (scale of 0-5, least to worst); unstageable; and "wet to dry dsg [dressing]." Weekly assessment documentation after 11/12/11 identified the ulcer decreased in size, to 1.5 cm x 1.5 cm x 0.25 cm by 04/20/12. Observation on all days of survey, April 23-25, 2012, showed the facility staff positioned Resident #1 in bed with the right foot elevated. The resident independently moved her legs off the bed and into her preferred position of lying on her left side with her feet on the floor. The facility staff re-positioned her or offered to re-position her and she would return to her preferred position or refuse re-positioning. Resident #1 sat in the wheelchair at times with the right leg elevated and the foot off the leg rest. The medical record included multiple episodes identifying Resident #1 resisted or refused cares or positioning. Observation on 04/24/12 at 10:05 a.m., identified a licensed nursing staff member (#3) provided a dressing change to Resident #1's right heel. The staff member removed the gauze dressing revealing a shallow ulcer approximately 1.5 cm in diameter just above the right heel. The licensed nurse (#3) applied gauze with Dakins solution and Santyl ointment to the ulcer and held it in place with roller gauze. The licensed nurse (#3)	F 314		

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F 314	Continued From page 5 reported the facility staff measure and record the ulcer size and appearance weekly. During interview with a nursing management staff member (#1), on 04/25/12 at 12:20 p.m., additional documentation regarding the facility's monitoring and treatment of Resident #1's right heel pressure ulcer before 11/12/11 was requested. On 04/25/12 at approximately 2:30 p.m., this staff member (#1) reported the facility lacked additional information. The facility staff identified Resident #1 was at risk for pressure ulcers on the October 2011 Braden Skin Assessment. Resident #1 complained of the right heel "burning" on 09/27/11 and pain on 09/28/11. Facility staff identified pressure from the immobilizer at the right heel causing the pain and placed sheepskin in the area, with relief, on 09/28/11. Resident #1's medical record lacked indication of monitoring or additional treatment approaches, until 11/12/11 (seven weeks) when a pressure ulcer with black eschar was identified. Failure to monitor Resident #1's skin condition and implement timely preventive/treatment measures may have resulted in Resident #1's right heel pressure ulcer.	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332		

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F 332	Continued From page 6 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation of 4 of 49 medications administered (April 24-25, 2012). This resulted in an eight percent error rate. Failure to ensure staff administered medications at the correct time, the correct dose, and as prescribed by the physician may adversely affect the desired benefits of medications administered to residents. Findings include: The facility policy "Administering Medication," dated 04/26/11, stated, "Medications shall be administered in a safe and timely manner, and as prescribed. . . . 3. Medications must be administered in accordance with the orders, including any required time frame. . . . 6. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication. . . . 9. Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). . . ." The following medication errors occurred during observations of medication pass: - 04/24/12 at 8:32 a.m., a nursing staff member (#2) administered omeprazole 20 milligrams (mg) to Resident #11, who identified he had finished breakfast. The card containing the omeprazole had a facility sticker of "night". The Medication Administration Record identified staff are to	F 332	F332 1. Resident # 11 has been assessed and it has been determined that no ill effects occurred from the incident on 4/24/12. Resident #8 has been assessed and it has been determined that no ill effects occurred from the incident that occurred on 4/24/12. Resident #12 has been assessed and it has been determined that no ill effects occurred from the incident that occurred on 4/24/12. 2. All residents have the potential to be affected by this practice 3. All licensed nursing staff will be in-serviced on our polices and procedures on medication administration. This in-service will be done by our Director of Nursing and our mds coordinator. This in-service will be done by May 18th, 2012. 4. A minimum of 2 med passes will be audited weekly for 6 weeks. These audits will be done	5-30-12

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F 332	Continued From page 7 administer the omeprazole at 7:00 a.m. The physician's order, dated 03/29/12, stated "Omeprazole 20 mg [by mouth] daily before breakfast." The nursing staff member (#2) administered the omeprazole 11/2 hours later and after breakfast instead of before breakfast. - 04/25/12 at 8:25 a.m., a nursing staff member (#3) dispensed liquid Colace 20 milliliters (ml) and Vitamin C 500 mg for Resident #8. The physician's order, dated 11/01/11, stated, "Colace 100 mg [by mouth] [twice a day]." The Colace bottle identified the concentration as 20 mg per 5 ml. The 20 ml dispensed contained 80 mg of Colace, not 100 mg. The physician order, dated 11/01/11, stated Chewable Vitamin C 100 mg [by mouth] [three times a day]." When questioned, the nursing staff member recalculated the dose of Colace and added 5 ml to the 20 ml, making the total Colace 100 mg. The Colace first dispensed and the Vitamin C administered were not what the physician had ordered.. - 04/25/12 at 8:56 a.m., a nursing staff member (#2) administered a multivitamin with minerals to Resident #12. The physician's order, dated 03/29/12, stated "Multivitamin one [tablet] [by mouth] daily." The nursing staff member did not administer the medication the physician had ordered. During an interview on 04/25/12 at 12:40 p.m., a supervisory nurse (#1) verified staff administered the omeprazole at the wrong time, staff miscalculated the amount of Colace liquid to administer, and the facility would make changes to correct the dose of vitamin C and type of multivitamin administered.	F 332	by the Director of Nursing or her designee. The results of these audits will be taken to the QA committee for further review and to decide if further action is necessary.	

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F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on facility record review, information from the North Dakota nurse aide registry, and staff interview, the facility failed to seek information	F 496	F496 1. All residents had the potential to be affected by this practice. 2. All residents have the potential to be affected by this practice. 3. The Director of Nursing has reviewed the guidelines for checking multiple state registries. In the future the Director of Nursing or her designee will check all state registries that a potential certified nursing assistant might have worked at. 4. The Business office manager will audit all can hires to make sure that all state regtries have been called. 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 to decide if further action is necessary.	5-30-12

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F 496	Continued From page 9	F 496		

from every State abuse registry in which 1 of 5 (Individual A) staff hired in the last four months worked as a certified nurse aide (CNA). Failure to obtain information from all State abuse registries has the potential to allow an individual to provide care to vulnerable residents even when their past history or background indicates they should not.

Findings include:

On the afternoon of 04/24/12, an administrative nurse (#1) provided a list of screenings completed by the facility before hiring a staff member. The list identified "Application, 2 References, Background Check through Courts, OIG (Office of Inspector General), Abuse Registry, [and] Check licensure."

A review of Individual A's employee file occurred on the morning of 04/25/12. The application identified Individual A worked as a CNA in another state from September of 2007 through August of 2009. Information obtained from the North Dakota nurse aide registry showed Individual A obtained her current North Dakota certification by testing in April 2011. The file lacked documentation the facility verified Individual A's CNA abuse registry status in the other state where she worked.

During the file review, on the morning of 04/25/12, an administrative nursing staff member (#1) stated she had checked the North Dakota abuse registry. The staff member (#1) stated she did not realize the facility is responsible to check the abuse registry of other states where potential staff, including Individual A, may have worked as a CNA.

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