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 _____	05/21/2015

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 05/18/15 and completed on 05/21/15, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	**F-225** **1. The result/summary of the investigation from the incident on 11-01-14 was submitted to the NDDH 05-28-15.** **2. All residents who live in the facility have the potential to be affected by this deficient practice. Rolette Community Care Center is dedicated to the care and services of our residents and any and all allegations of abuse and neglect will be reported to the NDDH, investigated and the appropriate action will be taken to protect our residents from abuse and neglect.** **3. A mandatory all staff and licensed/certified personnel meeting will be held 06-17-15 to re-educate on the policy and procedure for abuse and neglect reporting. Emphasis will be placed on the timeliness of the initial reports to be placed within 24 hours and summary reports submitted within 5 working days to NDDH, Administrator and DNS to ensure that appropriate actions are put into place to protect the resident, start the investigation process and submit the final report within 5 working days.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6-10-15

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.

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 225	Continued From page 1	F 225		

to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and review of Centers for Medicare and Medicaid Services (CMS) regulation, the facility failed to immediately report incidents of alleged neglect or abuse and/or failed to report the results of the investigation to the State Survey and Certification Agency for 1 of 4 investigations reviewed. Failure to report violations involving alleged abuse has the potential to place all residents at risk of neglect or abuse.

Findings include:

The CMS has outlined the key components for an effective abuse prohibition policy which states the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Review of Resident #7's medical record occurred on May 20-21, 2015. Diagnoses included dementia, hemiplegia, osteoarthrosis, and right hip fracture. The annual minimum data set (MDS), dated 09/05/14, identified extensive two

F 225

4. An audit will be developed to monitor the daily review of all incident reports. If any allegations of abuse or neglect were reported to the NDDH within 24 hours, if an investigation was started, if appropriate action was taken to protect the resident, and if the result of the investigation was reported back to the NDDH within 5 working days. The audit will be completed weekly for one month, then monthly times two months. The results of the audits will be reported to the QI committee for future recommendations. The audit will be completed by the social worker or her designee.

5. June 25, 2015

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 225	Continued From page 2 person assist with transfers. The residents care plan, edited 08/05/14, states, ". . . Problem . . . self care deficit related to right sided weakness and decreased function and age . . . Transfers . . . needs extensive assist of two to transfer to wheelchair with gait belt . . ." Resident #7's progress notes dated 11/01/14, stated, "Resident was found lying on bathroom floor in supine position . . . CNA [certified nursing assistant] was present when incident occurred . . . Was transferring Resident to wheelchair form [sic] toilet. Comments that the wheel chair [sic] went back a little and resident fell on right side of body . . ." The record showed the CNA transferred the resident without a second person assist. Review of the facility's investigations of abuse/neglect occurred on May 20-21, 2015 and identified the allegation/incident occurred on 11/01/14. The facility initially contacted the State Agency on 11/02/14. The facility failed to submit results of the completed investigation within five working days. The department received the final report on 05/28/15.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	**F-246** **1. Resident #7 was evaluated for proper dining room table positioning by nursing on 05-26-15 and PT on 06-03-15. It was determined that resident #7 had proper positioning by ensuring that the wheelchair was properly placed at the table with a table height suitable for resident #7 to dine. This has promoted easier access to meal items. The care plan was updated on 05-26-15 to reflect the need for table positioning and staff assistance with positioning.**	

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F 246	Continued From page 3	F 246		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and resident interview, the facility failed to ensure 1 of 4 sampled residents (Resident #7) observed sitting at the dining room table in a wheelchair received reasonable accommodation of individual needs regarding dining room table positioning. Failure to offer and provide appropriate dining room table height limited the residents access to meal items and limited the quality of the dining experience.

Findings include:

Review of Resident #7's medical record occurred on 05/20/15. The resident's diagnoses included cerebrovascular hemiplegia. The annual Minimum Data Set (MDS), dated 08/25/14, and the quarterly MDS, dated 05/06/15, identified the resident as a one person assist with eating. The care plan, dated 02/25/14 and edited 05/11/15, stated, ". . . Problem . . . self care deficit related to right sided weakness and decreased function and age . . . Eating . . . staff assists with set up and supervision with eating. Extensive assistance is needed at times . . ."

Observation on 05/19/15 at 11:35 a.m. and 05/20/15 at 11:52 a.m. showed Resident #7 seated at the table in the dining room in her wheelchair. The observations showed the arms of the wheelchair unable to fit under the table, thus not allowing the resident easy access to meal items. The resident's food dropped from the utensils before they reached the resident's mouth. No staff member assisted with meals.

During an interview, on 05/20/15 at 12:10 p.m.,

2. All residents who live in the Rolette Community Care Center have the potential to be affected by this deficient practice.

3. A mandatory licensed and certified personnel meeting will be held 06-17-15 to re-educate on the policy and procedure Quality of Life-Accomodation of Needs. Emphasis will be placed on individual dining room needs being met through proper positioning and table height when indicated according to resident care plan.

4. An audit will be developed to interview and determine if residents that require staff assistance according to resident care plan with meal set up or assistance are being provided an optimal dining experience. Proper positioning will be evaluated by nursing and changes or revisions may be made, including referral to PT/OT for optimal dining experience.
The audit will be completed weekly for one month, then monthly times two months. The results of the audits will be reported to the QI committee for future recommendations. The audit will be completed by DNS or her designee.

5. June 25, 2015

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 _____	05/21/2015

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F 246	Continued From page 4 Resident #7 answered "yes" when asked if it would be easier to eat if staff placed her closer to the table.	F 246		
F 274 SS=E	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 5 of 9 sampled residents (Resident #1, #2, #3, #5, and #6) within 14 days after a significant change in the resident's condition. This limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include:	F 274	**F-274** **1. Resident #1-MDS dated 03-17-15 was inactivated on 06-08-15 and a Significant Change Status Assessment was completed. Resident #2-MDS dated 01-22-15 was inactivated on 06-08-15 and a SCSA was completed. Resident #3 has expired. Resident #5-MDS dated 01-05-15 was inactivated on 06-08-15 and a SCSA was completed.** Refer to F 278 re: Resident #6 per Sherri Evans, MDS coordinator on 6/23/15 at 9:40 a.m. **2. All residents in the Rolette Community Care Center have the potential to be affected by this deficient practice.** **3. A mandatory licensed and certified personnel meeting will be held 06-24-15 to provide education with emphasis on accurate coding and documentation to ensure that all SCSA are identified and completed as required. Information from the RAI manual and F-0tag 274 will be used as educational reference materials.**	

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F 274	Continued From page 5 The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual, "Version 3.0, October 2014, pages 2-20 and 2-23 states, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/ or revision of the care plan . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement), . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included muscle weakness, heel pressure ulcer, bed confinement, abnormal weight loss, diabetes mellitus, and chronic stage 3 kidney disease. Resident #1's admission Minimum Data Set (MDS), dated 06/23/14, identified limited one person assist with bed mobility; extensive one person assist with locomotion on unit; one person assist with dressing; limited assist with personal hygiene; and extensive assist with bathing. Resident #1's quarterly MDS, dated 03/17/15, identified extensive two or more person assist with bed mobility; two or more person assist with locomotion on unit; extensive two or more person assist with dressing; extensive one person assist personal hygiene; limited one person assist with bathing. The record lacked evidence staff completed a	F 274	**4. An audit will be developed to monitor every MDS that is done to identify changes that would require a SCSA to be completed. This audit will be completed weekly for three months. The results of the audits will be reported to the QI committee for review and recommendations. This audit will be completed by the MDS coordinator or designee.** **5. June 25, 2015**	

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 274	Continued From page 6	F 274		

SCSA following Resident #1's decline in functional status.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included muscle weakness, left below the knee amputation, right heel ulcer, hypertension, end stage renal disease, organ transplant, neuropathy, and congestive heart failure.

Resident #2's annual MDS, dated 10/22/14, identified limited two or more person assist with bed mobility; limited one person assist with locomotion on unit, off unit, and dressing; limited two or more person assist with toileting.

Resident #2's quarterly MDS, dated 01/22/15, identified extensive two or more person assist with bed mobility; extensive two or more person assist with locomotion on unit, off unit, and dressing; extensive two or more person assist with toileting.

The record lacked evidence staff completed a SCSA following Resident #1's decline in functional status.

- Review of Resident #3's medical record occurred on May 18-21, 2015. Diagnoses included Alzheimer's disease and chronic stage 3 kidney disease.

Resident #3's admission MDS, dated 09/18/14, identified the resident as independent with set up assist for bed mobility, limited assistance of one staff member for transfer, walking in room/corridor, locomotion on/off unit, dressing, toilet use, and hygiene. A quarterly MDS, dated 12/11/14, identified Resident #3 required:

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	355081	A. BUILDING _____ B. WING _____	05/21/2015

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F 274	Continued From page 7	F 274		

extensive assistance of one person for bed mobility, transfers, walk in room/corridor, locomotion on/off unit; dressing, toilet use and hygiene.

The record lacked evidence staff completed a SCSA following Resident #3's decline in functional status.

- Review of Resident #5's medical record occurred on May 18-21, 2015. Diagnoses included insulin dependent diabetes mellitus, heart failure, and chronic kidney disease.

Resident #5's annual MDS, dated 10/05/14, identified the resident as independent with set up assist for dressing and toilet use. A quarterly MDS, dated 01/05/15, and a quarterly MDS, dated 02/22/15, identified Resident #5 required extensive assistance of one person for dressing and toilet use. The quarterly MDS, dated 02/22/15, also identified the presence of two stage two pressure ulcers.

The record lacked evidence staff completed a SCSA following Resident #5's decline in functional status.

- Review of Resident #6's medical record occurred on May 18-21, 2015. Diagnoses included muscle weakness and paraplegia.

Resident #6's significant change MDS, dated 01/27/15, identified the resident required supervision of one person for bed mobility; independent in locomotion on the unit; supervision of one person for locomotion off the unit; independent in dressing and limited assistance of two persons in toileting. A quarterly

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 _____	05/21/2015

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ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

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F 274	Continued From page 8 MDS, dated 04/28/15, identified Resident #6 required supervision of two or more persons for bed mobility; limited assistance of two or more persons for locomotion on the unit; extensive assistance of two or more persons off the unit; and extensive assistance of two or more persons for dressing. The record lacked evidence staff completed a SCSA following Resident #6's decline in functional status. During an interview on 05/20/15 at 10:30 a.m., a nursing staff member (#3) agreed coding for a SCSA should occur with changes in ADL self performance from independent, supervision, or limited assistance to extensive or total dependence; and with changes from ADL support from no support or one person support to two or more person physical assistance.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT 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	F 278	**F-278** **1. Resident #3 has expired. Resident #5-MDS dated 02-22-15 was modified on 06-09-15 to correctly show the presence of one pressure ulcer, not two and resubmitted 06-11-15. Resident #6-per phone conversation with Lucille Rostad at NDDH, I was instructed to respond that the coding on the MDS is correct and that during the reference period for this resident his electric Wheelchair was out of the facility for repairs. He is independent when using his electric wheelchair. He was using a manual wheelchair at the time and required limited staff assistance for mobility.**	

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 _____	05/21/2015

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 278	Continued From page 9 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: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 3 of 9 sampled residents (Resident #3, #5 and #6). Failure to code portions of the MDS correctly including a urinary catheter (Resident #3), number of pressure ulcers (Resident #5), and changes in activities of daily living (ADL) self performance and support (Resident #6) does not provide an accurate assessment of a resident's current status may prevent staff from developing an effective comprehensive care plan. Findings Include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2013, stated the following: * Page G-3, "G0110: Activities of Daily Living (ADL) Assistance . . . Steps for Assessment 1. Review the documentation in the medical record	F 278	**2. All residents in the Rolette Community Care Center have the potential to be affected by this deficient practice. There was one additional resident in the facility at the time of the survey that had a catheter. The MDS was reviewed and found to have been coded correctly. There were also four additional residents in the facility at the time of the survey that had pressure ulcers. These MDS's were reviewed and found to have been coded correctly.** **3. The nursing representative (DON/Nurse Manager) shall give a report to include wounds/pressure ulcers, catheters, falls, notable weight loss or gain and change in condition at the daily managers meetings. The MDS coordinator and DON or Nurse Manager will review each MDS prior to finalization and submission.** **4. An audit has been developed to monitor the accuracy of the MDS coding. Audits will be done weekly for three months. The results of the audit will be reported to the QI committee for review and recommendations. The audits will be completed by the MDS coordinator or designee.** **5. June 25, 2015**	

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 278	Continued From page 10	F 278		

for the 7-day look-back period. 2. Talk with direct care staff from each shift that cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. . . ."

* Page H-2, "H0100: Appliances . . . Coding Instructions . . . Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. . . . H0100A, indwelling catheter . . . H0100Z, none of the above. . . ."

* Page M-10, "M0300B: Stage 2 Pressure Ulcers . . . Coding Instructions for M0300B: Enter the number of pressure ulcers that are currently present . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included bladder disorder - post void residual.

A quarterly MDS, dated 03/12/15, identified no coding at H0100, and at H0300 Urinary Continence identified "9" defined as "Not rated, resident has a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days."

Review of nursing progress notes from January 1-31, 2015, showed Resident #3 experienced one day of not voiding, several days of voiding once a day, and a straight catheterization resulting in a 250 milliliter post void residual. The physician ordered placement of an indwelling catheter on 01/31/15.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses

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 _____	05/21/2015

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(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 278	Continued From page 11 included insulin dependent diabetes mellitus, heart failure, and chronic kidney disease. Resident #5's quarterly MDS (following a hospitalization), dated 02/22/15, identified the presence of two stage two pressure ulcers. The record identified the presence of one stage two pressure ulcer and lacked evidence of two stage two pressure ulcers during the look back period. - Review of Resident #6's medical record occurred on May 18-21, 2015. Diagnoses included muscle weakness and paraplegia. A progress note, dated 04/27/15, stated, "[Resident] is up in his electronic wheelchair everyday and about the facility. Now that it is nice outside, he does go out and around the parking lot many times per day. . . ." Resident #6's quarterly MDS, dated 04/28/15, identified the resident required limited assistance of two or more persons for locomotion on the unit; and extensive assistance of two or more persons off the unit. During interview on 05/20/15 at 10:30 a.m., a nurse (#3) stated when she realized she had miscoded the MDS she should have done a correction.	F 278		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the	F 334	**F-334** **1. Upon investigation it has been discovered that Resident #1 is up to date having received a pneumococcal vaccine on 02-12-13, Resident #2 received the vaccine 05-27-03, after educating Resident #4 on risks versus benefits regarding the pneumococcal vaccine, Resident #4 refused**	

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	355081	A. BUILDING _____ B. WING _____	05/21/2015

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F 334	Continued From page 12	F 334		

benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the

vaccination on 06-02-15, Resident #9 was discovered to have had the pneumococcal vaccination 12-10-02 and was provided education on the risks versus benefits 06-02-15

2. All residents in the Rolette Community Care Center have the potential to be affected by this deficient practice.

3. A mandatory licensed personnel meeting will be held 06-17-15 to re-educate on the policy and procedure "Pneumococcal Vaccine". Emphasis will be placed on forms that will be in the admission packet. New admissions will be provided education on the risks versus benefits and the opportunity to accept or refuse the pneumococcal vaccine unless otherwise contraindicated. Residents in the facility will be assessed to determine if pneumococcal vaccination is current and vaccination education will be offered if indicated.

4. An audit will be developed to monitor all new admissions to the facility for pneumococcal vaccination education and acceptance or refusal of vaccination as well as the proper transcription of that information to the residents chart. The audit will be completed weekly for one month, then monthly times two months. The results of the audits will be reported to the QI committee for future recommendations. The audit will be completed by HIM or her designee.

5. June 25, 2015

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F 334	Continued From page 13	F 334		

following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on policy review, record review, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving pneumococcal immunization for 4 of 9 sampled residents (Resident #1, #2, #4, and #9). Failure to offer pneumococcal immunization on admission to all residents, provide education to residents and their legal representatives, and document the vaccine administration or refusal has the potential for non-immunized residents to contact pneumonia and also spread the infection to other residents, visitors, and staff.

Findings include:

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F 334	Continued From page 14	F 334		

Review of the facility policy titled "Pneumococcal Vaccine" occurred on 05/21/15. This policy, dated December 2012, stated, ". . . Policy Statement: All residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections . . . Policy Interpretation and Implementation . . . 1. Prior to or upon admission, residents will be assessed for eligibility to receive Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccine within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated . . . 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission . . . 3. Before receiving the Pneumovax, the resident or legal representative shall receive information and education . . . of the pneumococcal vaccine . . . 4 . . . if refused, appropriate entries will be documented . . ."

- Review of Resident #1's medical record occurred on all days of the survey. The resident was admitted 06/17/14. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or their legal representative.

-Review of Resident #2's medical record occurred on all days of the survey. The admission assessment, dated 04/22/15, lacked evidence the facility assessed the resident's pneumococcal immunization status on admission, almost one and a half years later, and provided education to the resident and/or their legal representative.

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F 334	Continued From page 15 - Review of Resident #4's medical record occurred on all days of the survey. The facility admitted the resident in June 2014. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or his legal representative. - Review of Resident #9's medical record occurred on May 20-21, 2015. The facility admitted the resident in June 2013 and diagnoses included congestive heart failure. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or her legal representative. During an interview on 05/19/15 at 1:30 p.m., an administrative nurse (#4) stated the facility is not up to date with assessing residents for their pneumococcal vaccine status.	F 334		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	**F-441** **1. Residents #2 and #5 are now receiving fingerstick glucose level checks according to the proper infection control standards utilizing alcohol cleansing of the fingertip.** **2. All residents who receive blood glucose monitoring and require a fingerstick glucose level in the Rolette Community Care Center have the potential to be affected by this deficient practice.**	

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F 441	Continued From page 16 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure, and staff interview, the facility failed to follow standard infection control practices for 2 of 2 sampled residents (Resident #2 and #5) observed during a blood glucose check. Failure to follow infection control practices during blood glucose monitoring has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy "Obtaining a Fingerstick Glucose Level" occurred on 05/20/15. The policy, dated 12/02/11, stated, ". . . Wash the	F 441	**3. A mandatory licensed personnel meeting was held 05-27-15 to re-educate on the policy and procedure "Obtaining a Fingerstick Glucose Level". Emphasis was placed on cleansing the fingertip with alcohol and allowing the fingertip to dry completely in order to have the most accurate recording of the blood glucose level.** **4. An audit will be developed to monitor fingerstick glucose infection control standards. The audit will be completed weekly for one month, then monthly times two months. The results of the audits will be reported to the QI committee for future recommendations. The audit will be completed by the Infection Control Nurse or her designee.** **5. June 25, 2015**	

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F 441	Continued From page 17	F 441		

selected fingertip . . . with warm water and soap. (Note: If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Repeated use of alcohol may toughen the skin.) . . ."

During observation on 05/19/15, a nursing staff member (#1) performed a blood glucose check on Resident #2 at 11:00 a.m., and Resident #5 at 11:10 a.m. On each occasion the nurse did not wash nor cleanse the resident's finger tip prior to performing the finger stick puncture to obtain the blood sample.

During interview on 05/19/15 at 11:35 a.m., a nursing staff member (#1) verified she did not clean the fingertip.

During interview on the afternoon of 05/20/15, a supervisory nurse (#2) stated the protocol within the facility was to no longer use alcohol for cleaning the fingertip unless there is visible evidence of contamination of the finger.