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 _____	06/08/2017

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 06/05/17 and completed on 06/08/17, 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 one (1) additional resident to verify specific concerns during the survey.	F 000		
F 203 SS=C	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 203		

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

Electronically Signed | 06/22/2017

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F 203	Continued From page 1 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 203		

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F 203	Continued From page 2 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State	F 203		

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F 203	Continued From page 3 Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to notify a representative of the Office of the State of Long-Term Care Ombudsman of a resident transfer or discharge, including destination, the reason for the transfer and the resident's right to appeal the action, for 15 of 15 resident transfers and or discharges. Failure to provide a notice of transfer or discharge to the State Ombudsman does not allow the State Ombudsman to act as an advocate for the resident if necessary. Findings include: The facility identified 11 hospital transfer and four discharges occurred from January - June 05, 2017. The facility failed to notify the State Ombudsman of these transfers/discharges. During an interview on 06/06/17, a social service staff member (#1) stated she was notified in January 2017 regarding the requirement to send a copy to the State Ombudsman.	F 203	1.The Ombudsman was notified for 15 of 15 residents 06/09/2017. 2. All residents at the Rolette Community Care Center have the potential to be affected. 3. A mandatory Licensed Nurses In-Service will be held 06-28-17 by the DNS and Social Services to review the "Guide for Implementation of Transfer or Discharge Requirements" with an emphasis on notification to the Ombudsman. 4. An audit will be created to monitor proper documentation and notification to the Ombudsman upon transfer or discharge. These audits will be performed weekly x 4 weeks and monthly x 2 months. The audits will be completed by Social Services or her designee. The audits will be reported to the QAPI Committee for review and recommendations.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement	F 226		7/13/17

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F 226	Continued From page 4 written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure, and staff interview, the facility failed to develop and operationalize 1 of 1 policy and procedure that prohibit abuse of residents. Failure to develop a policy to protect resident's privacy and prohibit mental abuse related to photographs and audio/video recordings by nursing home staff	F 226	1. A revision was made to the "Confidentiality Agreement". No residents were involved. 2. All residents at the Rolette Community Care Center have the potential to be affected.	

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F 226	Continued From page 5 placed all residents at risk for mental abuse. Findings include: Review of the facility policy titled "Preventing Resident Abuse" occurred on the morning of 06/06/17. The facility administrator (#2) stated the facility had not yet developed a policy on prohibiting nursing home staff (employees, consultants, volunteers, and other care givers) from taking or using photographs or video recordings in any manner that would demean or humiliate a resident.	F 226	3. An All Staff Mandatory In-service will be held on 06/29/2017. All departmental personnel will be educated on the revision to the "Confidentiality Agreement" with emphasis on #3. " I will not take, keep and/or distribute any photographs and/or recordings of residents. Any photographs or recordings that demean or humiliate residents will be subject to investigation as abuse defined as mental abuse". All staff will sign the new "Confidentiality Agreement". All new hire orientation will have the revised agreement and there will be special emphasis on "#3" during the abuse policy/prevention portion or orientation. 4. The revision to the "Confidentiality Agreement" brings the facility into compliance. An audit will be created to monitor employee records monthly x 6 months. These audits will be performed by the Administrator or her designee beginning 06/09/2017. The audits will be reported to the QAPI Committee for review and recommendations.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's	F 309		7/13/17

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F 309	Continued From page 6 comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's physician standing orders, and staff interview, the facility failed to implement the standing orders to promote regular bowel elimination for 2 of 9 sampled residents (Resident #1 and #9) with bowel elimination exceeding two days. Failure to follow the facility's standing orders may have contributed to residents experiencing constipation and discomfort due to delayed bowel	F 309	1.Resident #1 was assessed for signs/symptoms of constipation. Resident #1 shows no obvious signs/symptoms of constipation. Resident #9 was assessed for signs/symptoms of constipation. Resident #9 shows no obvious signs/symptoms of constipation.	

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F 309	Continued From page 7 elimination. Findings include: Review of the facility's Physician Standing Orders occurred on 06/08/17. These undated orders, stated, "Day 2 [give] fruit crax [for constipation] and prune juice [for constipation]. Day 3 [give] milk of magnesia [laxative], senna [laxative], colace [stool softener], or dulcolax [laxative] tablets. Day 4 [give] dulcolax suppository and fleet enema [laxative]." - Review of Resident #1's medical record occurred on all days of survey. Medications to aid in bowel elimination included colace 100 mg (milligrams) twice a day, dulcolax suppository 10 mg rectal PRN (as needed) daily per standing orders, milk of magnesia suspension 2,400 mg/10 mL (milliliters) one ounce every 2 to 3 days PRN, senna 8.6 mg 2 tablets daily, dulcolax tablets one to two tablets every 2 to 3 days PRN, fruit crax 1-2 tablespoons every day PRN on day 2, and prune juice/fruit crax/prunes once a day PRN. Review of Resident #1's bowel elimination records, dated 04/01/17 through 05/31/17, showed the following: * No BM (bowel movement) from 04/12/17 to 04/15/17 (4 days). Dulcolax suppository administered on 04/16/17 with results. * No BM from 05/16/17 to 05/20/17 (5 days). Fruit crax administered on 05/19/17 without results, dulcolax tablets given 05/20/17 and 05/21/17 without results, and dulcolax suppository administered on 05/21/17 with results.	F 309	2.All residents at the Rolette Community Care Center have the potential to be affected. 3.A Mandatory All Nursing Staff In-service will be held for all nursing staff on June 28,2017. Review of facilities Bowel Protocol . All Nursing staff will be educated on following the bowel protocol for day 2,3,4,5. CNA□s will be educated on importance of documenting BM□s in the electronic health record. 4.An audit will be created to monitor resident bowel management. These audits will be performed daily x 2 weeks, then weekly x 10 weeks then monthly x 3 months. These audits will be performed by the DNS or her designee beginning 06/09/2017. Audits will be reported to the QAPI Committee for review and recommendations.	

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F 309	Continued From page 8 Facility staff failed to follow the standing orders on day 2, 3, and 4 on both occasions. - Review of Resident #9's medical record occurred on all days of survey. Medications to aide in bowel elimination include colace 100 mg one capsule three times a day, dulcolax suppository 10 mg rectal PRN every 2 to 3 days, miralax (laxative) powder 17 grams daily, senokot 8.6 mg 2 tablets twice a day, dulcolax one to two tablets PRN every 2 to 3 days, fruit crax/prune juice daily, milk of magnesia 1 ounce every 2 to 3 days PRN, and prune juice/fruit crax/prunes once a day PRN. Review of Resident #9's bowel elimination records, dated 01/01/17 through 01/31/17, showed the following: * No BM from 01/19/17 to 01/22/17 (4 days). Dulcolax tablets administered on 01/22/17 with results on 01/23/17. Staff failed to follow the standing orders on day 2 and 3. * No BM from 01/25/17 to 01/29/17 (5 days). The Resident #9 had results on 01/30/17. Staff failed to follow the standing orders on day 2, 3, 4, and 5 During an interview on 06/08/17 at 11:18 a.m., an administrative nurse (#4) stated she expected the facility staff to administer PRN bowel medications per the standing orders.	F 309		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 371		7/13/17

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F 371	Continued From page 9 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, manufacturer's instructions, and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 facility kitchen. Failure to dispose of contaminated stored food, maintain proper hot holding temperatures for serving, separate ready-to-eat food from raw food, and refrigerate time sensitive items may result in a food borne illness. Findings include: The Food and Drug Administration (FDA) Food Code 2013, page 60, stated, ". . . Food packages shall be in good condition and protect the	F 371	1.No residents were involved. The bag of ground cornmeal with the liquid stain was discarded immediately. The unpasteurized eggs were placed on a drip proof pan and moved to the lowest shelf with no items stored below them. The hot food holding table was adjusted to ensure hot foods hold a temperature of 135 degrees F- 160 degrees F. The butter/margarine blend sticks on the counter were immediately discarded. 2. All residents at the Rolette Community Care Center have the potential to be affected.	

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F 371	Continued From page 10 integrity of the contents so that the food is not exposed to adulteration or potential contaminants. . . ." page 68, stated, "Food shall be protected from cross contamination by . . . separating raw animal foods during storage . . . from raw ready to eat food including fruits . . ." page 91, stated, ". . . [Food Hot Holding] shall be maintained at 57 C [Celsius] (135 F [Fahrenheit]) or above . . . [Food Cold Holding] at 5 C (41 F) or less . . ." Review of the facility policy titled "Food Receiving and Storage" occurred on 06/06/17. This policy, revised July 2014, stated, ". . . Uncooked and raw animal products and fish will be stored separately in the drip-proof containers and below fruits, vegetables and other ready-to-eat foods. . . ." Review of the facility policy titled "Food Preparation and Service" occurred on 06/06/17. This policy, revised July 2014, stated, ". . . The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry . . . Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness. . . ." Review of the manufacturer insert for Butter Margarine Blend titled "Marg Palm ESBB PRT 36/1#" occurred on 06/06/17. This insert, dated 05/31/17, stated, ". . . Handling suggestions: Ship and store at 33-40 F. Must keep cool. . . ."	F 371	3. There will be a Mandatory Dietary Staff In-service 06/29/2017. Review of the "Food Code 2013" page 60 (3-202.15)"Package Integrity",68 (3-302.11) "Packaged and Unpackaged Food..." and 91 (3-501.16) "Time/Temperature Control...". Review of facility policies "Food Receiving and Storage, Preventing Food Bourne Illness-Food Handling" with an emphasis on storage of "Refrigerated foods must be stored...", "uncooked and raw animal products..." and "Potentially Hazardous Foods...". 4. Audits will be created for butter/margarine blend storage, dry food storage, refrigerated food storage and hot food holding temperatures. The butter/margarine storage audit will be weekly x 12 weeks then monthly x 3 months. The dry food storage and refrigerator food storage audit will be weekly x 12 weeks and monthly x 3 months. The hot food holding temperature audit will be daily x 1 week, weekly x 11 weeks, then monthly x 3 months. The results of the audits will be reported to the QAPI Committee for review and recommendations. These audits will be performed by the Dietary Director or her designee beginning 06/09/2017.	

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F 371	Continued From page 11 An initial tour of the facility's kitchen occurred on 06/05/17 at 12:15 p.m. Observation of the dry storage room showed a shelf contained a half full 25 pound paper bag of ground corn meal with a liquid stain on the outside. An observation of meal service in the kitchen occurred on 06/06/17 at 11:45 a.m., The dietary manager (#3) temped the chicken tenders on the steam table at 118.9 degrees F and mashed potatoes at 119.4 degrees F. The dietary manager (#3) confirmed the chicken and mashed potatoes temperature should be at 135 degrees F or above. A tour of the facility's kitchen occurred on 06/06/17 at 2:00 p.m. Observation of the dry storage room showed a half full 25 pound paper bag of ground corn meal with a liquid stain on the outside. Observation of the walk-in fridge showed unpasteurized (raw) eggs in a large cardboard box on a shelf above whole oranges. Observation of the food serving area showed 4 one pound butter margarine sticks sitting on the counter. The dietary manager (#3) confirmed the paper bag containing ground corn meal had a liquid stain and should be thrown, oranges should not be stored below the raw eggs and moved the oranges to the fruit shelf, and the butter is left out on the counter and not refrigerated. Failure to: properly dispose of a stained paper bag containing food, maintain proper hot holding temperatures for serving, store non-pasteurized eggs below ready to eat foods, and refrigerate a butter blend margarine may result in a foodborne	F 371		

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F 371	Continued From page 12 illness.	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in	F 428		7/13/17

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F 428	Continued From page 13 the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility's consulting pharmacist failed to recommend a gradual dose reduction (GDR) to the attending physician for 1 of 2 sampled residents (Resident #1) receiving Lorazepam. Failure to report any irregularities to the attending physician has the potential for residents to receive unnecessary medications and experience adverse side effects. Findings include: Review of the facility policy titled "Medication Therapy" occurred on 06/07/17. This policy, revised April 2007, stated, ". . . Upon or shortly after admission, and periodically thereafter, the staff and practitioner, assisted by the consultant pharmacist, will review an individual's current medication regimen to identify whether: a. there is a clear indication for treating that individual with the medication b. the dosage is appropriate c. the frequency of administration and duration of	F 428	1.Consulting Pharmacist recommended GDR for Resident #1 Lorazepam, this was completed on 06/09/2017. Primary provider reviewed and completed recommendation on 06/15/2017. 2.All residents at the Rolette Community Care Center receiving psychotropic medications have the potential to be affected. All residents who receive psychotropic medications were reviewed 06/21/2017 for recommendations. 3.Phone Conference was set up with DNS and Pharmacy Consultant on 06/09/2017 and the Pharmacy Consultant received education on the policy titled, "Medication Therapy" with the emphasis on "situations that warrant tapering or changing medications". A Mandatory Licensed Nurse In-service	

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F 428	Continued From page 14 use are appropriate d. potential or suspected side effects are present. . . . The consultant pharmacist shall review each resident's medication regimen monthly . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, borderline personality disorder with aggressive behaviors, restlessness and agitation, dysthmic disorder with anxiety/depression. Current psychopharmacological medication orders include Depakote (mood stabilizer), Lorazepam (anti-anxiety), Paxil (anti-depressant), and Seroquel (antipsychotic). The current care plan states, ". . . Psychotropic drug use . . . Resident takes Ativan (Lorazepam). At risk for unwanted side effects. . . ." Current Lorazepam medication orders and start dates include: * 01/05/16 to 4/26/17, 0.5 mg tablet by mouth daily * 12/08/16 to current, 0.5 mg tablet by mouth as needed every six hours * 04/26/17 to current, 0.5 mg tablet by mouth twice a day Review of Resident #1's "Consult Pharmacist Medication Review" forms, from June 2016 through June 2017, failed to address the use of Lorazepam. During an interview on 06/07/17 at 11:10 a.m., the facility pharmacist (#5) stated a GDR review for Lorazepam should be two times in the first year and annually there after. The pharmacist (#5) confirmed Resident #1 had no GDR	F 428	will be held on 06/28/2017 for staff education on the policy titled, "Medication Therapy" with the emphasis on "situations that warrant tapering or changing medications". 4.An audit began 06/09/2017 to monitor residents receiving psychotropic medications and timeliness of reviews and recommendations. These audits will be performed weekly x 4 weeks until all residents on psychotropic medications are reviewed. Then, monthly x 5 months. These audits will be completed by the DNS or her designee. These audits will be reported to the QAPI Committee for review and recommendations.	

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F 428	Continued From page 15 recommendation for Lorazepam in the last year.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		7/13/17

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F 431	Continued From page 16 (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 facility policy, review of professional reference, and staff interview, the facility failed to ensure proper temperature controls for 1 of 1 medication refrigerator. Failure to maintain the refrigerator temperature within an acceptable range has the potential to affect the potency and efficacy of medication. Findings include: The "Nursing 2017 Drug Handbook," Wolters and Kluwer, Pennsylvania, page 786-787, stated, "Insulins . . . Levemir . . . Lantus . . . Store unused (unopened) insulin vials and pens between 36 degrees and 46 degrees F [Fahrenheit] . . . Don't Freeze. . . ." Page 795 stated, "Novolin . . . Store unopened vials in refrigerator at 36 degrees and 46 degrees F . . . Don't Freeze . . ."	F 431	1. No residents were involved. The Medication refrigerator was replaced on 6/9/2017 and placed on the red outlet-emergency power source. 2.All residents at the Rolette Community Care Center have the potential to be affected. 3.All Medications that were stored in medication fridge were assessed for possible signs of freezing such as ice crystals- solidifying of liquids etc. A Mandatory Licensed Nurse In-service will be held on June 28,2017. Nursing staff will be educated on RCCC□'s policy and procedure titled, "Medication Refrigeration Temperature". Education on the importance of reporting, adjusting and documenting temperatures that are out of	

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F 431	Continued From page 17 Observation of the medication storage room occurred on 06/07/17 at 10:15 a.m. with a staff nurse (#8). The medication refrigerator thermometer showed a temperature of 30 degrees F. The refrigerator contained numerous insulin vials including Lantus, Novolin, Levemir and Novolog Flex Pens; influenza vaccine; pneumonia vaccine; acetaminophen suppositories; and dulcolax suppositories. Observation showed the refrigerator plugged into a standard outlet and not a red outlet which would provide emergency power in an outage. Review of the medication refrigerator temperature log occurred on 06/07/17 at approximately 11:00 a.m. This log, dated 05/01/17 through 06/07/17, stated, "The refrigerator temperature range is 36 to 46 degrees. If outside this range, check control knob for settings. At the discretion of the charge nurse, call maintenance immediately or adjust the control knob and recheck the temperature within two hours. If still outside the acceptable range, remove medications to another refrigerator and notify maintenance. . . ." The log showed the medication refrigerator measured below 36 degrees F nine times in May and three times in June. The log failed to identify if staff rechecked the temperature, adjusted the control knob, or notified maintenance. During an interview on 06/07/17 at approximately 11:00, an administrative nurse (#4) stated the medication refrigerator should not measure below 36 degrees F and she expected facility staff to adjust the temperature, re-check the temperature, and document their findings.	F 431	range. 4.An audit was started 6/09/2017 to ensure the temperatures are within acceptable range and that staff will adjust and monitor temperature to maintain within the range of 36-46 degrees. These audits will be performed every shift for 2 weeks then daily x 14 weeks then weekly x 2 months. These audits will be completed by the DNS or her designee. The results of the audits will be reported to the QAPI Committee for future recommendations.	

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F 431	Continued From page 18 During an interview on 06/08/17 at approximately 9:15 a.m., an environmental manager (#9) stated the red outlets are the only outlets on emergency power.	F 431		