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 _____	06/09/2016

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, started on 06/06/16 and completed on 06/09/16, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the care plan for 7 of 9 sampled residents (Resident #1, #2, #3, #4, #6, #8, and #9). Failure to revise the care plan as	F 280	F-280 1. Resident #1 Care Plan was reviewed and updated on 6/15/16 with individual goals and interventions related to	7/14/16

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

Electronically Signed | 06/28/2016

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F 280	Continued From page 1 each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity of care. Findings include: Review of the facility policy titled "Care Planning-Interdisciplinary Team" occurred on 06/09/16. This undated policy, stated, "Rolette Community Care Center's Care Planning/Interdisciplinary Team is responsible for the development of an individualized care plan for each resident. . . . The care plan is based on the resident's comprehensive assessment and is devolved by a Care Planning/Interdisciplinary Team . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included diabetes, pain in left shoulder, and fibromyalgia. Resident #1's current care plan stated, "Problem . . . Incontinent of bowel and bladder. . . ." The CNA care card stated, "Toileting: Urine Catheter . . . Comments: Foley Catheter . . ." The care plan lacked goals and interventions related to Resident #1's indwelling catheter to ensure the resident received appropriate and consistent care. A physician order dated 05/16/16 identified a full liquid diet. Observations throughout the survey showed Resident #1 received a full liquid diet. The current care plan stated, "Problem: Nutrition concern due to receiving a therapeutic diet and elevated BMI [body mass index]. . . . Approach:	F 280	Indwelling Catheter Care, Full Liquid Diet, Episodes of Crying and Activity Preferences to ensure appropriate and consistent care. Resident #2 Care Plan was reviewed and updated on 6/15/16 to reflect the use of plastic silverware at meals times as an intervention. Resident #3 Care Plan was reviewed and updated on 6/08/16 with goals and interventions to ensure appropriate and consistent Colostomy Care. On 6/23/16 a Care Plan was created for Resident #4 need for dialysis, including the location, care of, and/or precaution of dialysis fistula/permacath, including specific restrictions and other assessment/monitoring needs for end stage renal failure to ensure appropriate and consistent care. Resident #6 CNA Care Card was updated 6/15/16 to reflect the current smoking status. On 6/23/16 a Care Plan was created for Resident #8 need for dialysis and current fluid restriction with goals and interventions to ensure appropriate and consistent care. On 6/23/16 a Care Plan was created for Resident #9 with goals and interventions related to the obsessive behavior with clocks and time.	

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F 280	Continued From page 2 Favorite foods may be brought in by family and given as snacks. Monitor chewing ability - has her own teeth. . . . Provide ADA diet . . ." The CNA care card stated, "Diet: Full Liquid Diet." The care plan failed to include interventions relevant to Resident #1's full liquid diet. Review of Resident #1's current physician orders identified the following pain medications: * Tylenol Extra Strength 500 milligrams (mg) four times a day * Fentanyl patch 50 micrograms per hour (mcg/hr) change every 72 hours * Tylenol 650 mg every six hours as needed * Tramadol 50 mg every six hours as needed Review of June 01-09, 2016 progress notes identified the following: * 06/01/16 at 1:37 p.m.: "Resident c/o [complaining of] 'allover [sic] back pain.' '5'. PRN [as needed] Tylenol given . . ." * 06/01/16 at 8:07 p.m.: "Resident complaining of back pain with no pain relief from scheduled Tylenol. Unable to redirect with food TV [television] music or reading material. Admin [administered] tramadol for back pain" * 06/02/16 at 9:56 a.m.: "Resident c/o bilateral shoulder pain at 8:55 a.m. PRN Tylenol given . . ." * 06/03/16 at 1:30 p.m.: "resident requested PRN pain medication for pain all over resident was given PRN tramadol per request" * 06/04/16 at 1:47 p.m.: "Resident is crying out in pain. Resident given PRN Tramadol . . ." * 06/05/16 at 12:14 p.m.: ". . . stated her whole body hurt, so resident was given PRN Tramadol . . ." * 06/07/16 at 6:48 a.m.: "Resident medicated at	F 280	2. All residents at the Rolette Community Care Center have the potential to be affected by this deficient practice. 3. All Care Plans and CNA Care Cards for residents will be reviewed and updated. An All Staff Meeting was held 6/22/16. Nursing Staff was educated on RCCC Policy and Procedure "Care Planning-Interdisciplinary Team". Education on the importance of updating Care Plans and CNA Care Cards with resident information and continuity of care was emphasized. 4. An audit was started 6/30/16 to ensure that the information on Care Plans and CNA Care Cards reflect the residents current status. These audits will be performed weekly times four weeks then monthly times two months. The results of the audits will be reported to the QI committee for future recommendations. The audits will be completed by the DNS or her designee. 5. July 14, 2016	

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F 280	Continued From page 3	F 280		

this time with PRN Tylenol for c/o abdominal pain . . ."
* 06/07/16 at 9:30 a.m.: "Spoke with [name of doctor] regarding Resident pain and management, also discussed with him how Resident has been continuously upset and crying. New order made to increase Resident fentanyl patch and scheduled Tylenol. . . . Also new orders made to increase sertraline. . . ."
* 06/07/16 at 3:57 p.m.: "resident crying in room, resident having complaints of abdominal pain rated a 7/10, a PRN tramadol was administered"

The care plan failed to address Resident #1's pain, including goals and interventions to ensure the resident received appropriate and consistent care.

A progress note dated, 06/08/16 at 7:30 p.m., stated, "resident very weepy and states she is lonesome for her family when asked, resident has had some complaints of pain and discomfort earlier this shift but does not have any complaints at this time"

The current care plan stated, "Problem: Resident receives antidepressant medication Sertraline. . . . Approach: Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Pharmacy consultant review. . . ." The care plan failed to address Resident #1's crying, including goals and interventions to ensure the resident received appropriate and consistent care.

The admission MDS, dated 02/24/16, identified the following activity preferences to be very important to Resident #1: music, animals, news,

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F 280	Continued From page 4	F 280		

and religion.

The care plan failed to address Resident #1's activity preferences, including goals and interventions to ensure the resident received appropriate and consistent care.

- Review of Resident #2's medical record occurred on all days of survey.

Observations during meal times showed Resident #2 used plastic silverware to eat his meal. The current care plan stated, "Problem: Nutrition . . . Approach . . . Provide regular diet, small servings. . . . Tray set up at meals. . . ." The care plan lacked plastic silverware as an intervention.

During an interview on 06/08/16 at 5:10 p.m. a dietary staff member (#5) stated Resident #2 scratched the table with normal silverware and the plastic silverware was implemented and should be care planned.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a colostomy. The quarterly Minimum Data Set (MDS) identified Resident #3 with a colostomy. The current care plan stated, " . . . Problem: ADL [activity of daily living] . . . is incontinent of BM [bowel movement] . . . Peri care after each incontinent episode. . . ." The CNA care card identified a colostomy. The comprehensive care plan lacked a problem related to Resident #3 having a colostomy along with goals and interventions to ensure the resident received proper care for the colostomy. Observation on 06/07/16 at 10:15 a.m. showed

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F 280	Continued From page 5 Resident #3 with a colostomy. During an interview on the morning of 06/08/16, a nurse manager (#4) confirmed the care plan failed to address Resident #3's colostomy and the necessary interventions to ensure appropriate care was provided. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included end stage renal (kidney) disease with dependence on renal dialysis. Resident #4's current care plan stated, "Problem: Nutrition concern due to receiving a therapeutic diet, dialysis, . . . Approach: Offer Nepro [nutritional drink for people on dialysis] daily - receives a [sic] KDU [kidney dialysis unit] on dialysis days. . . . Provide liberalized ADA [American Diabetes Association] diet . . ." The certified nurse aide (CNA) care card stated, "Comments: . . . No BP [blood pressure] on LEFT ARM; Dialysis Wed. [Wednesday] . . ." A progress note dated, 03/29/16, stated, "To [name of hospital] . . . return with a permacath right upper chest." The facility failed to develop a care plan related to Resident #4's need for dialysis, including the location, care of, and/or precautions of her dialysis fistula/permacath, specific restrictions or needs for end stage renal failure, assessment/monitoring needs, or other interventions appropriate for a resident on dialysis. During an interview on 06/09/15 at 9:40 a.m., an	F 280		

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F 280	Continued From page 6 administrative nurse (#2) agreed Resident #4 should have a care plan specific to dialysis. - During an interview on the afternoon of 06/08/16 an administrative staff member (#3) stated Resident #6 lost smoking privileges from an incident on 05/08/16. The CNA care card stated, "Smokes in designated area." Staff failed to update information regarding Resident #6's smoking status. - Review of Resident #8's medical record occurred on June 08-09, 2016. Diagnoses included end stage renal disease and dependence on renal dialysis. Physician orders identified a fluid restriction of 2500 milliliters (ml) per day. The current care plan stated, ". . . Problem: Nutritional Status . . . Encourage fluid intake within 1800 ccs [cubic centimeters] fluid restriction. . . ." Staff failed to update the care plan with the current fluid restriction, and the care plan failed to address Resident #8 received dialysis, including goals and interventions to ensure the resident received appropriate and consistent care. - Review of Resident #9's medical record occurred on June 08-09, 2016. Diagnoses included dementia. Review of Resident #9's May 2016 progress notes showed the resident's behavior related to checking clock/time occurred 17 times. The facility failed to develop a care plan to address Resident #9's obsessive behavior with clocks and time.	F 280		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		7/14/16

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F 314 SS=D	Continued From page 7 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 and record review, the facility failed to provide treatment and services to prevent the development of pressure ulcers for 1 of 3 sampled residents (Resident #1) with a pressure ulcer. Failure to consistently implement interventions as care planned may result in worsening pressure ulcers or the development of new ulcers. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included hemiplegia and a coccyx pressure ulcer. The admission Minimum Data Set (MDS), dated 02/24/16, identified extensive assistance from two or more people for bed mobility. The resident's current care plan stated, "Problem: Resident has a pressure ulcer located on coccyx . . . Problem: Has history of Pressure Ulcer . . . Approach . . . Heel protectors while in bed. . . ." Observation on 06/07/16 at 8:45 a.m. showed	F 314	F-314 1. On 6/09/16 Resident #1 was assessed for signs of skin breakdown on the heels. Staff on duty were immediately educated to keep heel protectors consistently in place. 2. All residents requiring pressure relieving devices at the Rolette Community Care Center have the potential to be affected by this deficient practice. 3. A mandatory licensed Nursing staff meeting was held 6/22/16 to review Policy and Procedure "Pressure Ulcer:Intervention and Prevention". Education was provided on the importance of heel protectors and the use of all types of pressure relieving interventions to prevent skin breakdown.	

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F 314	Continued From page 8 two certified nursing assistants (CNAs) (#6 and #7) transferred Resident #1 from the wheelchair to her bed. The CNAs failed to apply the resident's heel protectors or float her heels. Observation showed Resident #1 remained in bed without heel protectors and her heels resting directly on the mattress until 11:35 a.m. (approximately 2.5 hours) when a nurse (#4) and two CNAs (#8 and #9) assisted her out of bed. Observation on 06/07/16 at 1:57 p.m. showed Resident #1 in bed without heel protectors and her heels resting directly on the mattress. The resident remained in this position until 5:28 p.m. (approximately 3.5 hours). Failure to apply Resident #1's heel protectors while in bed as care planned may result in skin breakdown and/or the development of pressure ulcers.	F 314	4. An audit started 6/24/16 to ensure pressure relieving devices are consistently in place to prevent worsening pressure or the development of new ulcers. This audit will be done daily times two weeks, then weekly times 2 weeks, then monthly times two months. The results of the audits will be reported to the QI Committee for future recommendations. The audits will be completed by the DNS or her designee. 5. July 14, 2016	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility education records, and staff interview, the facility failed to ensure safe transportation in the facility van for 1 of 6 sampled residents (Resident #4)	F 323	F-323 1. On 4/29/16 the driver was immediately removed from that position and Resident	7/14/16

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F 323	Continued From page 9 who uses a wheelchair for mobility. Failure to safely position and secure residents in the facility van during transport resulted in Resident #4 receiving a head contusion (bruise) and may result in additional residents sustaining injuries. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dependence on wheelchair. A progress note, dated 04/29/16 at 5:20 p.m., stated, "Received telephone call from [name of dialysis center] . . . resident had a fall out of wheelchair while being loaded into van. States they did a manual blood pressure which was 76/42, and resident has a large bump on the back of her head. . . . Resident to be sent to ER [emergency room] for evaluation. . . ." During an interview on the afternoon of 06/08/16, an administrative staff member (#3) stated the fall happened during transport with the van, not while the resident was being assisted into the van. The physician's ER progress note, dated 04/29/16 at 7:10 p.m., stated, "[Resident] on way back from KDU [kidney dialysis unit] in transport van when the van apparently stopped abruptly and she fell back in her wheelchair hiting [sic] the back of her head. . . . Physical Exam: . . . mild tenderness of occiput [back of head] . . . minimal [neck] tenderness . . . Data: CT Head and Neck: neg [negative] for any acute process. Impression: Head contusion. Plan: Family requwst [sic] pain shot for tonight (Diluadid [sic] [narcotic] 0.5 mg/Phergan [sic] [antiemetic] 12.5mg IM [intramuscular] given . . ."	F 323	#4 has since been and currently being transported by another driver. 2. All residents at the Rolette Community Care Center that are wheelchair bound and rely on the facility for transportation to and from appointments have the potential to be affected by this deficient practice. 3. A mandatory transport/driver personnel meeting was held 5/02/16 to review the "Q-Straint" system in response to the incident 4/29/16. A mandatory transport/driver personnel in service will be held 6/29/16 to review "Q-Straint Wheelchair and Occupant Securement System Training" with an emphasis on placement of wheelchairs in vehicles and proper use of restraints. 4. An audit started 6/29/16 to ensure residents are secured using the Q-Straint system. 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 audits will be completed by the Director of Maintenance or his designee. 5. July 14, 2016	

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F 323	Continued From page 10 Resident #4's progress notes stated: * 04/29/16 at 8:40 p.m., ". . . resident is ready to be picked up . . . [Name of ER nurse] states resident is fine, CT [computed tomography] and x-rays were negative and resident was going to be given something for pain due to complaints of rib pain, stating the pain was there before fall in facility vehicle. . . ." * 04/29/16 at 9:47 p.m., ". . . Neuro [neurological] check WNL [within normal limit]. . . . Resident states she is not in any pain at this time." * 04/30/16 at 4:23 a.m., "resident voiced soreness of head when palpated-lump area -refused something for pain at this time . . . will continue to monitor." * 04/30/16 at 7:01 a.m., "Resident requested PRN [as needed] Tramadol [pain medication] 50 mg [milligrams] . . . for pain on lump on back of resident's head. Resident stated her pain level is an 8 on a scale 1-10. . . ." * 04/30/16 at 1:49 a.m., "Resident is requesting PRN Tramadol, 50 mg, . . . stating she has pain in the lump on the back of her head. She rates her pain a 5 on a scale 1 through 10. . . ." * 04/30/16 at 7:25 p.m., "Resident is requesting PRN Tramadol for pain in back of her head. . . ." * 04/30/16 at 9:18 p.m., ". . . Resident states she is a little sore from fall yesterday but denies any other complaints or needs. . . . Neuro check performed this shift WNL. VS [vital signs] WNL." * 05/01/16 at 11:37 a.m., "Crani [neuro] checks continue to be okay. Resident had tramadol once this shift for left rib and head pain. . . ." Review of the May 2016 Medication Administration Record (MAR) showed Resident #4 received no further pain medication related to	F 323		

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F 323	Continued From page 11 her head contusion after 05/01/16. During an interview on 06/08/16 at 1:20 p.m. regarding Resident #4's fall in the facility van, an administrative staff member (#3) stated the facility's investigation identified Resident #4's wheelchair was not properly latched to the floor and when the van stopped at the first stoplight, the wheelchair tipped backwards and the resident hit her head. The driver either missed one of several steps in the process or latched the wheelchair incorrectly. This staff member (#3) stated the driver (#4) was new and had recently received training on latching a wheelchair in the van per video and instruction from the Maintenance Manager. Review of the facility's training material showed the driver (#4) completed "Q'straint Wheelchair and Occupant Restraint System Training Program" on 04/19/16. During an interview on the afternoon of 06/08/16, an administrative staff member (#3) stated the driver of the van was not retrained after the incident on 04/29/16 as the driver requested to no longer be a transport aide. Failure to appropriately secure the wheelchair in the van resulted in Resident #4's wheelchair tipping backwards causing her to hit her head, sustain a contusion, and required the use of PRN pain medication for pain relief.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328		7/14/16

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 _____	06/09/2016

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F 328	Continued From page 12 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and professional reference, the facility failed to safely store oxygen cylinders in 1 of 1 oxygen storage room. Failure to store an oxygen tank securely placed residents, staff, and visitors at risk for harm. Findings include: NFPA 55, 7.1.4.4 states, "Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7". Review of the oxygen storage room occurred on 06/08/16 at 1:15 p.m. with a maintenance staff member (#1). Observation showed an oxygen tank stood freely behind the door unsupported. The staff member (#1) stated staff are expected to secure oxygen tanks.	F 328	F-328 1. The oxygen cylinder was immediately placed in the proper holding device 6/08/16. 2. All residents at the Rolette Community Care Center have the potential to be affected by this deficient practice. 3. An All Staff meeting was held 6/22/16 to provide education regarding the importance of proper oxygen cylinder storage and the requirement from NFPA 55 7.1.4.4 was reviewed. 4. An audit started 6/24/16 to monitor the proper storage of oxygen cylinders. This audit will be completed daily times two weeks, weekly times two weeks, then monthly times two months. The results of the audits will be reported to the QI Committee for future recommendations. The audits will be completed by the DNS or her designee. 5. July 14,2016	

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F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure sanitary conditions for 2 of 3 cutting boards and 40 of 60 drinking glasses stored in the kitchen. Failure to identify environmental hazards in the kitchen has the potential to result in contamination of food and dishware. Findings include: Review the facility policy titled "Dishwashing Machine Use" occurred on 06/08/16. This policy, dated 2010, stated, " . . . 1. The following guidelines will be followed when dishwashing: . . . f. After running items through entire cycle, allow to air-dry. . . ." Observation of the kitchen occurred on 06/08/16 at 1:25 p.m. with a dietary manager (#5). Observation showed the following: * 20 stacks of clear colored drinking glasses stacked three high on a shelf. The top two glasses of each stack contained moisture on the	F 371	F-371 1. On 6/08/16 the stacked dishes were immediately rewashed and allowed time to dry completely prior to stacking for storage. Dietary Staff on duty were immediately educated to allow more drying time for all washed dishes in order to ensure they are all completely dry before stacking for storage. On 6/09/16 Dietary Staff removed the marked and discolored cutting boards from service and ordered new cutting boards. 2. All residents at the Rolette Community Care Center have the potential to be affected by these deficient practices. 3. A mandatory Dietary personnel meeting was held 06/22/16 to review Policy and Procedure "Dishwashing Machine Use". Emphasis was placed on all dishes being completely dry prior to	7/14/16

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F 371	Continued From page 14 bottom of the glass. * two cutting boards with deep discolored cut marks. During the observation, the dietary manager (#5) confirmed staff failed to allow the glasses to completely air-dry before stacking and staff should remove the cutting boards from use.	F 371	stacking for storage. Staff were also educated on the importance of monitoring all cutting surfaces and ensuring that equipment is replaced promptly and/or as needed. 4. An audit started 6/23/16 to ensure that dishes are dry prior to stacking and that cutting boards do not have deep and discolored marks. Audits will be completed weekly times one month then monthly times two months. The results of the audits will be reported to the QI Committee for future recommendations. The audits will be completed by the Dietary Manager or her designee. 5. July 14, 2016	