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	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolette Community Care Center	804 State Street Rolette, ND 58366

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46963 Based on record review and staff interview, the facility failed to provide the resident or the resident's representative a written notice of transfer for 1 of 2 sampled residents (Resident #13) transferred to the hospital. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of Resident #13's medical record occurred on all days of survey and identified a hospital transfer on 06/28/24. The medical record lacked evidence the facility provided the resident and/or representative with a written transfer notice. During an interview on 09/10/24 at 4:55 p.m., an administrative staff member (#6) confirmed the facility failed to complete a Notice of Transfer for hospitalization for the resident.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Rolette Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 804 State Street Rolette, ND 58366	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37620 42397 Based on record review, staff interview, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and review of the federal database for Long-Term Care Survey, the facility failed to ensure timely electronic data submission of required Minimum Data Set (MDS) assessments for 3 of 12 sampled residents (Resident #4, #5, and #20) and one supplemental resident (Resident #75). Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.18), page 2-34, stated, . The MDS must be transmitted . electronically no later than 14 calendar days after the MDS completion date . Page 2-35 stated, . The ARD [assessment reference date] must be within 92 days after the previous OBRA assessment . The MDS completion date (item Z0500B) must be no later than 14 days after the ARD. Page 2-38 stated, Entry Tracking Records . Must be submitted no later than the 14th calendar day after the entry . Page 5-1 stated, . All Medicare and/or Medicaid-certified nursing homes . must transmit required MDS data records to CMS' [Center for Medicare and Medicaid Services] Internet Quality Improvement and Evaluation System (iQIES) Assessment Submission and Processing (ASAP) system. - Review of Resident #4's medical record occurred on all days of survey and showed a quarterly MDS with an ARD date of 07/29/24 and a completion date of 08/23/24 (completed 30 days late). - Review of Resident #5's medical record occurred on all days of survey and showed a quarterly MDS with an ARD of 6/26/24, a completion date of 06/28/24, and transmitted to iQIES on 09/01/24 (transmitted 44 days late). - Review of Resident #20's medical record occurred on all days of survey and showed the following: * A discharge return anticipated MDS with an ARD of 6/27/24, and a completion date of 08/17/24 (completed 51 days late). * An entry tracking MDS with an ARD of 6/30/24 and transmitted to iQIES 08/13/24 (transmitted 61 days late). * A quarterly MDS with an ARD of 7/6/24, and a completion date of 08/17/24 (31 days late). - Review of Resident #75's MDS occurred on 09/09/24 and showed the facility completed and transmitted quarterly MDSs with ARD dates of 02/27/24 and 08/27/24. The facility failed to submit an MDS 92 days after the MDS dated [DATE]. During a phone interview on 09/12/24, a facility nurse (#5) confirmed staff failed to submit MDSs in a timely manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 12 sampled residents (Resident #1, #13, #16, #18, and #20). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2023, pages K-2 through K-11, stated, . K0200: Height and Weight . Weight . Base weight on most recent measure in the last 30 days, . K0520: Nutritional Approaches . PARENTERAL/IV FEEDING Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). FEEDING TUBE Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to . percutaneous endoscopic gastrostomy (PEG) tubes. - Review of Resident #1's medical record occurred on all days of survey and showed a physician's order for Jevity 1.5 cal (a nutritional formula) per PEG Tube, four times a day. The quarterly MDS, dated [DATE], identified parenteral feeding coded incorrectly and failed to identify Resident #1's feeding tube. During an interview on 09/11/24 at 3:55 p.m., an administrative staff member (#5) confirmed staff failed to code the MDS correctly for Resident #1. - Review of Resident #18's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], identified Resident #18's weight as 155 pounds. Review of the record identified Resident #18's weight 167 pounds. The facility failed to use the most recent weight when completing the MDS. SECTION N: MEDICATIONS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2023, pages N-6 through N-8, stated, . N0415: High-Risk Drug Classes: . Coding Instructions .N0415A1. Antipsychotic: Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period . N0415F1. Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period . N0415G1. Diuretic: Check if a diuretic medication was taken by the resident at any time during the 7-day look-back period .N0415H1. Opioid: Check if an opioid medication was taken by the resident at any time during the 7-day look back period . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin .) was taken by the resident at any time during the 7-day observation period . N0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period . - Review of Resident #13's medical record occurred on all days of survey. Review of the medication administration record (MAR) for July 2024, showed Resident #13 received the following medications: * clindamycin, an antibiotic * tramadol, an opioid * aspirin, an antiplatelet * Fiasp insulin and Levemir insulin, hypoglycemics The quarterly MDS, dated [DATE], showed staff failed to identify Resident #13 received an antibiotic, opioid, antiplatelet, and hypoglycemics. - Review of Resident #16's medical record occurred on all days of survey. Review of the MAR for June 2024, showed the resident received azithromycin, an antibiotic. The quarterly MDS, dated [DATE], showed staff failed to identify Resident #16 received an antibiotic. - Review of Resident #18's medical record occurred on all days of survey . Review of the MAR for August 2024, showed the resident received bumetanide, a diuretic. The quarterly MDS, dated [DATE], showed staff failed to identify Resident #18 received a diuretic. - Review of Resident #20's medical record occurred on all days of survey. Review of the MARs for June-July 2024, showed Resident #20 received the following medications: * quetiapine, an antipsychotic * amoxicillin, an antibiotic The quarterly MDS, dated [DATE], showed staff failed to identify Resident #20 received an antipsychotic and antibiotic. During an interview on 09/11/24 at 3:59 p.m., an administrative staff member (#5) confirmed staff failed to code the MDS correctly for Resident #13, #16, #18, and #20. 46963

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37620 42397 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 7 of 12 sampled residents (Resident #1, #5, #7, #9, #10, #18, and #20). Failure to review and revise the care plan limited staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered occurred 09/11/24. This policy, revised March 2022, stated, A comprehensive, person-centered care plan that includes measurable objectives and timetables. The comprehensive, person-centered care plan: . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . the interdisciplinary team reviews and updates the care plan . - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included gastrostomy status. The current care plan stated, . Feeding Tube . Resident requires tube feeding . Observation on 09/09/24 at 4:08 p.m. showed a medication aide (MA) (#10) don a gown and gloves prior to entering Resident #1's room. When asked why they were wearing the gown and gloves, the MA (#10) stated, For enhanced barrier precautions because he has a feeding tube. The facility failed to update Resident #1's care plan to include enhanced barrier precautions. - Review of Resident #5's medical record occurred on all days of survey. A progress note, dated 03/09/24, at 8:05 p.m., stated, Fall precaution in place bed in low position. The facility failed to update Resident #5's care plan to include the new fall intervention. - Review of Resident #7's medical record occurred on all days of survey. Observation on 09/09/24 at 12:45 p.m. showed the resident using a pommel cushion (supports the body, prevents slipping and relieves lower back pain). The facility failed to update Resident #7's care plan to include the use of the pommel cushion. - Observations on all days of survey identified an isolation cart outside Resident #9 and #10's rooms with signage identifying the resident required enhanced barrier precautions. The facility failed to update Resident #9 and #10's care plans to include enhanced barrier precautions. - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included end stage renal disease and hyperkalemia (high potassium). The current care plan stated, . Nutritional Status . Resident is on a diabetic diet. Long Term Goal . Resident will accept and be satisfied with meals over the next 90 days. Approach . Resident will be provided with diabetic diet as ordered. (continued on next page)

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Rolette Community Care Center	804 State Street Rolette, ND 58366

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A dietary note, dated 05/13/24 at 9:12 p.m., stated, . is a new admit . with a medical hx [history] significant for type 2 diabetes, renal disease, . dialysis . receives a nutrition score of 8 indicating she is at high nutrition risk. The facility failed to update Resident #18's care plan to reflect dialysis related nutrition. During an interview on 09/11/24 at 3:30 p.m., an administrative staff (#1) agreed Resident #18's care plan was very vague. - Review of Resident #20's medical record occurred on all days of survey. The current care plan stated, . Urinary Incontinence . Resident requires an indwelling urinary catheter. The facility failed to update Resident #20's care plan to include enhanced barrier precautions. During an interview on 09/11/24 at 5:35 p.m., an administrative staff member (#1) confirmed she expected enhanced barrier precautions to be identified on Resident #1 and #20's care plans. 46963

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 1. Based on observation, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #10) observed for insulin preparation. Failure to prime an insulin pen correctly may result in residents receiving an inaccurate dose. Findings include: Review of the manufacturer's guidelines titled Fiasp insulin aspart injection. Instructions for use. occurred on 09/11/24. This document, dated July 2023, page 8, states, . Priming your . Pen: Step 7: Turn the dose selector to select 2 units. Step 9: Hold the pen with the needle pointing up. Press and hold in the button until the dose counter shows0. A drop of insulin should be seen at the needle tip. Observation on 09/10/24 at 11:53 a.m. showed a nurse (#3) attached a needle to Resident #10's Fiasp FlexTouch insulin pen, selected two units of insulin, and depressed the plunger while the pen was in the horizontal position. The nurse (#3) failed to hold the pen with the needle pointing up while pushing the plunger button. During an interview on the afternoon of 09/10/24, an administrative nurse (#1) confirmed the nurse (#3) failed to prime the insulin pen correctly. 2. Based on observation, record review, review of policies/procedures, review of professional reference, and staff interview, the facility failed to follow physician's orders for 2 of 12 sampled residents (Resident #1 and #7). Failure to follow physician's orders for notification of blood glucose outside of specific parameters (Resident #7), for tardive dyskinesia assessments, range of motion (ROM) exercises, and changing of oxygen/respiratory tubing (Resident #1) placed Residents #1 and #7 at risk for delayed treatment and adverse health events. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. A review of the facility policy titled Physician Services occurred on 09/11/24. This policy, revised February 2021, stated, . The medical care of each resident is supervised by a licensed physician. Supervising the medical care of residents includes (but is not limited to): . monitoring changes in resident's medical status . - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included cerebral palsy and dependence on supplemental oxygen. Physician's orders identified the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 02/11/16 ROM both lower extremities 1-2 x [times] per day, flex extremities at knee 6 reps [repetitions] both extremities . Twice a day. * 12/30/23 change oxygen equipment, date equipment. 1. o2 [oxygen] bag 2. [NAME] [sic] lumen w/c [wheelchair] 3. concentrator 4. neb [nebulizer] (no blue mask) . Every 2 Weeks . * 02/01/24 TD [tardive dyskinesia] Assessment Reglan [anti-nausea medication] every 6 months . Review of Resident #1's point of care (POC) responses (CNA charting), dated 08/01/24 through 09/10/24, showed ROM completed 5 of 41 days. The medical record lacked a tardive dyskinesia assessment completed since 02/01/24. Observations on all days of survey showed Resident #1 wearing oxygen, the oxygen tubing on the concentrator dated 08/24/24, and the nebulizer tubing/mask dated 08/04/24. The facility failed to change oxygen and nebulizer tubing/mask every two weeks as ordered. During an interview on 09/10/24 at 1:59 p.m., a certified nurse aide (CNA) (#8) stated she is the restorative aide and is supposed to work as the restorative aide five times per week but is always on the floor due to staffing. She confirmed Resident #1 did not receive daily ROM exercises. During interviews on 09/10/24 at 2:40 p.m., and 09/11/24 at 8:45 a.m., an administrative nurse (#1) confirmed any CNA can perform ROM exercises for Resident #1, and she expected staff to document each shift if completed/attempted, and staff failed to complete a tardive dyskinesia assessment as ordered. - Review of Resident #7's medical record occurred on all days of survey and included a diagnose of Type 2 Diabetes Mellitus. A physician's order, dated 06/18/24, stated, . If Blood Sugar is less than 100 [mg/dL, milligrams per deciliter], call MD [medical doctor]. If Blood Sugar is greater than 450 [mg/dL], call MD. A physician's order, dated 11/13/23, stated, Accu-check [checks blood sugar levels] PRN [as needed] for symptoms of hypo/hyperglycemia [low blood glucose/high blood glucose] < [less than]100 or > [greater than] 400 CALL PHYSICIAN . Review of Resident #7's blood glucose checks from 08/04/24 through 09/08/24 showed the following: * 09/01/24 5:27 a.m., 63 mg/dL * 08/27/24 7:57 p.m., 403 mg/dL * 08/27/24 11:25 a.m., 55 mg/dL * 08/26/24 5:47 a.m., 80 mg/dL * 08/20/24 5:16 a.m., 421 mg/dL * 08/17/24 7:39 a.m., 430 mg/dL (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record showed the facility failed to notify the physician of Resident #7's blood glucoses that were less than 100 or greater than 400. During an interview on 09/11/24 at 08:44 a.m., an administrative nurse (#1) confirmed staff failed to notify the provider of Resident #7's blood glucose being out of parameters as ordered. 46963 46964

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37620 Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 2 of 4 sampled residents (Resident #5 and #11) reviewed for psychotropic medication use. Failure to limit as needed (PRN) psychotropic medication use to 14 days unless reevaluated by a practitioner, and failure to monitor the residents on psychotropics placed the residents at risk of receiving unnecessary medications and experiencing adverse drug effects and consequences related to their use. Findings include: Review of the facility policy titled Psychotropic Medication Use occurred on 09/11/24. This policy, dated July 2022, stated, . PRN orders for psychotropic medications are limited to 14 days. PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication. Resident receiving psychotropic medications are monitored for adverse consequences, including: . neurologic affects-agitation, distress . tardive dyskinesia . If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued, and document the rationale. - Review of Resident #5's medical record occurred on all days of survey. The current orders in the electronic medical record and the electronic medication administration record (EMAR) identified alprazolam (medication to treat anxiety) 0.5 milligrams (mg) every 12 hours as needed for uncontrolled anxiety started 08/09/24. The order lacked a stop date. Review of the resident's EMAR for August 1- September 11, 2024 identified the resident received alprazolam on 09/01/24 and 09/02/24. Review of the physician's orders in the resident's paper chart identified an order to discontinue the alprazolam on 07/09/24 with no order to restart the medication. Review of the resident's progress notes failed to identify the provider had given an order for the PRN alprazolam. The resident received two doses of the alprazolam after it was discontinued. The facility failed to write an order for the alprazolam started 08/09/24 and failed to have the physician or prescriber evaluate the resident's need to extend the psychotropic medication beyond the original 14 days. During an interview on 09/11/24 at 4:47 p.m., an administrative nurse (#1) confirmed the facility failed to write the physician's order received via phone for the Alprazolam started on 08/09/24 and failed to have the provider reevaluate the resident for further need of the medication after 14 days. - Review of Resident #11's medical record occurred on all days of survey. Physician's orders included Seroquel (antipsychotic medication) 25 mg at bedtime and a tardive dyskinesia (TD) assessment to be completed every 6 months while on Seroquel (the 6th of every 6th month). The medical record identified an incomplete TD assessment dated [DATE]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 8:57 a.m., an administrative nurse (#1) confirmed staff failed to fully completed the TD assessment on 02/06/24 and failed to complete another one in the last 6 months.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46964 Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications for 2 of 2 unlocked and unattended carts (medication and treatment carts). Failure to securely store medications may result in unauthorized access to medications. Findings include: Review of the facility policy titled Medication Labeling and Storage occurred on 09/11/24. This undated policy, stated, Policy Statement. The facility stores all medications. in locked compartments. Medication Storage. 2. The nursing staff is responsible for maintaining medication storage. 3. Compartments (including, but not limited to, drawers, . carts, .) containing medications. are locked when not in use, . carts used to transport such items are not left unattended if open or otherwise available to others. Observation on 09/11/24 at 8:18 a.m., showed an unlocked/unattended medication cart with medications on the top of the cart and an unlocked/unattended treatment cart in the 200-hallway. During an interview on 09/11/24 at 8:34 a.m., an administrative nurse (#1) stated she expected staff to lock the medication cart and keep all medications in the cart when the nurse or medication aide [MA] are not within sight/accessing them.

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NAME OF PROVIDER OR SUPPLIER Rolette Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 804 State Street Rolette, ND 58366	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46964 Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#4) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure staff have the qualifications to carry out the functions of food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: During an interview on 09/11/24 at 10:40 a.m., an administrative manager (#2) confirmed the dietary manager (#4) lacked the required training for the position. The facility failed to ensure the dietary manager (#4) completed the education for a certified dietary manager, certified food service manager, or national certification for food service management and safety from a national certifying body.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Rolette Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 804 State Street Rolette, ND 58366	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. 37620 42397 Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow standards of infection control for 3 of 12 sampled residents (Resident #1, #3, and #10) and 1 supplemental resident (Resident #14) observed during cares. Failure to follow infection control practices related to enhanced barrier precautions (Resident #1 and #10) and transmission-based precautions (Resident #3 and #14) has the potential to spread infection throughout the facility. During the on-site recertification survey, the team determined an Immediate Jeopardy (IJ) situation existed on 09/09/24 at 1:32 p.m. The IJ resulted from staff failure to properly doff an N95 mask upon exiting the room of a COVID positive resident and before entering the rooms of COVID negative residents, which had the potential to spread the infection to residents, staff and visitors. *09/19/24 at 11:45 a.m. The survey team notified the director of nursing (DON) and administrator of the IJ situation, presented the IJ template, and requested a plan for removal of the immediate jeopardy. *09/19/24 at 3:10 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Review of Infection Control, Isolation and personal protective equipment (PPE) policies. No changes needed. *Posted signs demonstrating proper donning and doffing of PPE on all doors of COVID positive resident rooms. *Educated all staff on proper application of gowns, masks (including N95), gloves, when to perform hand hygiene, and PPE guidelines for donning and doffing for COVID positive residents and residents in isolation. This education will be conducted either in person or via phone prior to next scheduled shift. *09/19/24 at 3:30 p.m. The survey team verified the implementation of the removal plan and the IJ removal. The deficient practice remained at a E scope and severity following the removal of the immediate jeopardy. Findings include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rolette Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 804 State Street Rolette, ND 58366	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled Isolation - Categories of Transmission-Based Precautions occurred on 09/11/24. This policy, revised September 2022, stated, . Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Staff and visitors wear gloves . when entering the room . Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room . Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets . that can be generated by the individual coughing, sneezing, talking . Masks are worn when entering the room . Review of the facility policy titled Enhanced Barrier Precautions occurred on 09/11/24. This policy, revised March 2024, stated, Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities . include: . transferring . device care or use (central line, urinary catheter, feeding tube, .); and . wound care . Signs are posted in [sic] the door or wall outside the resident room indicating the type of precautions and PPE required. Review of Infection Control Guidance: SARS-CoV-2 [COVID] at https://www.cdc.gov/covid/hcp/infection-control/, dated 06/24/24, stated, . Source control options for HCP [health care providers] include: . A NIOSH [National Institute for Occupational Safety and Health] Approved(R) particulate respirator with N95(R) filters or higher . If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated . they should be removed and discarded after the patient care encounter and a new one should be donned. During the entrance conference on 09/09/24 at 12:01 p.m., an administrative nurse (#1) identified Resident #3 and #14 as COVID positive. - Observation on 09/09/24 at 1:16 p.m. showed a certified nurse aide (CNA) (#9) wearing a gown, N95 mask, and face shield exited Resident #3's room and carried a trash bag down the hall to a larger trash cart. A sign on the resident's door stated, special droplet/contact precautions. The CNA failed to remove his gown, N95 mask, and face shield prior to leaving the room and completing other tasks. - Observation on 09/09/24 at 1:32 p.m. showed a CNA (#9) wearing an N95 mask and face shield exited Resident #14's room. A sign on Resident #14's door stated, special droplet/contact precautions. The CNA failed to remove the N95 mask and entered Resident #1's room followed by a staff nurse (#3) who wore a surgical mask. The staff transferred the resident from the wheelchair to the bed. The CNA (#9) exited Resident #1's room wearing the N95 mask worn upon entry, and entered two additional resident rooms. The CNA (#9) failed to remove the N95 mask upon exiting the room of a COVID positive resident (Resident #14) and before entering the rooms of COVID negative residents. During an interview on 09/09/24 at 2:12 p.m., the CNA (#9) stated he could wear the same N95 when providing care for COVID positive residents, but not when he provided care for COVID negative residents. (continued on next page)

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 09/09/24 at 2:30 p.m., an administrative nurse (#1) confirmed she expected staff to doff N95 masks prior to exiting COVID positive resident rooms and don a new mask prior to caring for COVID negative residents. - Review of Resident #1's medical record occurred on all days of survey and showed Resident #1 had a feeding tube. Observation on 09/09/24 at 1:32 p.m. showed Resident #1's room lacked signs indicating Resident #1 was in EBP. A CNA (#9) and a staff nurse (#3) entered Resident #1's room and transferred the resident from the wheelchair to the bed. Both staff failed to don gown or gloves. During an interview 09/11/24 at 5:35 p.m., an administrative nurse (#1) confirmed she expected staff to properly don/doff PPE. - Observation on 09/10/24 at 9:50 a.m. showed a nurse (#3) prepared to complete wound care on Resident #10. The nurse (#3) donned PPE and entered the room carrying a closed plastic container with the resident's wound supplies. The nurse placed the plastic container on the resident's bedside stand before cleaning the stand, completed the wound care, then exited the room without cleaning the plastic container and placed it in the bottom drawer of the treatment cart. The nurse (#3) failed to clean the plastic container prior to exiting the resident's room and/or before returning the container to the treatment cart. During an interview on 09/11/24 at 5:44 p.m., an administrative nurse (#1) stated she expected staff to clean any supplies with a disinfecting cloth before removing from a resident's room with EBP and before placing in the treatment cart.