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	12/04/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to monitor hot water temperatures in resident rooms for 1 of 3 wings (wing 200) with elevated water temperatures. Failure to monitor hot water temperatures in resident rooms may result in resident pain, serious harm, serious impairment, or death. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 09/29/25. The IJ was identified when facility water temperatures were taken in resident rooms on the 200 wing. Two of the resident rooms (room [ROOM NUMBER] and 208) registered a temperature of 137 and 133 degrees Fahrenheit (F). This finding placed all resident in immediate jeopardy for hot water burns. * 09/29/25 at 7:48 p.m. The survey team notified the Business Office Manager and the Director of Nursing (DON) of the IJ situation, provided the IJ template, and requested the facility's removal plan for the IJ. * 09/30/25 at 3:50 p.m., the SSA reviewed and accepted the removal plan for the IJ.The removal plan contained the following:* Enviornmental service director (ESD) immediately adjusted the water heater down to 105 degrees F to decrease the temperature of the water and adjusted the temperature control of the recycle water heater to a low temperature. * 09/29/25 at 9:00 p.m.: hot water temperatures were taken in all resident rooms on the 200 wing with a results of 102 degrees F. * 09/29/25 at 9:00 p.m.: hot water temperatures of all resident rooms on the 100, 200, 300, and 400 wings were taken to check for compliance* 09/30/25 at 12:00 a.m. and 4:00 a.m.: hot water temperatures were taken in all resident rooms on the 200 wing with results of less than 110 degrees F.* 09/30/24 at 12:00 a.m., 4:00 a.m.: hot water temperatures were taken in all resident rooms on the 100, 200, 300, and 400 wings were taken to check for compliance.* A new policy titled Safe Water Temperature was implemented.* The ESD was educated by the Business Manager and DON on the policy for safe water temperature, checking for water temperatures, and the proper documentation of water temperature monitoring. * Education to all staff was provided by the ESD on 09/29/25 and 09/30/25 regarding what to do when they identify a change in water temperature. * Audits will be completed by the ESD.* 09/30/25 at 5:13 p.m. the survey team verified the implementation of the removal plan. The deficient practice remained at a scope and severity of an E following the removal of the IJ.The SA called IJ on 09/29/25 at 7:48 p.m. for F689 and presented the facility with the IJ template (attached).The SA accepted the removal plan on 09/30/25 at 3:50 p.m.Verification of the removal plan was confirmed on 09/30/25 at 5:13 p.m.09/29/2025 5:08 PM water temp checked in room [ROOM NUMBER] and noted hot water to be cool to touch and only got warm after about 45 seconds. 09/29/2025 6:15 pm PM Hot water temperatures checked in rooms as follows:rm: 207 137rm: 208: 133Rm 213: 122Rm: 214: 121215: 126At 6:20 observed Maintenance [NAME] entered utility room. Also observed unable to get hot water in multiple rooms down 200. (Rm 207/205)6:25 pm Interview with [NAME] in Maintenance. Denied turning off water or adjusting water temperatures. Stated he was doing weekly water temperature checks and had a spread sheet. Would adjust temperatures if he found any issues.6:30 Went with [NAME] to his office so he could show us his water temperature spread sheet. Unable to find any water temperature documentation. When asked again, admitted he is not checking water (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. Building B. Wing	12/04/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	temperatures weekly and is doing quarterly. Still unable to find any documentation. When asked why he adjusted the hot water heater temperature, stated I just wanted to be sure no one had messed with it and found the temperature was 115 and felt that was too high and turned it down to 105.Temperature rechecks completed as followsRm 207: 120 6:37 pm

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	12/04/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of professional reference, review of facility policy, review of refrigerator temperature logs, and staff interviews, the facility failed to maintain cold storage areas and kitchen equipment in a sanitary manner for 1 of 1 kitchen. Failure to clean fans, shelving, and bulk bins in areas where food is stored, failure to ensure proper concentration of sanitizer solution, failure to discard outdated foods, failure to monitor refrigerator temperatures daily, and ensure refrigerator temperatures are within acceptable ranges has the potential for contamination of food and may result in a foodborne illness. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3-16, Section 3-305.11 Food Storage, stated, A. Food shall be protected from contamination by storing the food: . 2) Where it is not exposed to . dust, or other contamination. Chapter 3-28, Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, stated, . shall be maintained . At 57 degrees C [degrees Celsius] (135 degrees F [Fahrenheit]) or above. At 5 degrees C (41 degrees F) or less. Chapter 4-20 and 4-21, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, stated, . (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . Chapter 4-23, Section 4-602.13 Nonfood-Contact Surfaces, stated, . shall be cleaned at a frequency necessary to preclude accumulation of soil residues. The 2022 FDA Food Code, Annex 3, Chapter 4, Equipment . Section 4-101.11 Characteristics, stated, . Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens . Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food. Review of the facility policy Refrigerators and Freezers occurred on 09/30/25. This undated policy stated, . Acceptable temperature ranges are 35 degrees F to 40 degrees F for refrigerators . Monthly tracking sheets will include . action taken . if temperatures are not acceptable. Food Service Supervisors or designated employees will check and record refrigerator . temperatures daily. The supervisor will take immediate action if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet, including the repair personnel and/or department contacted. Review of the facility policy Sanitizations occurred on 09/30/25. This undated policy stated, . All kitchens . shall be kept clean, free from litter and rubbish . Sanitizing of environmental surfaces must be performed with . 150-200 [parts per million (ppm)] quaternary ammonium compound (QAC) . The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen . Observation of the kitchen on 09/29/25 at 11:40 a.m. with a dietary staff member (#7) showed the following:*Box with 16 containers of raspberries covered in mold. *Upright beverage refrigerator identified a temperature of 50 degrees Fahrenheit. The dietary staff member #7 confirmed the temperature is to be between 41 and 42 degrees. Observation of the kitchen on 09/30/25 at 1:15 p.m. showed the following: (continued on next page)

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	12/04/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Walk in Cooler - accumulation of thick, dark black dust/dirt on the fans and accumulation of dust on the shelving where food is stored. * Box dated 09/01/25 with 3 containers of raspberries and 3 containers of blueberries covered in mold. * Gallon container of Ranch dressing with mold on the lid and sides, expired September 2024. * Gallon container of mustard with mold on the lid and sides, expired 10/12/24. * Gallon container of coleslaw dressing with mold on the lid and sides, expired June 2025.* Four quarts of heavy whipping cream dated 09/22/25. * Build-up of grease on the handle of the stove and inside the oven. - Observation on 09/30/25 at 10:03 a.m. showed the lids on the bulk storage containers for flour, thickener, and sugar covered with food particles. Two dietary staff members (#8 and #13) stated they did not know where the cleaning schedule was located. - Observation on 09/30/25 at 10:17 a.m. showed a dietary staff member (#13) tested the solution in a sanitization bucket with results of 50 ppm. Review of the upright refrigerator temperature logs, dated August 1 through September 28, 2025, showed 20 of the 58 days without a temperature recorded, and 18 of the 39 temperatures recorded were greater than 40 degrees F (temperatures varied from 41- 48 degrees F). Facility staff failed to check the temperature daily and take immediate action when temperatures were out of range. During an interview on 09/29/25 at 11:40 a.m., an administrative staff member (#7) confirmed the target range for the sanitizing solution is 200 ppm. During an interview on 09/30/25 at 1:15 p.m., an administrative staff member (#7) identified the facility staff had not cleaned the ice machine. The staff member (#7) stated, It's fairly new so we have not cleaned it, no one told us how to clean it. The administrative staff member also confirmed the facility lacked cleaning schedules/logs to document staff routinely cleaned the kitchen and kitchen equipment. During an interview on 09/30/25 at 8:14 p.m., an administrative staff member (#1) stated refrigerator temperatures should be between 32 and 40 degrees.

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	12/04/2025

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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on staff interviews and review of facility job description the facility administrator failed to report to and remain accountable to the governing body. Failure to develop a process and frequency by which the administrator reports to and communicates with the governing body may result in a lack of information necessary for management of the facility. Findings include:Review of the Rolette Community Care Center (RCCC) job description for the administrator occurred on 11/18/25. This unsigned job description, revised on 03/12/23, stated, Duties: As Administrator, Employee will devote his/her full time, energy and skill solely and exclusively to the performance of his/her duties here under and to the day-to-day operations of RCCC. Duties of Administrator include, but are not limited to supervision of staff and employee operations . implementing the board's wishes and directives; internal oversight and timely implementation of state and federal requirements . The expectation is that Administrator will work a minimum of 40 hours a week with regular schedule and work additional hours as needed to meet business needs and workload .On the morning of 11/18/25 an administrative staff member (#6) provided a form identifying the names and addresses of the two board members. The administrative staff member (#6) identified the facility is actively seeking more board members.During a phone interview on 11/18/25 at 2:34 p.m., the facility administrator (#14) stated, If they [Board Members] have any questions for me, they can call me. We meet every once in a while, but I'm not on every one of the meetings. If something needs to be brought to them, [Business Office Manager] or [Director of Nursing] will notify them. When asked who the members of the board were, the administrator replied, I'm not even sure at the moment. I believe there are three board members. When asked how frequently he is able to be present in the facility, the administrator stated, Just depends on if I'm needed then I try to make it, but it's sometimes a couple times a year.Refer to F689 and F868

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	12/04/2025

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of the Quality Assurance and Performance Improvement (QAPI) Team Member Attendance Forms and staff interviews, the facility failed to ensure required members of the QAPI Committee, attended 4 of 4 quarterly meetings (October 2024, 01/23/25, 04/24/25, and 07/24/25). Failure to have all required QAPI committee members attend and participate at QAPI meetings deprives the committee of each member's unique contribution for analysis of quality concerns and assisting with decision making based on identified concerns.Findings include:Review of QAPI team member attendance forms occurred on 09/30/25. The July 24, 2025, April 24, 2025, January 23, 2025, and October 2024 (no specific date identified on the form) failed to identify that all required QAPI team members attended the quarterly meetings. The attendance forms show three committee members attended in October 2024, five committee members attended on January 23, 2025, five committee members attended on April 24, 2025, and four committee members attended on July 24, 2025. The facility administrator failed to attend any of the above listed committee meetings.During an interview on 09/30/25 at 7:47 p.m. an administrative staff member (#5) confirmed the facility administrator is not a member of the QAPI committee and has not attended the QAPI committee meetings. The administrative staff member (#5) confirmed the current QAPI committee members are the Director of Nursing (DON) who is also the Infection Control Nurse, Business Office Manager, Minimum Data Set Registered Nurse (MDS, RN), environmental services staff member, Medical Director (MD), pharmacist, Registered Health Information Technician (RHIT) who is also the Social Services Designee (SSD) and Quality Assurance (QA) staff member.During an interview on 09/30/25 at 8:26 p.m. an administrative staff member (#6) confirmed he/she does not have a facility leadership title, and the facility administrator is not a member of the QAPI committee, however, the facility administrator attended one QAPI meeting via Zoom (live stream) but could not identify when.

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	12/04/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, review of facility policy, and staff interview, the facility failed to complete a self-administration of medication (SAM) assessment for 1 of 1 sampled resident (Resident #4) observed with medications at the bedside. Failure to determine a resident's capacity to safely self-administer medications may result in medication errors, adverse drug events, and/or harm to the resident. Findings include:Review of the facility policy titled Self-Administration of Medication's occurred on 01/14/26. This policy, dated February 2021, stated, . comprehensive assessment, interdisciplinary team (IDT) assesses each resident to determine whether self-administration of medications is safe and clinically appropriate for the resident. If deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and in the care plan. Review of Resident #4's medical record occurred on January 13-14, 2026. The record lacked a SAM assessment to determine whether self-administration of medications is safe and appropriate for this resident. Observation on 01/13/26 at 12:30 p.m. identified a clear plastic medication cup containing six pills on the resident's bedside table. During an interview on 01/13/26 at 12:30 p.m. Resident (#4) identified the pills as his/her 8:00 a.m. medications and they've been on the bedside table since this morning.Review of the resident's medications showed morning medications included: aspirin, Coreg (a heart medication), Metformin (a diabetic medication), folic acid, cyanocobalamin (vitamin B-12), and Colace.During an interview on the afternoon of 01/14/26 an administrative staff (#3) confirmed the facility failed to complete a SAM assessment.

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	12/04/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, the facility failed to promote privacy and confidentiality of the medication administration records for 1 of 2 days of survey. Failure to lock the electronic medication administration record (eMAR) may result in unauthorized viewing of confidential resident records by other residents, unlicensed staff, and visitors.Findings include:Review of facility policy titled Security of the Medication Cart occurred on 09/30/25. This policy, revised April 2007, stated, . electronic medication administration records (eMars) are kept locked when not in direct use.Observation on 09/30/25 at 5:46 p.m. showed a medication cart unattended in the living area with the (eMAR) opened to a resident's record for 26 minutes.During an interview on 09/30/25 at 8:30 p.m., an administrative nurse (#4) confirmed she expected nursing staff to lock the eMar at all times when the medication cart is unattended.

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	12/04/2025

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 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. 1.Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 2 of 12 sampled residents (Resident #12 and #14) reviewed for blood sugars and weights. Failure to follow physician's orders for out-of-range blood sugars and weight changes may result in adverse health events.2.Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 1 supplemental resident (Resident #3) observed for medications administration via enteral tube. Failure to properly administer medications via feeding tube may result in adverse health events and/or a clogged tube.Findings include: Base 1 Findings: Review of the facility policy titled Change in a Resident's Condition or Status occurred on 09/30/25. This policy, dated February 2021, stated, . The nurse will notify the resident's attending physician on call when there has been a (an): . specific instruction to notify the physician of change in the resident's condition. Review of Resident #12's medical record occurred on 09/30/25. Diagnoses included diabetes mellitus. A physician's order, dated 12/24/24, stated, Humalog insulin . per sliding scale . If Blood Sugar is greater than 450, call MD [Medical Doctor]. Review of Resident #12's blood sugars from August 16 through September 17th, 2025, showed the following: *08/16/25 at 7:32 p.m. 451 *09/14/25 at 5:45 p.m. 455 *09/17/25 at 11:56 a.m. 475 During an interview on 9/30/2025 at 9:13 p.m., an administrative nurse (#4) confirmed the medical record failed to show staff notified the provider of Resident #12's blood sugars greater than 450. -Review of Resident #14's medical record occurred on all days of survey. Diagnoses included chronic kidney disease with renal dialysis. A physician's order dated 09/16/25, stated, Wt [weight] check twice a week, call [provider] with increase or decrease of 4 lbs. [pounds] from base wt. [weight] 146Lbs [pounds] . Review of Resident #14's weights showed the following decreases from baseline: *09/19/25 138.5 lbs (7.5 lbs) *09/22/25 135 lbs (11 lbs) *09/24/25 140.5 lbs (5.5 lbs) *09/26/25 134 lbs (12 lbs) (continued on next page)

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	12/04/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*09/29/25 120.5 (26 lbs) On request on 9/30/2025 5:56 p.m., an administrative nurse (#4) confirmed the medical record failed to show staff notified the provider of Resident #14's weight changes greater or less than 4 lbs. Base 2 Findings include: Review of the facility policy titled, Administering Medications through an Enteral Tube [tube placed directly into the stomach or small intestine] occurred on 09/29/25. This policy, dated November 2018, stated, . The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Do not add medication directly to the enteral feeding tube . Dilute medication: Dilute crushed (powdered) medication with at least 30 ml [milliliters] purified water (or prescribed amount) . administer each medication separately . -Review of Resident #3 medical record occurred on all days of survey and identified an enteral tube. A physician's order, dated, 7/26/2015, stated, . crush medications . administer via PEG [type of gastrostomy tube] . Observation 09/29/25 at 1:06 p.m. showed a nurse (#9) crushed and placed a medication in a medicine cup with no water. The nurse poured the crushed medication into Resident #3's PEG tube without diluting in water, then poured water down the tube. During an interview on 09/30/25 at 9:00 p.m., an administrative nurse (#4) stated she expected staff to dilute crushed medications with water prior to administering Resident #3's medications through the PEG tube to prevent clogging.

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	12/04/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and resident interview, the facility failed to ensure 1 of 1 sampled resident (Resident #15) with contractures received the necessary hand devices. Failure to consistently place a carrot hand device or small towel roll to the resident's left hand may result in worsening of the contracture, pain, and skin breakdown. Findings Include:Review of Resident #15's medical record occurred on all days of survey. The care plan stated, The resident has hemiplegia [weakness or paralysis] of the L [left] UE [left upper extremity] . to maintain/improve UE ROM [range of motion] to prevent contractures. Recommend for the resident to use a carrot hand positioner or small towel roll for left hand.Observation occurred on all days of survey and showed Resident #15's left hand contracted in a gripped position with no rolled towel or carrot hand positioner in place and the carrot hand positioner on the resident's nightstand. During an interview on 09/30/2025 at 5:59 p.m., Resident #15 stated staff were not placing the carrot support or a rolled washcloth to his left hand and denied pain with placement and denied refusal of placement. Resident #15's medical record failed to show refusal of the carrot hand positioner or a rolled washcloth to the left hand.

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	12/04/2025

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 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. Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications, discard expired medications and label medications for 1 of 2 medication carts. Failure to securely store, label and discard expired medications may result in unauthorized access to medications, or residents receiving expired or incorrect medications.Findings include:Review of the facility policy titled Medication Labeling and Storage occurred on 09/29/25. 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. If the facility has discontinued, outdated . medications . the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .4. 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. Medication Labeling . 1. Labeling of medications . dispensed by the pharmacy . the medication label includes . medication name . prescribed dose . strength . expiration date . resident's name . route of administration . appropriate instructions . -Observation on 09/28/25 at 5:20 p.m., showed an unlocked/unattended medication cart in the main living area with medications on the top of the cart for 26 minutes. -Observation on 09/29/25 at 7:23 p.m. showed a medication cart with a glucagon syringe pen (for low blood sugar) with an expiration date of October 2024.-Observation on 09/30/25 at 7:30 p.m., showed three unlabeled Novolog (insulin) pens in the medication cart.During an interview on 09/30/25 at 9:00 p.m., an administrative nurse (#4) stated she expected staff to lock the medication cart, store all medications in the cart when the nurse is not within sight, discard expired medications, and label all resident medications.

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	12/04/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received food served in the appropriate consistency for 1 of 2 sampled residents (Resident #13) with an altered diet. Failure to serve liquids according to the physician's diet order may place residents at risk of inadequate nutrition, unplanned weight loss/gain, choking, aspiration, aspiration pneumonia, and worsening of medical conditions.Findings include: Review of the undated facility policy titled Tray Identification occurred on 09/29/25. This policy stated . To assist in setting up and serving the correct food trays/diets to residents, the Food Services Department will use appropriate identification (e.g, color coded or computer generated diet cards) to identify the various diets. The Food Services Manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. Nursing staff shall check each food tray for the correct diet before serving the residents. Review of Resident #13's medical record occurred on all days of survey. A physician's order dated 08/20/2024 identified pureed diabetic diet with honey thickened liquids. A nursing progress note, dated 09/01/25, stated, Recent decline in food [intake due] to coughing and trouble with swallowing. Review of Resident #11's meal card identified nectar thick liquids which differs from the physician's order for honey thickened liquids.During an interview on 09/30/2025 at 3:45 p.m., an administrative dietary staff #7 confirmed meal cards are to identify special diets and supplements and staff have no way to communicate changes with dietician.

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	12/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 12 sampled residents (Resident #22) and one supplemental resident (Resident #3) observed during cares. Failure to practice infection control standards related to hand hygiene and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: -Review of Resident #22's medical record occurred on 09/30/25 and identified EBP. A sign outside the door identified EBP and stated caregivers must, clean their hands, including before entering and when leaving the room and providers and staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities including . transferring . device care or use: central line . Observation on 09/30/25 at 10:00 a.m. showed two certified nurse aides (CNAs) (#11 and #12) transferred Resident #22 from the wheelchair to the bed without washing their hands and without wearing gloves and a gown. -Review of Resident #3's medical record occurred on 9/30/25. Diagnosis included dysphagia, and gastrostomy status (feeding tube). The current care plan stated, . the resident needs Enhanced Barrier Precautions related to an indwelling feeding tube . Observation on 09/29/25 at 1:30 p.m. showed a nurse (#9) entered Resident #3's room and administer a nutritional supplement through the feeding tube. The nurse touched the resident's feeding tube and other items in the room, removed her PPE (personal protective equipment) and left the room without performing hand hygiene. Observation on 9/29/25 at 1:45 p.m. showed a CNA (#10) applied a gown and gloves, entered Resident #3's room, provided incontinent cares, removed the soiled gloves and without performing hand hygiene, applied new gloves, and applied a protective barrier cream. After cares, the CNA (#10) removed the soiled gown and gloves and exited the room. The CNA failed to perform hand hygiene. During an interview on 09/30/25 at 9:20 p.m., an administrative nurse (#4) confirmed she expected staff to perform hand hygiene upon entering Resident #3's room, in between glove changes and when exiting the room.