| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355107 | A. Building<br>B. Wing | 04/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Rose Care Center | 315 1st St SE<br>Lamoure, ND 58458 |

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

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on staff interview, the facility failed to ensure 1 of 1 culinary services supervisor (#2) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure the facility had qualified dietary management to carry out the functions of food and nutrition services may result in foodborne illness to residents, staff, and visitors.Findings include:During an interview on the afternoon of 03/31/26, the culinary services supervisor (#2) stated she is currently enrolled in a certified dietary manager course but has not completed it.The facility failed to ensure the culinary services supervisor (#2) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food service management and safety from a national certifying body. |

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 |
|---|---|---|
| | | |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to discard spoiled and expired food in 1 of 1 kitchen. Failure to discard spoiled and expired food may affect the quality of the food and may result in foodborne illness to residents, staff, and visitors.Findings include:Review of the facility policy titled Food Storage - Perishable occurred on 04/01/26. This policy, dated August 2019, stated, . Sanitary procedures will be maintained in perishable food storage to keep foods safe, wholesome and appetizing; and to prevent contamination.Observation of the main kitchen occurred on 03/30/26 at 11:05 a.m. and showed the following:* One unopened packaged head of lettuce with visible browning and moisture* One container of cottage cheese with an expiration date of 03/10/26* One snack Jello with an expiration date of 01/26/26* Butter scotch baking chips with an expiration date of May 2025During an interview on 03/30/26 at 11:30 a.m., the culinary services supervisor (#2) confirmed she expected staff to discard the expired and spoiled food items. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to implement standard infection control practices for 1 of 9 sampled residents (Resident #3) observed during cares and 1 of 1 laundry room observed. Failure to practice infection control standards related to hand hygiene, and handling/transporting of soiled linen has the potential to spread infection throughout the facility. Findings include:<br><br>Review of facility policy titled Hand Hygiene occurred on 04/01/26. This policy, dated September 2023, stated, . Times to Perform Hand Hygiene are, but not limited to: . After contact with a resident's . body fluids or excretions . After removing gloves .<br><br>Review of facility policy titled Linen and Laundry occurred on 04/01/26. This policy, dated 05/15/24, stated, .Clean linen must always be kept separate from contaminated linen. A functional barrier must separate soiled and clean area.<br><br>- Observation on 03/30/26 at 1:59 p.m. showed Resident #3 in bed. Two certified nurse aides (CNA) (#3 and #4) applied gowns, gloves, and masks, and entered Resident #3's room. The CNA (#3) removed the resident's soiled brief, completed perineal care, and without removing the soiled gloves or completing hand hygiene, applied a clean brief and applied clean shorts to Resident #3.<br><br>During an interview on 04/01/26 at 1:05 p.m., an administrative nurse (#1) confirmed she expected staff to remove gloves and perform hand hygiene after coming into contact with excretions/body fluids.<br><br>- Observation of the laundry room on 04/01/26 at 9:42 a.m. showed an uncovered linen cart of clean linen next to the dryers. An unidentified staff member transported uncovered soiled linen past the clean linen and placed the soiled items in the washing machines.<br><br>The laundry staff failed to ensure the clean linen remained covered while transporting/handling soiled linen in the same area.<br><br>During an interview on 04/01/26 at 1:20 p.m., an administrative nurse (#1) acknowledged clean linen should be covered during the transport and handling of soiled linen in the same area. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 12 sampled residents (Resident #2 and #13). 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:The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30-32, stated, . Section A1500: Preadmission Screening and Resident Review (PASRR) . Coding Instructions . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . and continue to A1510 . Coding instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness .- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included schizophrenia, generalized anxiety disorder, and bi-polar disorder. A PASRR Level II, dated 08/08/2025, identified a serious mental health illness and no services required. The annual MDS dated [DATE], showed the facility failed to code Section A1500 and A1510 for serious mental illness.<br><br>- Review of Resident #13's medical record occurred on all days of survey. Diagnoses included anxiety disorder, mild intellectual disabilities, mixed obsessional thoughts and acts, and schizoaffective disorder. A comprehensive MDS, dated [DATE], showed the facility coded A1500 as yes and A1510A as yes indicating a serious mental illness. Notice of PASRR Level II Outcome, dated 09/12/25, stated, . this evaluation has determined that you have a PASRR condition . The facility should mark yes for question A1500 on the Minimum Data Set . The annual MDS, dated [DATE], showed the facility failed to code Section A1500 and A1510 for serious mental illness.<br><br>During an interview in the afternoon on 04/01/26 an administrative staff nurse (#1) confirmed the facility failed to accurately code Resident #2's and #13's MDS. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, record review, policy review, and staff interview, the facility failed to ensure compliance with provider orders for 1 of 1 sampled resident (Resident #33), observed with medications at the bedside. Failure to follow physician orders may result in medication errors and place the resident and/or others at risk for harm.Findings include: Review of the facility policy titled Self-Administration of Medications occurred on 04/01/26. This policy, dated 04/10/25, stated, . The nursing associates will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. If it is determined a resident cannot safely self-administer medications, the nursing associates will administer the medication. Review of Resident #33's medical record occurred on all days of survey. A Self-Administration of Medication assessment, dated 11/25/25, stated, . Does the resident want to self-administer medications . No. A physician's order, dated 11/25/24, stated, Medications: May give Whole, observe her take. Observation on 03/30/26 at 11:19 a.m. showed two medications in a medication cup on Resident #33's bedside table. The resident was unaware of what the medications were. During an interview on 04/01/26 at 1:14 p.m., an administrative nurse (#1) confirmed Resident #33 was assessed to not have medications left at bedside. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure accurate medication labeling to facilitate precautions and safe administration for 1 of 1 sampled resident (Resident #42) receiving intravenous (IV) medication. Failure to include the infusion rate and specific administration route on the medication label may result in inaccurate medication administration and placed the resident at risk for adverse outcomes. Findings include: Review of facility the policy titled Infusion Therapy Medication Administration occurred on 04/01/26. This undated policy stated, . Regulate flow of medication infusion as prescribed. Review of the pharmaceutical professional reference [NAME], Rocephin occurred 03/31/26. This reference stated, . Intravenous injection . For i.v. injection, Rocephin 1 g [gram] in 10 ml [milliliter], of sterile water for injections. The intravenous administration should be given over 2-4 minutes.Review of Resident #42's medical record occurred on all days of survey. A physician's order, dated 03/26/26, stated, Ceftriaxone [Rocephin] [antibiotic] recon soln [reconstituted solution]; 1 gram; . administer 2000mg via IV push once a day x [times] 13 doses. Add 19.2 mL [milliliters] SW [sterile water] diluent prior to administration. The medication label failed to include the administration route of IV push and the IV push rate.Observation on 03/30/2026 at 1:47 p.m. showed a nurse (#1) administered Ceftriaxone by IV push. When asked how long the medication is administered, the nurse (#1) stated, at least over five minutes. |