STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET , ROLETTE, North Dakota, 58366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 09/29/25 and concluded 09/30/25. During the complaint investigation, the facility was found in compliance with regulatory requirements. Based on the results of the recertification survey, an extended survey was conducted on 11/18/25.	F0000		12/31/2025
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.	F0583	Corrective Action: No residents were affected by this deficient practice. Identification of Others: All residents have the potential to have their privacy violated. System Changes: Policies on Confidentiality and HIPPA were reviewed and found to be accurate. Face to face education was given to the nurses and CMAs regarding HIPPA, confidentiality and closing of the computers when walking away from the medication/treatment carts on 10.1.2025. Monitoring: The DON or her designee will monitor to assure that the computers on the medication/treatment carts are minimized or turned off when the staff are not present. The audit will be done daily for 4 weeks, weekly for 4, monthly for 3. This will then be submitted to QAPI for further review or recommendation. Corrective Date: 12.31.2025	12/31/2025

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 reverse for further 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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F0583 SS = D	Continued from page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: 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.	F0583		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: 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	F0658	Corrective Action: These residents with orders of notifying physician of out of range vitals have been observed and have not been affected by this deficiency. The tube feeding medications are properly dissolved prior to administration. Identification of Others: All residents who have orders for vital signs that are to be reported for variances have the potential to be affected by this deficient practice. All medications need to be administered according to policy and procedures. System Changes: Policies were reviewed and found to be accurate. Face to face education was provided to nursing staff regarding taking blood pressures and weights and notifying the physician of out of range variances on 10.1.2025. Education was provided to the nursing staff and CMAs regarding proper medication administration on October 1, 2025. Monitoring: Audits on vital variances and medication administration by DON or her designee will be completed	12/31/2025

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F0658 SS = D	Continued from page 2 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:	F0658	Continued from page 2 daily for 4 weeks, weekly times 4, monthly 3 and then quarterly thereafter, until 100% compliance. All audits will then be taken to QAPI for further review and recommendations. Corrective Date: 12.31.2025	

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F0658 SS = D	Continued from page 3 *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) *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.	F0658		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F0688	Corrective Action: Resident #15 was re-evaluated by PT for his hand contracture and had his hand held device (carrot) changed to a hand palm guard for which he	12/31/2025

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F0688 SS = D	Continued from page 4 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: 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	F0688	Continued from page 4 likes better. Identification of Others: All residents with contractures or potential of developing contractures have the potential to be affected by this deficient practice. System Changes: Face to face education to all nursing staff regarding PT recommendations and the importance of applying devices to prevent worsening contractures and to follow up with proper documentation of their usage on 10.1.2025. Monitoring: Audits of application of the device will be completed by DON or her designee daily times 3 weeks, weekly times 4, monthly times 2. The completed audit will be submitted to QAPI for review and further recommendations. Corrective Date: 12.31.2025	

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F0688 SS = D	Continued from page 5 washcloth to the left hand.	F0688		
F0689 SS = SQC-K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 207 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	F0689	Corrective Action Affected residents the Maintenance staff adjusted water heater and recycle water heater controls to reduce temperature to below 110 F to be in compliance. Maintenance staff were educated on the regulation for safe water temps in resident rooms 2. Identification of others a. The facility has determined that all residents can be affected by the water temperature. 3. Systemic Changes Policy Reinforcement: Safe water temperature policy reviewed and updated. b. Education: Environmental Services Director, Business Manager, and DON educated staff on: Monitoring water temperatures. Reporting abnormal findings (too hot/cold, burns, redness). Proper documentation procedures c. Maintenance Protocol: Weekly checks of water heater controls and tap water temperatures in all circuits. d. Documentation: Maintain logs for 3 years in the maintenance 4. Monitoring and Quality Assurance Environmental Services Supervisor or Designee will monitor the water temperatures to ensure they are at the correct temperature range to be below 110 degrees. Week 1: Daily audits on 5 rooms per wing, alternating shifts/times.	12/31/2025

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F0689 SS = SQC-K	Continued from page 6 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 215 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: 207 137 rm: 208: 133	F0689	Continued from page 6 Weeks 2–3: Daily audits on 5 rooms per wing, alternating rooms and shifts. Continuous Weekly audits on 5 rooms per wing. b. QAPI Review: Audit results presented to QAPI for further recommendation5. Corrective Date: 12.31.2025	

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F0689 SS = SQC-K	Continued from page 7 Rm 213: 122 Rm: 214: 121 215: 126 At 6:20 observed Maintenance Mike entered utility room. Also observed unable to get hot water in multiple rooms down 200. (Rm 207/205) 6:25 pm Interview with Mike 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 Mike 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 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 follows" Rm 207: 120 6:37 pm	F0689		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	Corrective Action: No residents were affected by this deficient practice. Identification of Others: All residents who receive medications or treatments have the potential to be affected. System Changes: All policies for medication labeling and storage were reviewed and found to be accurate. Face to face education was given to the nurses and CMAs to ensure that all medication labels are accurate on 10/1/2025. Monitor: The DON or her designee will complete audits daily times 2 weeks, weekly times 4, monthly times 3. Completed audits will be submitted to QAPI for review and further recommendations. Corrective Date: 12.31.2025	12/31/2025

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F0761 SS = D	Continued from page 8 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, 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	F0761		

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F0761 SS = D	Continued from page 9 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.	F0761		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: 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	F0808	Corrective Action: Residents #13 and #11 had their diet cards corrected to what the physician had ordered. Identification of Others: All residents who have therapeutic diets have the potential to be affected this deficient practice. System Changes: All resident dietary cards were updated with the correct physician orders. Face to face education was given to nursing and dietary that all new dietary orders need to be given to the dietary department. Dietary is to communicate to the dietitian of dietary orders and to keep the dietary cards up to date. Monitoring: HIM or designee will be auditing the diet cards weekly times 4, monthly times 4, quarterly times 2. The audits will be submitted to QAPI for further review and recommendations. Corrective Date: 12.31.2025	12/31/2025

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F0808 SS = D	Continued from page 10 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.	F0808		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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	F0812	Corrective Action: Thorough cleaning was completed in the coolers, refrigerators, and shelves. All outdated food was disposed of. Identification of Others: All residents have the potential to be affected by this deficiency. System Changes: The process of first in, first out to ensure older products with earlier expiration dates are used before newer ones, minimizing waste and preventing spoilage in food services. Shelf cleaning in the dry good storage area will be completed weekly. In refrigerators and coolers, all opened and reusable containers will be dated and checked weekly to ensure containers remain clean. Face to face education was given to dietary staff in regards to food storage and monitoring for outdated products, and cleaning to ensure that the problem does not reoccur. Monitoring: BOM or her designee will audit the dietary department for their daily cleaning daily times 4 weeks, weekly times 4, monthly times 2, until 100% compliance. The other processes will be audited weekly times 4, monthly times 4 and quarterly 2 until 100% compliance. These will be then submitted to QAPI for review and further recommendations. Corrective Date: 12.31.2025	12/31/2025

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F0812 SS = E	Continued from page 11 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°C [degrees Celsius] (135°F [Fahrenheit]) or above. . . At 5°C (41°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	F0812		

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F0812 SS = E	Continued from page 12 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: * 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	F0812		

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F0812 SS = E	Continued from page 13 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.	F0812		
F0837 SS = E	Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f).	F0837	Corrective Action: Information from the survey was immediately given to the administrator via email. All Board Members will have the administrator's contact information. Identification of Others: The administrator will be available to answer questions or concerns from the governing body and/or the facility management team when necessary for the best outcome for the residents. System Changes: The Administrator will be attending the Board meetings in person or by Web-ex, or Phone if not able to attend in person monthly. An agenda will be made for the meeting for any business that needs attention prior. He will also attend the QAPI meetings in person or by Web-ex, or Phone if not able to attend in person monthly. The administrator will have contact by person, phone or email with the governing board members and facility team between meetings on a regular basis weekly. Monitoring: The HIM Director or her designee will audit the governing board meetings and QAPI meeting attendance monthly times 4. and then audits will be submitted to QAPI for review and further revisions to the plan if needed.	01/08/2026

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F0837 SS = E	Continued from page 14 This REQUIREMENT is NOT MET as evidenced by: 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	F0837	Continued from page 14 Corrective Date: 1.8.2026	
F0868 SS = E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	F0868	Corrective Action: Information was immediately given to the administrator of the survey findings. Identifying Others: All attendees will be present in	12/31/2025

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F0868 SS = E	Continued from page 15 §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: 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	F0868	Continued from page 15 person or via phone or zoom if possible. QAPI chairman was directed to schedule QAPI meeting monthly. System Changes: QAPI policy and procedures were reviewed and is accurate on proper members and frequency of meetings. Invites for QAPI meetings will be sent out 1 week prior to meeting. If the invite is not accepted, it will return to the chairman. It also states if the member is not able to attend in person, to contact the chairman to make arrangements for a phone conference or zoom meeting. The first new QAPI meeting was held with new members and administration. The QAPI meetings will be scheduled every month starting December 2025. Monitoring: The RHIT or designee will audit attendance to include proper members monthly times 4 and then submit to the QAPI for review and further recommendations. Corrective Date:12.31.2025	

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F0868 SS = E	Continued from page 16 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.	F0868		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	Corrective Action: Educated the staff who failed to perform proper hand hygiene and the use of PPE in EBP for residents #22 and #3. Identification of Others: All residents have the potential to be affected by this deficient practice. System Changes: Hand Hygiene, Infection Control, and PPE were all reviewed and found to be accurate. All nursing staff were educated face to face on infection control policy and procedures, paying particular attention to hand hygiene with applying PPE on	01/07/2026

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F0880 SS = D	Continued from page 17 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F0880	Continued from page 17 10.1.2025. The importance of integrating glove use along with routine hand hygiene being recognized as the best practice for preventing healthcare-associated infections was reviewed. Monitoring: DON or her designee will be auditing daily times 3 weeks, weekly times 4, monthly times 2, until 100% compliance. This will then be submitted to QAPI for review and further recommendations. Corrective Date: 1/7/2026	

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F0880 SS = D	Continued from page 18 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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	F0880		

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ROLETTE COMMUNITY CARE CENTER	804 STATE STREET , ROLETTE, North Dakota, 58366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 19 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.	F0880		