STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING 02 ROLETTE COMMUNITY CARE CENTER B. WING	03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 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
K 000	INITIAL COMMENTS This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 18 New Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (III) construction that was protected with an automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000	Preparation and submission of this plan does not constitute an admission or agreement by the Rolette Community Cre Center of the truth of the facts alleged and shall not be construed in any administrative or judicial form for the purpose of establishing liability of our facility, its board of directors, administration, employees, or representatives. This plan is our allegation of substantial compliance. Completion Date: 4/15/14	4/15/14
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. 18.2.2.2.4 Exception No 2. Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.	K 038	Secondary egress exit access lock on gate on southwest exit will be removed by April 15, 2014 in accordance with this standard. Magnetic lock removal will esure compliance with this standard. The lock will be removed by the Maintenance Supervisor at Rolette Community Care Center. Completion Date: 4/15/14	4/15/14

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

M Culver | CEO | 4/15/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING 02 - ROLETTE COMMUNITY CARE CENTER B. WING _____	03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 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
K 038	Continued From page 1 The facility failed to provide a path of egress to a public way with not more than one locking device in the path of egress. ~~Observation determined~~ the door exiting the southeast wing (one of six exits) had a magnetic lock installed on the door. The path of egress led outside to a fenced courtyard. The gate exiting the courtyard to a public way also had a magnetic device installed on the gate.	K 038	completed on page 1.	4/15/14
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Review of the facility's fire drill records determined the facility failed to conduct quarterly drills on each shift. Fire drill records could not verify the facility had conducted a fire drill on the following shifts: 1- First shift of the second quarter of 2013. 2- Third shift of the fourth quarter of 2013.	K 050	Fire drills will be conducted and documented on each shift quarterly. The Maintenance Supervisor will conduct the fire drills and document them according to this standard. A meeting was held on 4/1/2014, where a plan was implemented to better train maintenance staff on the monthly fire drills and documentation used to record data. All staff will continue to receive orientation and training on fire drills. Fire drill was conducted and documented on 3/21/2014. See attached documentation. Completion Date: 4/15/14	4/15/14
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052	The fire alarm system will be tested according to the manufacurers specifications. The Maintenance Supervisor will keep records and maintain the system is tested and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING 02 - ROLETTE COMMUNITY CARE CENTER B. WING _____	03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 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
K 052	Continued From page 2 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: The facility failed to ensure the fire alarm system was maintained, inspected and tested in accordance with the manufacturer's specifications. Review of the fire drill/fire alarm test records indicated the facility failed to document the monthly testing of fire alarm system communication with emergency forces during April, May, and December of 2013, and February 2014.	K 052	document accordingly with the requirements of NFPA 70 and 72. Testing of the system monthly and documentation of these tests in accurate form. SimplexGrinnell tested the Fire Alarm System on 12/20/2013. See attached report. Completion Date: 4/15/14	4/15/14
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A functional test must be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test must be conducted on every required battery-powered emergency lighting system for not less than 1 1/2-hours. Equipment must be fully operational for the duration of the test. Written records of visual inspection and tests must be kept by the owner for inspection. 7.9.3 The facility failed to assure maintenance and testing of emergency lighting.	K 130	The facility will assure tesing and main tenance of the emergency lighting. The Maintenance Supervisor will test, document and verify that each montly test to include 30-second monthly testing is complete on two (2) of two (2) battery pack emergency lights. Completion Date: 4/15/14	4/15/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING 02 - ROLETTE COMMUNITY CARE CENTER B. WING _____	03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 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
K 130	Continued From page 3 Review of records could not verify 30-second monthly tests were done on two (2) of two (2) battery pack emergency lights during January and February, 2014.	K 130	completed on page 3.	4/15/14