STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8084	A. BUILDING: 01 - GOOD SAMARITAN SOCIETY B. WING	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA PLACE - A PROSPERA COMMUNITY	316 VERSAILLES AVE BISMARCK, ND 58503

(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) COMPLETE DATE
K 000	INITIAL COMMENTS This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 33 Existing Residential Board and Care Occupancies (Large), in compliance with NDAC 33-03-24.2. The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type V (111) construction that was protected by an automatic sprinkler system designed to meet the requirements of NFPA 13R Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height. The building was separated from the nursing home by an occupancy separation wall having a two-hour fire resistance rating. The lower floor was basic care and the main floor was assisted living. The assisted living was surveyed in addition to the basic care due to the absence of a two-hour fire rated separation between the basic care and assisted living units. Resident evaluation determined a Prompt level of evacuation difficulty. The E-Score was 1.075.	K 000		
K 229	HAZARDOUS AREAS Hazardous areas, which shall include, but shall not be limited to, the following, shall be separated from other parts of the building by construction having a minimum 1-hour fire resistance rating, with communicating openings protected by approved self-closing fire doors, or such areas shall be equipped with automatic fire-extinguishing systems: (1) Boiler and heater rooms (2) Laundries (3) Repair shops	K 229	1) K 229-The corrective action accomplished related to hazardous areas equipped with self-closing doors is that on 4/23/18 self-closing hinges and self-latching hardware was ordered for all sixteen furnace room closet doors in the assisted living resident rooms. Hardware will be installed immediately upon receiving to insure these areas meet the state licensing rule. 2) Facility maintenance personnel inspected all other portions of the facility on 4/19/18 and found no other portions of the facility to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that maintenance staff has verified per inspection on 4/19/18 that all furnace rooms/spaces meet the self-closing/self-latching door standard. A furnace room door audit will be completed by 5/31/18 with results reviewed by the QAPI team at the monthly QAPI meeting. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Environmental Services Supervisor or designee to monitor by using audits that closets containing furnace units have self-closing doors and self-latching hardware installed to meet the state licensing rule. An audit will be done after installation of hardware by 5/31/18 with results reported to the QAPI team with corrective action implemented.	06-17-18

Health Resources Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Kalb	Administrator	5/11/2018

North Dakota Department of Health

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K 229	Continued From page 1 (4) Rooms or spaces used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction 33.3.3.2.2 This state licensing rule is not met as evidenced by: The facility failed to ensure hazardous areas in fully sprinklered buildings were equipped with self-closing doors. 33.3.3.2.2. Observation determined sixteen (16) of sixteen (16) Furnace Rooms (sprinklered hazardous areas) in resident rooms did not have self-closing doors with self-latching hardware. The closets in all Assisted Living Resident Rooms contained natural gas-fired heaters. The closets containing the furnace units had doors that were not self-closing. Failure to ensure self-closing doors to hazardous areas increases the risk or death or injury due to fire. This deficiency affected sixteen (16) of numerous hazardous areas in the facility.	K 229	1) K 244-The corrective action accomplished related to emergency egress and relocation drills conducted in accordance with state licensing rules is that facility personnel responsible for conducting fire drills have been instructed on 4/19/2018 in the proper policy and procedures for conducting fire drills which includes participation by all residents present in the building at the time of the drill. In addition, all residents have been informed by facility personnel that participation in all fire drills is required. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that all Basic Care employees including management and maintenance personnel have been educated on the policy/procedure for conducting fire drills which includes required participation of all residents present in the building at the time of the drills. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Environmental Services Supervisor or designee to monitor by using audits that all residents in the building at the time of each fire drill participated in the fire drills. Audits will be done quarterly x 1 year. Results will be reported to the QAPI team with corrective action implemented.	06-17-18
K 244	Emergency Egress and Relocation Drills Emergency Egress and Relocation Drills: Emergency egress and relocation drills shall be conducted in accordance with 33.7.3.1 through 33.7.3.6. 33.7.3	K 244		

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K 244	Continued From page 2 This state licensing rule is not met as evidenced by: Fire drills must be held monthly with a minimum of twelve drills per year, alternating with all work shifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill, including the escape path used and evidence of simulation of a call to the fire department. Each resident shall receive an individual fire drill walk-through within five days of admission. Any variation to compliance with the fire safety requirements must be approved in writing by the department. Residents of facilities meeting a greater level of fire safety must meet the fire drill requirements of that occupancy classification. 4.7.4, NDAC 33-03-24.2-08. The facility failed to conduct fire drills as required. Record review and interview of staff determined: 1) A minimum of four (4) residents from the Basic Care facility refused and did not participate in the monthly fire drill in twelve (12) of twelve (12) fire drills in the past year. 2) On 07/21/2017, no residents participated in the monthly fire drill. Failure to conduct fire drills as required increases	K 244		

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K 244	Continued From page 3 the risk of death or injury due to fire. The deficiency affected all required fire drills in the past year.	K 244		
K 309	SMOKE DETECTION AND ALARM All living areas, as defined in 3.3.21.5, and all corridors shall be provided with smoke detectors that comply with NFPA 72, National Fire Alarm and Signaling Code, and are arranged to initiate an alarm that is audible in all sleeping areas, as modified by 33.3.3.4.8.2 and 33.3.3.4.8.3. 33.3.3.4.8.1 This state licensing rule is not met as evidenced by: A manual fire alarm system shall be provided in accordance with Section 9.6. 33.2.3.4.1. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless if it is an approved existing installation, which shall be permitted to be continued in use. 9.6.1.3. The facility failed to install the smoke alarms in accordance with NFPA 70 and 72. In the absence of specific performance-based design criteria, smooth ceiling smoke detector spacing shall be a nominal 30 ft (9.1 m). NFPA	K 309	1) K 309-The corrective action accomplished related to the installation of a smoke detector near an area around a fireplace is that on 4/18/18 facility maintenance personnel contacted a licensed electrician and fire alarm company to install a smoke detector in the area around the lower level fireplace in accordance with NFPA 70 and 72. The installation was completed on 5/9/18. 2) Facility maintenance personnel inspected all other portions of the facility on 4/18/18 and found no other portions of the facility to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that maintenance staff has verified per inspection on 4/18/18 that all other portions of the facility have smoke detectors installed in accordance with NFPA 70 and 72. A smoke detector audit is completed on an annual basis with results reviewed by the QAPI team. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Environmental Services Supervisor or designee to monitor by using audits that smoke detectors are installed in the future to meet the NFPA 70 and 72 code of compliance for smoke detection. Audits will be done monthly x 1 month with results reported to the QAPI team by 5/31/18 with corrective action implemented.	06-17-18

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K 309	Continued From page 4 72: 17.7.3.2.3.1 Observation determined an area around the fireplace on the lower level was not protected by smoke detection. The nearest smoke detector was more than 15 feet from the wall near the fireplace. Failure to install smoke detectors in accordance with NFPA 70 and 72 increases the risk of injury or death due to fire. This deficiency affected one (1) smoke detector in the facility. The smoke detection system serves the entire facility.	K 309		