Received 10/16/2025

North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8027	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BORG PIONEER MEMORIAL HOME	61 BORG DR MOUNTAIN, ND 58262

(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 three-story unsprinklered building of Type II (111) construction. A one-story wood framed Chapel/Dining Room of Type V (000) construction was attached to the west side of the building. This addition had a dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. A one-story unsprinklered ambulance garage was attached to the Chapel/Dining Room and was separated with one-hour fire rated construction. The three-story building was separated from the addition by a two-hour fire wall with self-closing doors having a 1-1/2 hour fire resistance rating. Resident evaluation determined a Slow level of evacuation difficulty. The E-score was 2.65. Note: A Fire Safety Evaluation System (FSES) was completed for Tag K 0217 as a result of the 10/13/2025 Life Safety Code survey.	K 000		
K 217	SEPARATION SLEEPING RMS FROM EXIT ACCS Access shall be provided from every resident use area to not less than one means of egress that is separated from all other rooms or spaces by walls complying with 33.3.3.6.3 through 33.3.3.6.6.3, unless otherwise indicated in 33.3.3.6.1.1 through 33.3.3.6.1.3.	K 217		

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Suzanne Askpole TITLE: Administrator (X6) DATE: 10/16/25

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K 217	Continued From page 1 33.3.3.6.1 This State Licensing Rule is not met as evidenced by: Doors in walls separating sleeping rooms from corridors must be self-closing or automatic-closing. 33.3.3.6.6.1 The facility failed to ensure sleeping room doors would self-close to the latched position. Observation determined the sleeping room doors were not equipped with self-closing hardware. Failure to ensure doors to sleeping rooms are self-closing increases the risk of death or injury due to fire. This deficiency affected forty (40) of forty (40) sleeping rooms.	K 217	10/13/25 Waiver received from Kevin Drader.	
K2130	Other LSC Deficiencies Other Life Safety Code deficiencies: This State Licensing Rule is not met as evidenced by: Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. Any device, equipment,	K2130		

Joanne Ashpole, Administrator 10/16/25

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K2130	Continued From page 2 system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.3, 4.6.12.4 Testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests. (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.1 The facility failed to ensure the emergency lighting was in proper operating condition to provide 1½ hours of emergency illumination in the event of failure of normal lighting. Record review determined annual 1½ hour testing of the emergency battery back-up lights was not documented in the last 12 months. Failure to test and maintain the emergency lights in accordance with NFPA 101 increases the risk of death or injury due to fire.	K2130	**Plan of Correction – Emergency Lighting System Testing** **1. Corrective Action to Be Accomplished** All emergency battery backup lighting units throughout the facility will be tested for full 1½-hour functionality on or before **November 5th, 2025.** Any units that fail to maintain illumination for the required duration will be immediately replaced or repaired. Documentation of this testing will be completed and filed in the Life Safety maintenance binder. **2. Identification of Other Areas Potentially Affected** A complete audit of all emergency lighting systems, including corridors, common areas, dining, mechanical, and utility spaces, will be conducted to verify that all units are operational and included in the testing schedule. Any additional areas found to be noncompliant will be immediately replaced or repaired. Audit to be completed on or before **November 5th, 2025.** **3. Measures or Systemic Changes to Prevent Recurrence** • The Preventive Maintenance Log was updated to include monthly 30-second function checks and annual 1½-hour duration tests. • The Maintenance Supervisor will be responsible for ensuring all tests are performed and documented according to NFPA 101 standards. • A written policy and new checklist for emergency lighting inspection and testing has been added to the facility's Life Safety Management Plan- **completed 10/15/25.**	

Dyanne Adpote, administrator 10/12/25

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K2130	Continued From page 3 The deficiency affected all emergency battery back-up lights throughout the building.	K2130	• Staff training was completed to ensure understanding of documentation and compliance requirements for all emergency lighting systems. **Completed October 13, 2025** **4. Monitoring to Ensure Ongoing Compliance** • The Administrator will review the emergency lighting log monthly to verify testing and documentation are up to date- **ongoing.** • The annual 1 ½ hr test has been scheduled annually in October to ensure consistent compliance. • Findings will be reported to the administrator, and any deficiencies will be corrected immediately. **Log updated 10/15/25. 1 1/2hr test to be completed on or before November 5th, 2025.** **5. Completion Date** **All corrective actions will be completed by November 5th, 2025,** unless otherwise instructed by the Department.	

Dyanne Ashpole, Administrator