

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355123</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - BEHANY ON 42ND</b><br><br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/26/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHANY ON 42ND</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4255 30TH AVE S<br/>FARGO, ND 58104</b>                                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| K 000                                                      | <p><b>INITIAL COMMENTS</b></p> <p>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).</p> <p>The facility was located in a one-story building of Type II (000) construction and a two-story building of Type II (111) construction. Resident sleeping rooms were located on both floors of the two-story building. The one-story building was separated from the two-story building by a wall having a two-hour fire resistance rating. The buildings were protected throughout by an automatic fire sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>An apartment building was attached to the west side of the one-story building and was separated by an occupancy separation wall having a two-hour fire resistance rating.</p> <p><b>Note:</b></p> <p>At the conclusion of the 11/26/13 Life Safety Code survey, it was determined the facility was in compliance with the provisions of NFPA 101, Life Safety Code.</p> | K 000                                                                      |                                                                                                                          |  |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.