

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

PRINTED: 04/10/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355123		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BETHANY ON 42ND B. WING _____		(X3) DATE SURVEY COMPLETED 12/07/2017	
NAME OF PROVIDER OR SUPPLIER BETHANY ON 42ND				STREET ADDRESS, CITY, STATE, ZIP CODE 4255 30TH AVE S FARGO, ND 58104			
(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 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The facility was located in a two-story building of Type II (111) construction. Resident sleeping rooms were located on both floors of the two-story building. An adjacent one-story building of Type II (000) construction was separated from the two-story building with a fire barrier designed to have a two-hour fire resistance rating. The one-story building housed resident services to include a theater, beauty salon, administrative offices and a cafe. A partial basement was beneath this building. The buildings were protected throughout by a wet automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. Apartment buildings were attached to the west and north sides of the one-story building and were separated by occupancy separation walls having a two-hour fire resistance rating. Note: At the conclusion of the 12/06/2017 Life Safety Code survey, it was determined the facility was in compliance with the provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.			K 000			

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

TITLE

(X6) DATE

Electronically Signed

12/08/2017

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.

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