

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

PRINTED: 10/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2016	
NAME OF PROVIDER OR SUPPLIER MOUNTRAIL BETHEL HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 615 6TH ST SE STANLEY, ND 58784			
(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 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70(a). This facility was located in a one-story building with a partial basement. The building was of Type II (000) construction protected with a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems and smoke detection throughout the corridor system. Attached to the west was a one-story hospital which was included in this survey due to a lack of a two-hour fire resistant rated occupancy barrier. An addition built in 2013 was attached to the west side of the hospital and was surveyed under Chapter 18 New Health Care Occupancies. The following were attached to the facility and separated by occupancy separation walls having a two-hour fire resistance rating: 1) Attached to the nursing home to the north were Independent Living Apartments. 2) Attached to the hospital to the north was a one-story clinic. 3) Attached to the nursing home to the south was a pool wing Aquatic Center (south side). Note: Records review and survey of the facility determined the facility was in compliance with the minimum requirements of the 2000 Life Safety Code.			K 000			

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

TITLE

(X6) DATE

Electronically Signed

08/26/2016

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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