

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

PRINTED: 11/06/2023  
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>355044</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____            |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/07/2022</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOUNTRAIL BETHEL HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>615 6TH ST SE<br/>STANLEY, ND 58784</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 |
| E 000                                                            | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | E 000                                                                               |                                                                                                                          |                                                        |                            |
| K 000                                                            | <p>A recertification survey conducted on 12/07/2022 found Mountrail Bethel Home in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness.</p> <p>INITIAL COMMENTS</p> <p>This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 18-New Health Care Occupancies, 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).</p> <p>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 and dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems. A one-story addition of Type II (000) construction was attached to the east side of the building in 2019. The 2019 addition was surveyed using Chapter 18.</p> <p>The following were attached to the facility and separated by occupancy separation walls having a two-hour fire resistance rating:</p> <p>1) Attached to the north were Independent Living Apartments.</p> <p>2) Attached to the south was a pool wing Aquatic Center.</p> <p>3) Attached to the west was a one-story hospital.</p> <p>Note:</p> |                                                                            |  | K 000                                                                               |                                                                                                                          |                                                        |                            |

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

TITLE

(X6) DATE

Electronically Signed

12/08/2022

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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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOUNTRAIL BETHEL HOME</b> |                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>615 6TH ST SE</b><br><b>STANLEY, ND 58784</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                                                            | Continued From page 1<br><br>Observation and records review determined the facility to be in compliance with the minimum requirements of the 2012 Life Safety Code and NFPA 99, Health Care Facilities Code. | K 000                                                                      |                                                                                                                          |  |                                                        |