

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

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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>355102</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____ |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/17/2012</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NAPOLEON CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>311 E 4TH ST<br/>NAPOLEON, ND 58561</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                                                           | <b>INITIAL COMMENTS</b><br><br><p>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).</p> <p>The facility was located in a one-story building of Type V (000) construction. The building was protected throughout with a wet and dry automatic fire sprinkler system designed in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Attached to the facility was an assisted living unit. An occupancy separation wall having a two-hour fire resistance rating was constructed between the assisted living unit and the health care occupancy.</p> <p>Note:</p> <p>At the conclusion of the 07/17/12 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.