

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2014
NAME OF PROVIDER OR SUPPLIER SELAH CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 203 WEST NACHES AVENUE SELAH, WA 98942		
(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	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced Federal Fire and Life Safety re-certification survey conducted on December 17, 2014, at Selah Convalescent located at 203 W. Naches Avenue, Selah, Washington, by a representative of the Washington State Fire Marshal's Office. This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health Services (DSHS).</p> <p>The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care.</p> <p>The Long Term Care 39 bed facility, census of 39 was provided by the Maintenance Director and verified by the Medical Records Staff. The facility is a one story building consisting of construction type V- 1 hour, with 2 partial basements. One basement has kitchen facility only. The second basement has activities, laundry, mechanical, and staff lounge. The facility was built in 1953. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade have been provided with an all weather surface and lead to a public way.</p> <p>The facility is in substantial compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The Surveyor was: Maria C. Valladares Deputy State Fire Marshal Nursing Home Surveyor 28058</p> <p>The Surveyor was from:</p>	K 000		

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

TITLE

(X6) DATE

Carol J. [Signature]

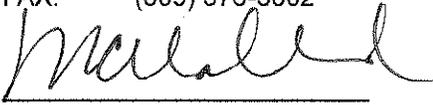
Admin

12/17/14

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.

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

Printed: 12/17/2014
FORM APPROVED
OMB NO. 0938-0391

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K 000	Continued From page 1 Washington State Patrol Fire Protection Bureau 2715 Rudkin Road Union Gap, WA. 98903-1795 Telephone: (509) 575-2190 FAX: (509) 576-3002  _____ Maria C. Valladares, DSFM 28058	K 000		