Printed: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	505361		**06/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	**917 7TH AVENUE** **LONGVIEW, WA 98632**

(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	K 000		

Surveyor: 29197
This report is the result of an unannounced Fire and Life Safety complaint survey conducted at Americana Health and Rehab Center on 6/22/2015 by a representative of the Washington State Patrol, Fire Protection Bureau.
Americana Health and Rehab Center has a total of 74 beds and at the time of this survey the census was 49.
The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70.
The facility is a one story structure of Type V(111) construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way.
The survey was conducted to clear the waivers for K144 remote stop switch and K46 emergency lighting. The facility had the items fixed on June 5, 2015.

The facility is in compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.

The surveyor was:

Dan Young
Deputy State Fire Marshal

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael [illegible]	Executive Director	6-22-15

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.