

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

Printed: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505496	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER AVALON CARE CENTER AT NORTHPOINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9827 NORTH NEVADA SPOKANE, WA 99218		
(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 Life Safety re-certification survey conducted at Avalon Care Center at Northpointe located at 9827 N. Nevada St, Spokane, WA on November 22, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Union Gap Detachment. 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 119 bed facility, census of 112 was provided by the Director of Nursing and verified by the Receptionist. The facility consists of a one story building construction type III (211) with a square footage of approximately 60,000 square feet. This 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:  Deputy State Fire Marshal Nursing Home Surveyor 28058</p> <p>The Surveyor was from: Washington State Patrol</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Mary Deen

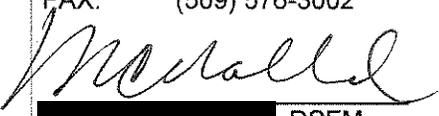
Administrative

11/22/13

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: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505496	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER AVALON CARE CENTER AT NORTHPOINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9827 NORTH NEVADA SPOKANE, WA 99218		
(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	Continued From page 1 2715 Rudkin Road Union Gap, WA. 98903-1795 Telephone: (509) 575-2190 FAX: (509) 576-3002  [REDACTED] DSFM 28058	K 000		