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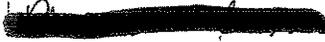
DEC 26 2013

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505496 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 FIRE PROTECTION BUREAU B. WING _____ | (X3) DATE SURVEY COMPLETED 12/18/2013 |
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| NAME OF PROVIDER OR SUPPLIER AVALON CARE CENTER AT NORTHPOINTE | STREET ADDRESS, CITY, STATE, ZIP CODE 9827 NORTH NEVADA SPOKANE, WA 99218 |
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| (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 |
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| K 000 | <p>INITIAL COMMENTS</p> <p>This is the report of a complaint investigation at Avalon Care Center at Northpoint located in Spokane, Washington.</p> <p>The complaint was self initiated by the Director of Nursing Services who reported to the Department of Social and Health Service's Complaint Resolution Unit. The complaint was received on 12-09-13 at approximately 1406 hours. The complaint was assigned an Intake ID number of 2921750.</p> <p>The reporter reported that a sprinkler on the wet pipe fire sprinkler system had activated in the dishwashing area of the main kitchen at approximately 1230 hours on 12-06-13. There were no injuries and the system was repaired on the same day and the system is operational.</p> <p>The investigation revealed that the probable cause of the sprinkler activation was due to the sprinkler head and piping being in close proximity to a cold air vent providing air into the kitchen area. Several days of single digit temperatures preceded the activation.</p> <p>The time of the incident was approximately 1215 hours and many residents were having lunch in the dining room. Interviews with staff indicated the the residents were secured in the dining room through the closing of doors and those enroute to the dining room were placed in rooms and doors closed.</p> <p>Staff responded in accordance with the emergency plan of the building.</p> <p>Sprinkler contractor was contacted and responded immediately and made repairs and the</p> | K 000 | | |
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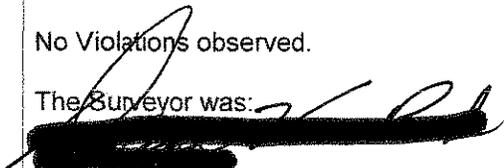
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|---|-------------------------------------|------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Admin Svcs Director | (X6) DATE 12-18-13 |
|---|-------------------------------------|------------------------------|

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

DEC 26 2013

Printed: 12/18/2013
FORM APPROVED
OMB NO. 0938-0391

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| 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 _____ | FIRE PROTECTION BUREAU | (X3) DATE SURVEY COMPLETED 12/18/2013 |
| 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 system was back in service approximately 2 hours after activation. No Violations observed. The Surveyor was:  Deputy State Fire Marshal Nursing Home Surveyor 15826 The Surveyor was from: Washington State Patrol Fire Protection Bureau 143302 East Law Lane Kennewick, WA. 993337-2011 Telephone: (509) 734-7029 FAX: (509) 734-7046 | K 000 | | | |