

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

SEP 06 2013

Printed: 04/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505331</b>	<p style="text-align: center;"><b>FIRE PROTECTION BUREAU</b></p> (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2013</b>
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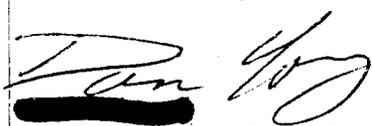
NAME OF PROVIDER OR SUPPLIER <b>VICTORY HEALTH &amp; REHAB OF BATTLE GRC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 NORTH PARKWAY BATTLE GROUND, WA 98604</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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** INITIAL COMMENTS

A Fire and Life Safety recertification survey was conducted at Victory Health and Rehabilitation by Deputy State Fire Marshal Dan J. Young on 4/8/13. The existing section on the 2000 Life Safety Code was used in accordance with 42CFR483.70. This is a one story facility of type 5 1-1-1 construction with a complete automatic sprinkler system and smoke detection interconnected to the fire alarm system in resident rooms and exit corridors. The census at time of the survey was 70 out of 76. The facility is not in compliance at this time.

The following are citations documented as a result of this survey:



Deputy State Fire Marshal  
29197

**K 012** NFPA 101 LIFE SAFETY CODE STANDARD  
**SS=F**

Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1

This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 0900 to 1300 on 4/8/13, the facility has failed to maintain penetrations through the ceiling. Ceilings that are not sealed properly to prevent the spread of smoke could result in smoke passing into the corridor or into rooms in the event of a fire. These findings were acknowledge by the Maintenance

**K 000**

Preparation and submission of this plan of correction by, Victory Health & Rehab of Battle Ground LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.

**K 012 F**

1. On 4/11/13 the penetration was sealed around the hood where it goes into the ceiling by the Maintenance Director and an outside contractor.

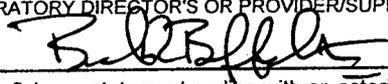
2. On 4/8/13 the Administrator and Maintenance Director completed rounds of the facility to ensure that there were no other concerns of unsealed ceiling penetrations in the facility; no other concerns were noted.

**K 012**

3. On 4/8/13 the Maintenance Director was re-educated on the requirements regarding having ceiling penetrations sealed by the Administrator.

4. Beginning the week of 4/16/13 The Maintenance Director will complete weekly rounds of the facility for 4 weeks and monthly for 2 months to ensure that there are not any ceiling penetrations in the facility. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee will review and determine if further interventions are needed at that time. The Maintenance Director will be responsible for monitoring and compliance.

Compliance date 4/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>4-17-13</b>
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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.

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K 012	Continued From page 1 Manager.  The findings include, but are not limited to:  The hood in the kitchen was observed to have an unsealed penetration.	K 012		
K 072 SS=B	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 0900 to 1300 on 4/8/13, the facility has failed to maintain corridors free of impediments to full instant use in the case of fire. Failure to maintain the corridors free of impediments could result in staff being unable to assist residents in the case of an emergency. These findings were acknowledged by the Maintenance Director.</p> <p>The findings include, but are not limited to:  A hoyer lift was observed to not move from its location in the 200 hall between 0907 and 0939.</p>	K 072	<p>K 072 B</p> <p>1. On 4/8/13 the Hoyer lift was moved during the survey and placed in a new location by the Maintenance Director to ensure that exits were not impeded.</p> <p>2. On 4/8/13 the Staff Development Coordinator (SDC), Maintenance Director, and Administrator made rounds of the facility to ensure that items in a hallway could be moved and are moved every half hour, no further concerns were noted.</p> <p>3. On 4/15/13 the facility staff were re-educated on having items that could impede an exit of the facility needing to be moved at least every half hour by the SDC.</p> <p>4. Beginning the week of 4/16/13, the SDC and Maintenance Director will conduct rounds weekly for 4 weeks and monthly for 2 months to ensure that items in hall are moved at least every half hour and do not impede exits. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee will review and determine if further interventions are needed at that time. The Maintenance Director and SDC will be responsible for monitoring.</p> <p>Compliance date 4/16/13</p>	