

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

Printed: 03/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2013</b>
--	---	---	---

**RECEIVED**  
JUN 25 2013  
FIRE PROTECTION BUREAU

NAME OF PROVIDER OR SUPPLIER <b>KINDRED TRANSITIONAL CARE &amp; REHAB CT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 BEACON HILL DRIVE LONGVIEW, WA 98632</b>
---	--

(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><b>INITIAL COMMENTS</b></p> <p>A Fire and Life Safety recertification survey was conducted at Kindred Transitional Care and Rehab Beacon Hill by Deputy State Fire Marshal Dan J. Young on March 14, 2013. The existing section of the 2000 Life Safety Code was used in accordance with 42CFR438.70. This is a facility that is split into three different levels on a hillside, each level has exits at ground level. The building is type 5 1-1-1 construction with a complete automatic sprinkler system. The first level is used for offices. The second and third levels are used to house residents. The first and second level have a smoke detection system in rooms and corridors interconnected to the automatic fire alarm system. The third level is the oldest portion of the nursing home and has smoke detection in the corridors interconnected to the automatic fire alarm system. The facility has a census of 58 out of 67 beds. The survey findings are as follows:</p> <p><i>Dan J. Young</i> Dan J. Young Deputy State Fire Marshal</p>	K 000	<p><i>This plan of correction is the center's credible allegation of compliance.</i></p> <p><b>DISCLAIMER STATEMENT:</b> "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."</p>	
K 066 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under</p>	K 066	<p>A) All staff will be re-educated on posted smoking areas and why they cannot smoke in non-designated areas.</p> <p>B) All staff will be re-educated on posted smoking areas and why they cannot smoke in non-designated areas.</p> <p>C) Maintenance Director or designee will walk the property to ensure that all no smoking signs are visible and look for evidence of compliance with this change.</p> <p>D) Maintenance Director or designee will do random walk throughs to check</p>	<p>12-Apr-13</p> <p>12-Apr-13</p> <p>12-Apr-13</p> <p>12-Apr-13</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <b>Executive Director</b>	(X6) DATE <b>3/20/13</b>
---	------------------------------------	-----------------------------

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: 03/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED

JUN 25 2013  
FIRE PROTECTION  
BUREAU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>KINDRED TRANSITIONAL CARE &amp; REHAB CT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 BEACON HILL DRIVE LONGVIEW, WA 98632</b>		
(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 066	Continued From page 1 direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 1100 to 1430 on 3/14/13, the facility has failed to maintain proper smoking areas. Areas used as a smoking area need to be provided ashtrays and metal containers with self-closing cover devices. Areas that are not provided with the required materials could result in the area becoming ignited and spreading to the facility. These findings were acknowledged by the Director of Maintenance and the Administrator.  The findings include, but are not limited to:  1. Employees were observed to be smoking in the trees located by the lower parking lot. The area observed had cigarettes laying in the bark dust.	K 066	<i>This plan of correction is the center's credible allegation of compliance.</i>  <b>DISCLAIMER STATEMENT:</b> "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."  K066 Con't.  D) compliance and report any person who is not compliant with the designated smoking area and educate them to the designated area.	12-Apr-13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147  A) The extension cord has been removed and power strips will be removed from resident rooms 312, 314, 316 and 318	12-Apr-13

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505294</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	JUN 25 2013 FIRE PROTECTION BUREAU	(X3) DATE SURVEY COMPLETED  <b>03/14/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>KINDRED TRANSITIONAL CARE &amp; REHAB CT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 BEACON HILL DRIVE LONGVIEW, WA 98632</b>		
(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 147	Continued From page 2  This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 1100 to 1430 on 3/14/13, the facility has failed to maintain the electrical system. Use of power strips and extension cords could result in the failure of the electrical system which could result in smoke passing into the corridor and resident rooms. These findings were acknowledged by the Director of Maintenance and Administrator.  The findings include, but are not limited to:  1. The facility was observed to be using power strips thru out the facility in resident rooms. Rooms 312, 314, 316 and 318.  2. An extension cord was observed to be in use in the administrators office.	K 147	<u>DISCLAIMER STATEMENT:</u> "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."  K147 - Con't.  B) All other power strips will be removed from all other resident rooms. C) Facility will have an electrician check to make sure surface raceway and moving of receptacles will not overload current system. Facility will use direct plug over current protectors in lieu of power strips. D) Maintenance Supervisor or designee will do random room audits to ensure that no power strips are being used.	12-Apr-13  12-Apr-13  12-Apr-13	