

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

Printed: 06/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505415	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER TEKOA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 330 NORTH MADISON TEKOA, WA 99033		
(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 the result of an unannounced Fire and Life Safety re-certification survey conducted at Tekoa Care Center in Tekoa, Washington on 6/23/2015 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Social and Health Services (DSHS) health survey teams. During the physical tour of the facility I was accompanied by the Facility Maintenance Director who witnessed any deficiency noted during this survey.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. The facility is one story of type V-A construction with exits to grade and is protected by a Type 13 sprinkler system and an Automatic / Manual Fire Alarm System with corridor smoke detection. The facility has installed single station smoke alarms in all resident rooms. The facility is licensed for 65 residents. The current census is 46 residents.</p> <p>The facility is in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:</p> <p>David Rogers Deputy State Fire Marshal Nursing Home Surveyor 32863</p> <p>The surveyor was from: Washington State Patrol Office of the State Fire Marshal Fire Protection Bureau</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

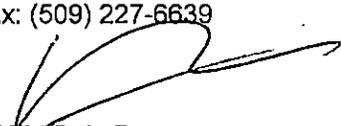
TITLE

(X6) DATE

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 000	Continued From page 1 PO Box 19130 Spokane WA 99219-9130 Telephone: (509) 954-2746 Fax: (509) 227-6639  DSFM D.A. Rogers	K 000		