

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2015
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NAME OF PROVIDER OR SUPPLIER FORT VANCOUVER CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8507 NORTHEAST 8TH WAY VANCOUVER, WA 98664
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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
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Fort Vancouver Convalescent Center on 07/06/15, 07/07/15, 07/08/15, and 07/09/15. A sample of 21 residents was selected from a census of 41. The sample included 16 current residents and the records of 5 former and/or discharged residents.</p> <p>The following complaint was investigated as part of this survey: #3119887</p> <p>The survey was conducted by: Sonya Conway, MSW Erika Hurley, MS, CPG Rebecca Kane, RN, MN</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3, Unit C P.O. Box 45819 Olympia, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451</p> <p>DEFICIENCY FREE SURVEY--Fort Vancouver Convalescent Center IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR Part 483, Subpart B, REQUIREMENTS FOR LONG TERM CARE FACILITIES.</p> <p>Residential Care Services _____ Date</p>	F 000		

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



**Residential Care Services
Investigation Summary Report**

Provider/Facility: FORT VANCOUVER CONVALESCENT CENTER (689580) **Intake ID(s):** 3119887

License/Cert. #: NH1278

Investigator: Conway, Sonya

Region/Unit: RCS Region 3/Unit D

Investigation Date(s): 07/08/2015 through 07/08/2015

Complainant Contact Date(s):

Allegations:

- 08 - Admission, Transfer, Discharge
- 11 - Quality of Care/Treatment

Resident is not being discharged until condition stabilize and care is being provided.

Investigation Methods:

Sample: 1 of 3 reviewed during annual survey

Observations: observations were made of care being provided.

Interviews: interview with DNS regarding this resident
interview with SSD regarding discharges

Record Reviews: record review of the residents progress notes and care plan

Allegation Summary:

Resident was not discharged due to ongoing required care and treatment needs. Resident will not be discharged at this time. Care for foot infection and c-dif are being met.

Unalleged Violation(s): Yes No

Conclusion: Failed Provider Practice Identified Failed Provider Practice Not Identified

Action: Citation(s) Written No Citation Written



**Residential Care Services
Investigation Summary Report**

RCPP Action: **Recommend Finding**

Recommend Close Investigation