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

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PRINTED: 09/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	50A174		09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORKS COMMUNITY HOSPITAL, LTCU	530 BOGACHIEL WAY FORKS, WA 98331

(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	INITIAL COMMENTS This report is the result of an unannounced Quality Indicator Survey conducted at Forks Community Hospital Long Term Care Unit on 09/03/13, 09/04/13, and 09/05/13. A sample of 15 residents was selected from a census of 20. The sample included 15 current residents. The survey was conducted by: [redacted] MSW [redacted] RN, BSN The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 3, Unit D P.O. Box 45819 Tumwater, Washington 98504-5819 Telephone: 360.664.8429 Fax: 360.664.8451 DEFICIENCY FREE SURVEY--Forks Community Hospital Long Term Care Unit IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR 483 Subpart B, REQUIREMENTS FOR LONG TERM CARE FACILITIES. Joan N. Pierce 9-10-11 Residential Care Services Date	F 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	50A174	B. WING _____	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORKS COMMUNITY HOSPITAL, LTCU	530 BOGACHIEL WAY FORKS, WA 98331

(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	INITIAL COMMENTS An unannounced Life Safety Code Survey was conducted at Forks Community Hospital, LTC, Forks, Washington, on September 4, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Oak Harbor Detachment. The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care. The LTC 20 bed facility with a census of 20, consisted of a V-111, 1 story structure, constructed in 1993 and has no basement. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and have an all weather surface and lead to a public way. A Federal Life Safety Survey was conducted September 4, 2013. The Maintenance Director accompanied the Deputy State Fire Marshal throughout the facility tour and paperwork verification from 8:30 AM to 11:00 AM. While conducting the survey on September 4, 2013, no deficiencies were found. The facility is in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S. [redacted] Paul V. Schow Deputy State Fire Marshal	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen J. Kellen	Director of Nursing	9-4-13

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.