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

Printed: 01/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505412	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLVILLE TRIBAL CONVALESCENT C	PO BOX 150 NESPELEM, WA 99155

(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 This report is a result of an unannounced Federal Life Safety Complaint - Waiver Inspection conducted at Colville Tribal Convalescent Center, 25 Convalescent Center Blvd, Nespelem, WA on December 29, 2014 by staff from the Washington State Patrol, Fire Protection Bureau, Union Gap Detachment. This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health Services (DSHS). 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 facility was issued a waiver approval for K144 - Generators, RCS Complaint ID #3057331. Inspection today revealed that the facility has met all the conditions of the waiver. No further inspections are required for this waiver. The facility is in substantial compliance with the Life Safety Code 2000 Edition as adopted by C.M.S. The Surveyor was: Maria C. Valladares Deputy State Fire Marshal Nursing Home Surveyor 28058 The Surveyor was from: Washington State Patrol Fire Protection Bureau 2715 Rudkin Road	K 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shoshanah E. Jordan	Nursing Home Administrator	12/29/2014

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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NAME OF PROVIDER OR SUPPLIER COLVILLE TRIBAL CONVALESCENT C	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 150 NESPELEM, WA 99155		

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K 000	Continued From page 1 Union Gap, WA 9803-1795 Telephone: (509) 575-2190 FAX: (509) 576-3002	K 000		

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