

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

PRINTED: 03/19/2013
FORM APPROVED
OMB NO. 0938-0391

858

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505459	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NISQUALLY VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 370 MCKENNA, WA 98558
---	---

(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>Surveyor: 19192 On March 19, 2013 an unannounced fire and life safety code re-certification survey was conducted at Nisqually Valley Care Center located at 9414 357 th st S McKenna WA, 98558 by a representative of the Washington State Patrol, State Fire Marshal's Office. This survey was conducted using the existing section of the 2000 life safety code in accordance with 42 CFR 483.70.</p> <p>This facility is a two story type V-A structure with exiting from the upper floors through exterior stair cases and direct to grade from the first floor. The building is protected throughout by a full NFPA 13 fire sprinkler system and an automatic smoke detection system.</p> <p>The licensed capacity is 63 with a census today of 42.</p> <p>Following are the deficiencies cited as a result of this survey:</p> <p><i>Donald West</i> Deputy State Fire Marshal</p> <p>K 040 NFPA 101 LIFE SAFETY CODE STANDARD SS=E Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5</p> <p>This Standard is not met as evidenced by:</p>	K 000	<p>RECEIVED APR 03 2013 FIRE PROTECTION BUREAU</p> <p>This plan of correction is being submitted in accordance with specific regulatory requirements. It shall not be construed as an admission of any deficiency cited.</p> <p>K040</p> <p>The facility has completed the FSES. And will review FSES on routine basis. Findings will be forwarded to QA.</p> <p>Administrator will be responsible for compliance.</p> <p>Donald West approved FSES.</p> <p>Completion Date: April 17, 2013</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donald West</i>	TITLE Administrator	(X6) DATE 3/28/2013
---	-------------------------------	-------------------------------

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

RECEIVED FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505459	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING FIRE PROTECTION BUREAU	APR 03 2013 (X3) DATE SURVEY COMPLETED 03/19/2013
--	---	---	--

NAME OF PROVIDER OR SUPPLIER MISSQUALLY VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 370 MCKENNA, WA 98558
--	---

(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 144	Continued From page 2 survey by the facility maintenance director and the Administrator. The finding was: 1. There is no remote annunciator panel or derangement signal at a normally attended location.	K 144		
K 147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on March 19, 2013 from 0830 to 1130 it was observed that the facility failed to maintain the facility free of the use of power strip devices, this has the potential for the circuits to be over loaded, this finding was acknowledged at the time of the survey by the facility maintenance director and the Administrator. The finding was:</p> <p>1. In resident rooms throughout the facility there are power strip devices operating a variety of electronic appliances.</p>	K 147	<p>K147</p> <p>Electrical strips will be removed from residents room.</p> <p>Maintenance Director will complete monthly check and results will be forwarded to QA.</p> <p>Maintenance Director will be responsible for compliance.</p> <p>Completion Date: April 17, 2013</p>	