

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER LAKELAND VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE S 2320 SALNAVE RD. PO BOX 200 MEDICAL LAKE, WA 99022
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K 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Fire and Life Safety Re-certification Survey conducted at Lakeland Village on the ICF/IID Cottages by a representative of the Washington State Patrol Office of the State Fire Marshal. The inspection was conducted on January 27, 2015 in cooperation with the Washington State Department of Social and Health Services (DSHS).</p> <p>The existing section of the 2000 Edition of the Life Safety code Chapter 33 was used in accordance with 42 CFR 483.70.</p> <p>Lakeland Village is owned and operated by the State of Washington Department of Social and Health Services. This Survey report is for the ICF/IID Cottages only and surveyed under the Residential Board and Care Section (Chapter 33-Small) of the Life Safety Code. A total of 9 Cottages located on the South and North portions of the Campus. The Cottages (4) located on the South Campus are protected by a Type 13 Automatic Fire Sprinkler System and the Cottages (5) on the North Campus are protected by a Type 13R Automatic Fire Sprinkler System. All cottages are of a Type V Non-rated Construction with Automatic/Manual Fire Alarm System.</p> <p>This Survey was conducted based upon an Evacuation Score (E-Score) of Impractical. During the Physical Tour and Documentation Review we were accompanied by the Facility Safety Officer who observed any deficiency noted during this Survey.</p> <p>The facility is not in substantial compliance with the Life Safety Code 2000 Edition as adopted by</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Superintendent</i>	(X6) DATE <i>02-06-15</i>
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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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 1 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 Union Gap, WA. 98903-1795 Telephone: (509) 575-2190 FAX: (509) 576-3002  Maria C. Valladares, DSFM 28058	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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K 018	<p>Continued From page 2</p> <p>This Standard is not met as evidenced by: The facility has failed to maintain doors without impediments to their closing and latching. This could result in a delay in getting the door to the room closed in the event of a fire. This could result in toxic products of combustion getting into the room and into the exit corridor which would endanger the residents, staff and/or visitors within the smoke compartment.</p> <p>The findings include, but are not limited to: Based upon observations and staff interviews on January 27, 2015 between the hours of 0930 and 1530 fire/smoke doors were found to have the following deficiencies:</p> <ol style="list-style-type: none"> 1. Dutch fire doors in Hillside were observed to have an excessive gap. 2. The smoke doors in Hillside on 73 side has broken glass. 3. Bigfoot fire dutch door was observed to have once been a solid door that was cut in half to create a dutch door. Cutting the door in half destroyed the fire rating of the door. 4. Apple fire dutch door was observed to have once been a solid door that was cut in half to create a dutch door. Cutting the door in half destroyed the fire rating of the door. <p>The above was discussed and acknowledged by the Safety Officer.</p>	K 018	<p>K018 Facility will ensure that all Dutch Doors upper and lower leaf edges are in compliance with all required Fire Safety Rating mechanisms. Meeting edges of upper and lower leaves will be equipped with an astragal. New Dutch Doors have been order to replace defective units. Broken glass pane will be replace</p> <p>Facility has submitted work orders to replace/repair the Dutch Doors and fire barrier door:</p> <ul style="list-style-type: none"> -Hillside Cottage Rm# 118 -Bigfoot Cottage Rm# 114/115 -Apple Cottage Rm# 114/115 -Hillside Cottage Hallway# 126 <p>Completion dates for deficiencies: March 4, 2015</p> <p>Upon discovery of deficiencies; work request have been submitted for repair. Compliance for cited deficiencies will be examined via Quarterly Safety Inspections, Cottage Environment Self Audit, and random no-notice Safety spot inspections.</p>	
K 021	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by</p>	K 021		

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K 021	Continued From page 3 devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This Standard is not met as evidenced by: The facility has failed to maintain vertical openings with a construction having a fire resistive rating of at least one hour. This could result in the passage of toxic products of combustion from one floor to another which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Based upon observations and staff interviews on January 27, 2015 between the hours of 0930 and 1530 we observed a vertical opening in the following location: At the Evergreen Cottage we observed that the access panel to the attic was in the open position. Interview with staff revealed that this door opens randomly. The above was discussed and acknowledged by the Safety Officer.	K 021	K021 Facility will ensure that there are no obstructions which inhibit the proper closure of doors and that any missing mechanism is repaired or replaced. Furthermore, the facility will ensure the proper closure of these doors to provide protection to the facility and said doors are provided with a method suitable for ensuring proper closure and latching capability. Facility has submitted a work order that will repair and adjust the access panel door for proper closure and latching: -Evergreen Cottage Room# 116 Completion dates for deficiencies: March 4, 2015 Upon discovery of improper function; work request have been submitted for repair. Compliance for cited deficiencies will be examined via Quarterly Safety Inspections, Cottage Environment Self Audit, and random no-notice Safety spot inspections.	
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is	K 046		

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K 046	Continued From page 4 provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: The facility has failed to maintain records of testing for the emergency battery backup lighting. This could result in the failure of the battery powered backup lighting in the event of a power outage and render the means of egress dark. This could result in tripping and fall injuries to residents, staff and/or visitors. The findings include, but are not limited to: Based upon observations and staff interviews on January 27, 2014 between the hours of 0930 to 1530, I observed emergency lighting deficiencies in the following locations: 1. Hillside Cottage south exit lights on 64 side did not work when tested. 2. During document review and staff interviews revealed that the facility has failed to conducted monthly 30 second tests and annual 90 minute testing of the emergency lighting batteries. The above was discussed and acknowledged by the Safety Officer.	K 046	K046 Facility will verify that all Emergency Egress lights properly function as designed. Facility has submitted a work order to have the light repaired and tested In Accordance With (IAW) NFPA code requirements. -Hillside Cottage Emergency Egress Light Hallway# 126 Completion dates for deficiencies: March 4, 2015 Compliance for properly functioning Emergency Egress Lighting System is maintained by Consolidated Support Services / Electrical Shop IAW NFPA code requirements. The section has been briefed to provide more detailed documented information. Any discrepancies are identified during testing and corrected by this section.	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056		

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K 056	Continued From page 5 switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: The facility has failed to provide fire sprinkler protection to all required areas of the facility. This could result in a fire not being contained to the area of origin and could endanger residents, staff and/or visitors. The findings include, but are not limited to: Based upon observations and staff interviews on January 27, 2015 between the hours of 0930 and 1530, we observed automatic sprinkler deficiencies in the following locations: 1. Apple Cottage was observed to have a sprinkler head obstruction created by lattice in the ACM office. 2. Document review of the facility's automatic sprinkler servicing reports revealed that deficiencies were noted by the sprinkler company and no evidence was provided that these deficiencies were corrected. The above was discussed and acknowledged by the Safety Officer.	K 056	K56 Facility will verify that there are no obstructions to the proper function and flow pattern of all automatic sprinkler systems Facility has submitted a work order that will remove the obstruction: -Apple Cottage ACM Office Room# 102 Completion dates for deficiencies: March 4, 2015 Compliance for properly functioning Automatic Sprinkler System is maintained by Consolidated Support Services / Plumbing Shop IAW NFPA code requirements. The section has been briefed to provide more detailed documented information. Any discrepancies are identified during testing and corrected by this section.	
K 211	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to	K 211		

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K 211	<p>Continued From page 6 an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>This Standard is not met as evidenced by: The facility has failed to properly install alcohol based hand sanitizer (ABHS) dispensers. Dispensers installed improperly could result in hand rub coming in contact with an electrical source resulting in a fire causing potential endanger to residents, staff and/or visitors within the facility. The findings include, but are not limited to: Based upon observations and staff interviews on January 27, 2015 between the hours of 0930 and 1530, we observed ABHS too close to electrical units in the following locations: 1. Apple Cottage was observed to have ABHS dripline over an electrical switch in the ACM office. 2. In the hallway by sink the ABHS was too close to an electrical switch on the 83 side. The above was discussed and acknowledged by the Safety Officer.</p>	K 211	<p>K211 Facility will verify that there is no Alcohol Based Hand Rub (ABHR) dispensers installed over or directly adjacent to an ignition source</p> <p>Facility had Housekeeping remove and relocate the ABHR dispensers IAW NFPA code requirements: -Apple Cottage ACM Office Room# 102 -Sunrise 82/83 Cottage Room# 115A</p> <p>Completion dates for deficiencies: February 3, 2015</p>	