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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505395	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2013
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NAME OF PROVIDER OR SUPPLIER STAFHOLT GOOD SAMARITAN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 456 C STREET BLAINE, WA 98230
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K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Life Safety Code Survey was conducted at Stafholt Good Samaritan Center, Blaine, Washington, on October 29, 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.</p> <p>The LTC 57 bed facility with a census of 56, consisted of a Type V-111, 1 story structure, built in 1991 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.</p> <p>The deficiencies identified during this survey are listed below.</p> <p>The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p> Deputy State Fire Marshal</p>	K 000		
K 012 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the integrity of smoke barriers. This potentially allows the spread of</p>	K 012		

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.

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K 012	Continued From page 1 smoke to other areas of the facility, exposing residents to a smoke or fire environment. The findings are as follows. During the facility tour on October 29, 2013 from 9:45 AM to 3:00 PM penetrations were observed in the following location(s) 1. Around sprinkler head in storage room 8 - east hallway 2. Around sprinkler head in maintenance directors office These findings were acknowledged by the Maintenance Director.	K 012		
K 018 SS=D	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: Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment. Findings include:</p> <p>During the facility tour on October 29, 2013 from 9:45 AM to 3:00 PM it was observed that the following doors did not close, latch or open properly when tested:</p> <ol style="list-style-type: none"> 1. Activity Room double doors - decorations hanging from closure assemblies 2. Activity Room double doors - failed to latch when tested 3. Activity Room single door - failed to latch properly due to sticky door handle <p>These findings were acknowledged by the facility Maintenance Director.</p>	K 018		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observations and staff interview, the</p>	K 029		

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K 029	Continued From page 3 facility failed to provide functional fire doors in a hazardous area. This has the potential to expose residents to a fire or smoke environment. The findings are as follows: During the facility tour on October 29, 2013 from 9:45 AM to 3:00 PM the linen storage room hallway door in the maintenance corridor had been damaged and is delaminating These findings were acknowledged by the Maintenance Director.	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review, the facility failed to assure that the LTC staff was adequately trained to respond to fires. This potentially exposed residents to smoke and fire in the facility. Findings include: An examination of the facility ' s fire drill records on October 29, 2013 at 12:50 PM revealed that the fire drill for calendar year 2013, 2nd quarter, 2nd shift had not been completed. These findings were acknowledged by the	K 050		

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K 050	Continued From page 4 Maintenance Director.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observations, the facility failed to maintain the proper operational condition of the sprinkler system. This has the potential of having a non-functional sprinkler system that would expose residents to a fire or smoke environment. The findings are as follows: During the facility tour on October 29, 2013 from 9:45 AM to 3:00 PM, the following deficiencies were found: 1. The following sprinkler heads flow pattern was obstructed due to light fixtures being within 12 inches of the deflector plate: a. east wing clean utility b. director of nursing office c. west wing dining room d. kitchen dishwashing area e. sprinkler riser/mechanical room f. central supply g. maintenance directors office These findings were acknowledged by the Maintenance Director.	K 062		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in	K 070		

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K 070	Continued From page 5 non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This Standard is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper heating conditions. This potentially allows for the spread of fire through mismanagement of equipment or the possibility for harm to a resident. The findings are as follows. During the facility tour on October 29, 2013 from 9:45 AM to 3:00 PM portable space heating devices were observed in the following location(s) 1. In the Activity Room used by residents These findings were acknowledged by the Maintenance Director.	K 070		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observations, the facility did not have Carbon Monoxide Detectors installed in the building in accordance with NFPA Standard 720 2012 edition. This has the potential of having a leak with no detection that would expose residents, visitors and staff to a hazardous environment. The findings are as follows: During the facility tour on October 29, 2013 from	K 130		

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K 130	Continued From page 6 9:45 AM to 3:00 PM the following deficiencies were found: 1. No CO detector coverage in the South Hallway 2. No CO detector coverage in the East Hallway 3. No CO detector coverage in West Wing Hallway 4. No CO detector coverage in kitchen 5. No CO detector coverage in the laundry room These findings were acknowledged by the Maintenance Director.	K 130		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observations, the facility failed to maintain proper electrical conditions per NFPA 70, National Electrical Code. This has the potential to expose staff and patients to a fire environment. The findings are as follows: During the facility tour on October 29, 2013 from 9:45 AM to 3 PM the following deficiencies were found: 1. Conference Room - multi plug adapter plugged into multi plug adapter at TV stand 2. Conference Room - multi plug adapter hanging by cord 3. Infection Control Office - portable heater plugged into multi plug adapter 4. Activity Room - portable heating device plugged into multi plug adapter 5. DNS Office - portable heater plugged into multi plug adapter	K 147		

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K 147	Continued From page 7 6. West Wing Dining Room - hand sanitizer located above electrical source 7. Kitchen - multi plug adapter hanging by cord 8. Kitchen - hand sanitizer located above electrical source 9. Front Office - multi plug adapter hanging by cord 10. Front Office - electrical cords taped to carpet in walking path These findings were acknowledged by the Maintenance Director	K 147		