

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

Printed: 01/20/2016
FORM APPROVED
OMB NO. 0938-0391

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 01/20/2016
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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>This report is a result of an unannounced Federal Fire and Life Safety re-certification survey conducted on January 20, 2016, Stafholt Good Samaritan Center, 456 C Street, Blaine, Washington, by a representative of the Washington State Fire Marshal's Office. This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health Services (DSHS).</p> <p>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 Long Term Care 57 bed facility, census of 49 was provided by the Maintenance Director and verified by the Health Information Manager. The facility is a one story building consisting of construction type V-A, built in 1990. The facility is fully sprinkled with an automatic fire alarm system in place. All exits are to grade and lead to a public way with a hard compact surface.</p> <p>The facility is not in substantial compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The Surveyor was: Maria C. Valladares Deputy State Fire Marshal Nursing Home Surveyor 28058</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau 2715 Rudkin Road</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE 	TITLE AO7	(X6) DATE 1/28/16
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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 000	Continued From page 1 Union Gap, WA. 98903-1795 Telephone: (509) 575-2190 FAX: (509) 576-3002  Maria C. Valladares, DSFM 28058	K 000		
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This Standard is not met as evidenced by: The facility has failed to clearly identify exits with appropriate signs in the case of delayed egress. This could delay egress from the building and expose residents, visitors, and staff to the threat of fire. The findings include, but are not limited to: During the facility tour on January 20, 2016 from the hours of 10:45am to 12:30pm, I observed delayed egress without the required signage in the following locations: 1. At 11:30am, I observed that the East Wing South hall does not have the required delayed	K 022	1. Signs that say "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 30 SECONDS" will be attached on all applicable egress doors at Stafholt. Please see the attached letter of transmittal from the Washington State Department of Health/ Construction Review Services that authorizes 9 egress doors to be set at 30 seconds. Current delay is 20 seconds. 2. All residents have the potential to be affected by this practice. 3. New doors or changes will be submitted to the DOH/ Construction Review Services. Any new egress doors will be requested with a 30 second delay. 4. Completion of signage will be reported to the Quality Assurance and Performance Improvement committee. 5. Completion date of 2/23/2016.	

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K 022	<p>Continued From page 2</p> <p>egress sign.</p> <p>2. At 11:39am, I observed that the East Wing East hall does not have the required delayed egress sign.</p> <p>3. At 11:51am, I observed that the North Wing exit does not have the required delayed egress sign.</p> <p>Interview with Maintenance Director revealed he was not aware of the sign required. The sign is required to state: PUSH AND DOOR WILL OPEN IN 15 SECONDS.</p> <p>These findings were observed and discussed with the Maintenance Director.</p>	K 022	6. Compliance will be assured by the Maintenance Director or designee.	
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This Standard is not met as evidenced by: The facility has failed to maintain the exit access corridors free of obstructions and impediments to full and instant use in the event of an emergency. This could result in the delays in smoke compartment evacuations or full evacuation of the building due to a fire or other emergency which would endanger the residents, visitors, and/or staff within the facility. The findings include, but are not limited to: During the facility tour on January 20, 2016, between the hours of 10:45am and 12:00pm, I observed obstructions in the exit corridors in the</p>	K 072	<p>1. Chairs and bird cage as cited have been removed from both East and West Wings to permit egress. All soiled linen and trash carts will be put into locked hazardous area when not in use. Likewise lifts will be stored in a designated area outside of the path of egress when not in use. All items when in use will be temporarily placed on a single side of the hall.</p> <p>2 The entire facility was inspected for additional impediments to egress. No additional violations of egress were identified.</p>	

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K 072	Continued From page 3 following locations: 1. At 10:57am, I observed West corridor to be used to store soiled linen and trash carts, chair, and chair lifts. 2. At 11:25am, I observed East wing south corridor to be used to store soiled linen, trash carts, and lifts. 3. At 11:34am, I observed East Wing east corridor used to store soiled linen, trash carts, lifts, and bird cage. Interview with Maintenance Director revealed that he was not aware that items used for resident assistance could not be stored in the corridor. These findings were observed and discussed with the Maintenance Director.	K 072	3. All staff will be trained on proper placement of equipment when in use as well as the proper storage of equipment when not in use. 4. Compliance will be informally assessed on a daily basis by charge nurses. Formally, practices will be audited weekly X 4, monthly X 2 and quarterly X 3. Results of formal audits will be reported to the Quality Assurance and Performance Improvement committee for review.	
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This Standard is not met as evidenced by: The facility has failed to ensure that soiled linen or trash collection receptacles do not exceed 32 gal in capacity and are stored in a hazardous area when not attended. This could allow for fire loading the corridor and fuel for a fire and	K 075	5. Completion date 2/23/16. 6. Charge nurses will monitor for compliance. 1. All soiled linen and trash receptacles exceeding 32gallons will be stored in a room protected as a hazardous area when receptacles are not in use. 2.The entire facility was inspected for additional impediments to egress. No additional violations of egress were identified. 3. All staff will be trained on proper use and storage of soiled linen and trash receptacles.	

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K 075	<p>Continued From page 4 thus expose residents, visitors, and staff to threat of smoke, heat, and fire.</p> <p>The findings include, but are not limited to:</p> <p>During the survey tour on January 20, 2016 between the hours of 10:45am and 12:00pm, I observed soiled linen and trash collection bins in the following locations:</p> <ol style="list-style-type: none"> 1. At 10:57am, I observed that West corrdor was being used to store 4 carts of soiled linen and trahs. Interview with housekeeping that was around at the time indicated that these carts are in the same place throught the day. 2. At 11:25am, I observed that the East Wing South hall corridor was being used to store 4 carts of soiled linen and trash. 3. At 11:34am, I observed that East Wing East corridor was being used to store 4 carts of soiled linen and trash. 4. Medicare wing also has soiled linen and trash carts being stored in the corridor. <p>Interview with the Maintenance Director revealed he was not aware of the limits on soiled linen and trash</p> <p>These findings were observed and discussed with the Maintenance Director.</p>	K 075	<ol style="list-style-type: none"> 4. Proper egress will be monitored by charge nurses during each shift to assure the receptacles in use will be on one side of hall and all linen and trash carts exceeding 32 gallons and not in use will be stored in a room protected as a hazardous area. Formally, practices will be audited weekly X 4, monthly X 2 and quarterly X 3. Results of formal audits will be reported to the Quality Assurance and Performance Improvement committee for review. 5. Completion date 2/23/16—with new carts with less than 32gal capacity. 6. Charge nurses will monitor for compliance. 	
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 144	<ol style="list-style-type: none"> 1. An emergency stop button will be installed on the generator unit on 2/4/16 by Tom Sutton Enterprises. Will either be installed on post outside generator enclosure or on facility wall directly behind the generator enclosure. 	

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K 144	Continued From page 5 This Standard is not met as evidenced by: The facility has failed to provide a required emergency stop button for the existing generator in an approved location. This could allow for a problem to exist at the generator and staff not have a means to shut off the generator. Failure to have an emergency shut off switch could potentially create a greater hazard during a power outage and thus expose residents, visitors, and staff to a power outage without generator power coverage. The findings include, but are not limited to: Observations made during the survey tour on January 20, 2016 at 10:45am, revealed that the generator did not have an emergency stop button. Interview with Maintenance Director revealed he was unaware of the requirement for the Emergency Stop Button. This finding was observed and discussed Maintenance Director.	K 144	2. No additional persons beyond those identified by the surveyor have the potential to be affected. 3. The presence of an emergency stop button will bring generator to level of LSC 2000. Provide extra safety and security to staff, residents and the facility. Visual inspection of emergency stop button will occur on a monthly basis. 4. Administrator will monitor installation. Completion of installation will be reported to the Quality Assurance and Performance Improvement committee. 5. Completion date 2/23/16. 6. Maintenance Director or designee will monitor for compliance.	
K 147 SS=E	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: The facility has failed to maintain the premises free of electrical hazards as required. This could allow for electrical fire to start and expose	K 147	1. Removed all power strips noted in survey i.e. Rehab office (microwave), resident room 25 (recliner and stereo) and staff development office (refrigerator). Have also removed all power strips in resident rooms. Completed 1/25/16.	

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K 147	Continued From page 6 residents, visitors, and staff to the threat of smoke and fire. The findings include, but are not limited to: During the facility tour on January 20, 2016 between the hours of 10:45am and 12:00pm, I found power strips in use in the following locations: 1. At 11:23am, I observed the Rehab office to have a microwave plugged into a power strip. 2. At 11:36am, I observed Resident Room #25 to have a power strip for recliner and stereo. 3. At 11:55am, I observed Staff Development Office to have refrigerator on a power strip. Interview with Maintenance Director revealed that he was unaware of need for Waiver for power strips in resident rooms and that specific power strips are required for medical equipment and non-medical equipment. This finding was observed and discussed with the Maintenance Director.	K 147	2. An inspection of the facility occurred and no other power strips were identified. 3. In future, will only permit power strips where and as "categorical" waiver permits. Admits upon admission will be informed of power strip regulation per LSC 101 2000 Edition. Maintenance Director or designee will audit building quarterly X 4 for compliance. 4. Results of audits will be reported to the Quality Assurance and Performance Improvement committee quarterly X 4. 5. Completion date 2/23/16. 6. Maintenance Director or designee will monitor for compliance.	
K 211 SS=F	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 an ignition source. o If the floor is carpeted, the building is fully	K 211	1. Improperly installed alcohol based hand sanitizer dispensers in all rooms or areas near electrical sources were removed 1/22/16. Includes rooms, 4,5,6,10,11,13,14,15, 17,18,26,27,28,30,31 as noted and observed elsewhere after a thorough inspection by the Maintenance Director.	

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K 211	Continued From page 7 sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This Standard is not met as evidenced by: Based upon observations and staff interviews on January 20, 2016 between approximately 10:45am and 12:00pm, 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: ABHS dispensers improperly mounted in the following locations: Resident Room #'s: 4, 5, 6, 10, 11, 13, 14, 15, 17, 18, 26, 27, 28, 30, and 31. This finding was observed and discussed with the Maintenance Director.	K 211	2. The facility was inspected and no additional dispensers were identified as being in violation of code requirements. 3. All new hand dispensers will be installed only in reference to LSC 101 2000 Edition. Maintenance staff will be educated regarding the installation requirements of alcohol based hand sanitizer dispensers. 4. Maintenance Director will consult with reference before proceeding to install hand sanitizers to assure compliance with LSC 101 2000 Edition in regard to electrical sources. Completion of proper installation will be reported to the Quality Assurance and Performance Improvement committee. 5. Removal of sanitizers in proximity to electric sources were removed as of 1/22/16. Completion date 2/23/16. 6. Maintenance Director or designee will monitor for compliance.	

FIRE PREVENTION
DIVISION

FEB 08 2016

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