

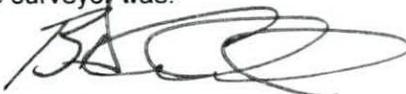
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

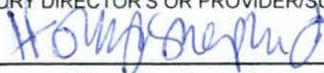
Printed: 08/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2015
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NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE	STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370
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(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
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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 Martha and Mary Health Services on August 4, 2015, by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Social and Health Services (DSHS) health survey teams.</p> <p>Martha and Mary has a total of 190 beds and at the time of this survey the census was 157.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70.</p> <p>The facility is a three story structure of Type V construction with exits to grade or protected vertical openings. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way.</p> <p>The facility is not in compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:  Blaine D. Gunkel Deputy State Fire Marshal</p>	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4 Aug 2015
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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 018	<p>Continued From page 1</p> <p>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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on August 4, 2015, between approximately 8:00 a.m. and 11:00 a.m. Martha and Mary 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:</p> <ol style="list-style-type: none"> 1. The corridor fire door in the Marina Unit failed to close upon release. 2. The Marina Unit office manager's door was wedged open. <p>The above was discussed and acknowledged by the maintenance director.</p>	K 018	<p>K 018: On 4 Aug 15, the Marina Unit corridor fire door closure was immediately assessed, corrected and tested by Facility staff to ensure the doors properly closed when released. As an additional safety measure, a new closure mechanism was ordered to replace the closure that malfunctioned and can be installed as needed. Also on 4 Aug 15, the Marina Unit Manager office door wedge was immediately removed (disposed of) and education provided to ensure the door remains free of impediments and able to close at all times.</p> <p>Facilities staff conducted immediate preventive maintenance rounds to ensure all doors were free of impediments and able to close and latch per Life Safety Code (LSC).</p> <p>Facility staff will be re-trained regarding requirement to maintain doors without impediments to closing and/or latching.</p> <p>Facilities staff will conduct daily preventive maintenance rounds and correct any discrepancies to ensure all doors remain free of impediments and are able to close and latch per LSC on an on-going basis.</p> <p>Findings will be reported to QAPI for review and further follow-up as needed.</p> <p>Corrective action will be completed by 8 Sep 2015.</p> <p>The Facilities Director and Administrator will ensure on-going compliance.</p>	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

ADMITTED
8/11/15

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K 050	<p>Continued From page 2</p> <p>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</p> <p>This Standard is not met as evidenced by: Based upon record review and staff interviews on August 4, 2015, between approximately 8:00 a.m. and 11:00 a.m. Martha and Mary failed to provide fire drill records reflecting drills being conducted on all shifts for the past 12 months. This could potentially result in the staff not responding in a coordinated manner in the event of a fire or other emergency and endangering residents, staff and/or visitors.</p> <p>The findings include, but are not limited to: 1. The facility failed to provide documentation of a fire drill for third quarter of 2014. The above was discussed and acknowledged by the maintenance director.</p>	K 050	<p>K 050: Fire Drill documentation was provided for day and night shift drills for 14 Aug 14 and 25 Sep 14 respectfully. Documentation was not located as evidence that an evening drill was completed in Q3 2014, but documentation was available as evidence that drills have consistently been conducted every quarter according to LSC prior to Q3 2014 and since.</p> <p>On 4 Aug 15, Facilities staff were immediately re-trained on requirement to conduct fire drills at least quarterly on each shift.</p> <p>Facilities staff will continue to schedule fire drills in accordance with LSC standards. Following each drill, the Facilities Director will review the Fire Drill Log Book to ensure documentation is completed and available in the log book. Facilities staff will also continue to provide fire drill results to the Safety Committee on a monthly basis. The Safety Committee will also monitor for LSC compliance for completed fire drills on a monthly basis.</p> <p>Findings will be reported to QAPI for review and further follow-up as needed.</p> <p>Corrective action was completed on 4 Aug 2015.</p>	
K 141 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on August 4, 2015 between approximately 8:00 a.m.</p>	K 141	<p>The Facilities Director and Administrator will ensure on-going compliance.</p>	

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K 141	Continued From page 3 and 11:00 a.m. Martha and Mary failed to provide signage where oxygen is in use or stored. This could result in the rapid spread of smoke and fire in the event of ignition which could potentially endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. Oxygen was observed in the physical therapy room with no posted sign. The above was discussed and acknowledged by the maintenance director.	K 141	K 141: On 4 Aug 15, temporary "oxygen in use" signs were immediately posted at the South entrance to the building and outside the Physical Therapy Gym. Facility will order permanent signs to be posted in same areas plus all entrances and areas that temporary oxygen storage is possible indicated oxygen in use/stored on campus and prohibition of smoking anywhere on campus. Facilities staff conducted rounds to ensure all oxygen use and storage areas were properly signed. Facility staff will be re-trained on requirement to post signage where oxygen is in use or stored. Facilities staff will conduct daily preventive maintenance rounds and correct any discrepancies to ensure all oxygen use/storage areas are properly signed. Findings will be reported to QAPI for review and further follow-up as needed. Corrective action will be completed by 8 Sep 2015. The Facilities Director and Administrator will ensure on-going compliance.	