

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

PRINTED: 12/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2014
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NAME OF PROVIDER OR SUPPLIER ENUMCLAW HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 JENSEN STREET ENUMCLAW, WA 98022
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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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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Enumclaw Nursing and Rehabilitation conducted on 12/15/2014. The sample of one resident was based on a census of 73.</p> <p>The following complaint was investigated as part of this survey:</p> <p>3063556</p> <p>The survey was conducted by:</p> <p>Susan Loewen, MSN, RN Complaint Investigator</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234-6005 Facsimile: (253) 395-5070</p> <p><i>Mike Ambrose</i> 12-16-14 Residential Care Services Date</p>	F 000 18	<p>1. How corrective action accomplished for the identified residents?</p> <p>No residents were identified.</p> <p>2. How you will identify other residents with the potential of being affected by the same practice?</p> <p>All residents have the potential to be affected.</p> <p>Baseboard heaters audited to look for similar issues.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>Staff have been re-educated on facility Fire Life Safety policy and procedures including pulling fire alarm on earliest sign of fire indication.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 12/23/14
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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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F 518 SS=D	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to educate staff on and implement facility Fire Life Safety policies and procedures. Failure of staff to pull the Fire Alarm prevented a rapid response from emergency personnel, automatic doors to close and prevented staff and residents from knowing a potential fire existed and implementing other Fire Safety interventions thus ensuring their safety. All residents, staff and visitors were placed at risk for injury and death.</p> <p>Findings included:</p> <p>The facility's undated Code Red, Fire policy instructed staff, upon identification of a fire and after removal of the residents to "...Call for assistance and pull the nearest fire alarm..."</p> <p>Staff A, interviewed on 12/15/2014 at 5:00 p.m., said staff smelled something hot on 12/12/2014. Staff A indicated direct-care staff found the baseboard heater in room 514 was to be the problem, the extent of which was unknown. Resident 1 was removed and Staff A called 911.</p> <p>When asked why the Fire Alarm was not pulled according to facility policy, Staff A was unsure.</p>	F 518	<p>The baseboard heaters have been placed on a preventative maintenance schedule.</p> <p>4 How will the plan be monitored to ensure the solutions are sustained?</p> <p>Executive Director educates employees to Fire Life Safety policy and procedures during new employee orientation.</p> <p>The Staff Development Coordinator to re-educate staff annually on fire Life Safety policy and procedures.</p> <p>Facility to continue to conduct monthly fire drills.</p> <p>The ED to audit preventative maintenance log to validate baseboard heaters are being checked on a regular basis.</p>	12/24/14

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F 518	Continued From page 2 When Staff A was informed that pulling the alarm was part of the facility's policy and would send automatic messages to emergency personnel as well as facility staff, residents and shut automatically closing doors, he said he now understood the reason for pulling the Fire Alarm and would do so in the future.	F 518	<p>Audits to be brought to QAPI for further review and educational opportunities.</p> <p>5. The ED is responsible for compliance</p> <p>Compliance date 12/24/2014</p> <p>DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH 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 PROVISIONS OF FEDERAL AND STATE LAW.</p>		