

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

Printed: 03/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

1309

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505278	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/10/2014
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NAME OF PROVIDER OR SUPPLIER <b>HEALTH AND REHABILITATION OF NORTH S</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>13333 GREENWOOD AVENUE NORTH SEATTLE, WA 98133</b>
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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><b>INITIAL COMMENTS</b></p> <p>An unannounced Life Safety Code Survey was conducted at Health and Rehabilitation of North Seattle, Seattle, Washington, on March 10, 2014 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 119 bed facility with a census of 75, consisted of a Type V-111, 2 story structure built in 1952. The facility has a basement area that is used for physical therapy of the residents, storage, environmental services as well as the kitchen. 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 has an outstanding construction project #60444762 for water damage. Resident rooms [redacted], [redacted], [redacted], [redacted], and [redacted] as well as the laundry room are affected.</p> <p>The facility is in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>[redacted signature] Deputy State Fire Marshal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-10-14</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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505278	DATE SURVEY COMPLETE: 03/10/2014
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NAME OF PROVIDER OR SUPPLIER HEALTH AND REHABILITATION OF NORTH SEATTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 13333 GREENWOOD AVENUE NORTH SEATTLE, WA. 98133
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 147 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 March 10, 2014 from 8:45 AM to 1:30 PM the following deficiencies were found:

1. Resident room ● - non approved multi plug adapter in use.
2. Resident room ● - extension cord powering multi plug adapter
3. Clean utility room across from resident room ● - hand sanitizer above electrical source
4. Staff Development office - multi plug adapter plugged into a multi plug adapter
5. Director of Nursing - refrigerator plugged into multi plug device
6. Resident room ● - non approved multi plug device in use.

*OK DM 3-20-14*

THESE DEFICIENCIES WERE CORRECTED IMMEDIATELY BY THE MAINTENANCE DIRECTOR AND VERIFIED BY THE INSPECTING DEPUTY STATE FIRE MARSHAL.

These findings were acknowledged by the Maintenance Director

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The above isolated deficiencies pose no actual harm to the residents