

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

Printed: 06/19/2013
FORM APPROVED
OMB NO. 0938-0391

1324

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505507	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2013
NAME OF PROVIDER OR SUPPLIER SHELTON HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 153 JOHNS COURT SHELTON, WA 98584		
(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
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32862 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Shelton Health and Rehab Center on 06/19/13 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>Shelton Health and Rehab Center has a total of 76 beds and at the time of this survey the census was 64.</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 one story structure of Type 5(1-1-1) construction with exits to grade. 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 substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p><i>Maureen Starnie</i> Deputy State Fire Marshal</p> <p><i>Dan J...</i> Deputy State Fire Marshal</p>	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>		TITLE EXECUTIVE DIRECTOR		(X5) DATE 6-28-13

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>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center has 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: Door to kitchen from the corridor not latching in the closed position.</p>	K 018	<p>K018 The fan system was on in the kitchen at this time creating a negative air flow that increased the amount of pressure the door closer had to utilize to close and latch the door. On Thursday 6/27/2013 a new stronger door closer was installed on this door to insure the door is able to close and latch under all conditions. All other doors in the facility have been checked to insure there are no impediments to their closing under any condition. This will be reviewed as part of our ongoing checks and maintenance schedule and will be reviewed in our Continuous Quality Improvement meeting (CQI).</p>	6/28/13

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K 018	Continued From page 2 The above was discussed and acknowledged by the Facility Administrator and the Maintenance Director.	K 018		
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: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center failed to maintain the fire sprinkler riser free from storage. This could result in the failure of the fire sprinkler system to operate properly in the event of a fire and allow the fire to increase in size and intensity which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Storage of items around the sprinkler riser in the Maintenance/Sprinkler Riser Room. The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 062	The sprinkler riser has been cleared and will be routinely checked as part of our maintenance and checks. This will be reviewed in our Continuous Quality Improvement meeting (CQI).	
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	K064 An audit of all fire extinguishers in the building has been conducted and any fire extinguisher mounted higher than 5 feet has been re-mounted at a height of 5 feet from the floor or less.	

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K 064	Continued From page 3 This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center has failed mount portable extinguishers not higher than 5 feet measured from the top of the extinguisher.. This potentially delays a quick response to contain a fire from spreading which could expose and endanger residents, staff and/or visitors within the facility. The findings include, but are not limited to: Portable extinguisher in the Front Office and the Laundry Room. The above was discussed and acknowledged by the Facility Administrator and the Maintenance Director.	K 064	This will be reviewed as part of our ongoing checks and maintenance schedule and will be reviewed in our Continuous Quality Improvement meeting (CQI).	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center has failed to provide the proper maintain proper clearance of combustibles to heaters. Failure to property clearance could result in the ignition of the combustible materials adjacent to the staff smoking area which would endanger the	K 067	K067 All heaters in the building have been audited to insure proper clearance of combustibles from heaters and an area has been taped off in front of the heater in areas identified as deficient. This will be reviewed as part of our ongoing checks and maintenance schedule and will be reviewed in our Continuous Quality Improvement meeting (CQI).	

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K 067	Continued From page 4 residents, staff and/or visitors within the facility. The findings include, but are not limited to: Storage of combustibles too close to heater in the Activities Office. The above was discussed and acknowledged by the Facility Administrator and the Maintenance Director.	K 067		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center 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, staff and/or visitors within the facility. The findings include, but are not limited to: Storage of lifts on corridor by rooms 107 and 108. Gate outside the Therapy Gym dragging on the concrete when moved to the open position. The above was discussed and acknowledged by the Facility Administrator and the Maintenance	K 072	K072 We have a waiver for lifts stored in the hallway. It is our standard to keep lifts out of the hallway whenever possible. The gate outside the therapy gym has been repaired and opens with no dragging or impediment. This will be reviewed as part of our ongoing checks and maintenance schedule and will be reviewed in our Continuous Quality Improvement meeting (CQI).	

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K 072	Continued From page 5 Director.	K 072		
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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. This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center has 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: Oxygen sign not posted on Resident Room 151 where oxygen was in use. The above was discussed and acknowledged by the Facility Administrator and the Maintenance Director.	K 141	K141 An audit of all rooms with residents using oxygen has been completed and oxygen signs have been put in place on the exterior door frame. An "oxygen in use No smoking" sign has been placed on the exterior door to our entrance. This will be reviewed as part of our ongoing checks and maintenance schedule and will be reviewed in our Continuous Quality Improvement meeting (CQI).	
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: Surveyor: 32862 Based upon observations and staff interviews on 6/18/13 between approximately 09:15 and 11:30 hours Shelton Health and Rehab Center has failed to restrict the use of multi-plug outlets (power strips) to providing power to permitted	K 147	K147 An audit of all power strips in use in the building has been conducted and any power strip found to not be in optimal condition has been replaced. No other power strips have been identified as being plugged into another power strip. The power strip plugged into another power strip in the	

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K 147	Continued From page 6 electrical equipment, or has failed to maintain the multi-plug outlet (power strips) in optimal condition. This could result in a fire from overheating of the plug strip due to the heavy power draw endangering the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Power strip plugged into another power strip in the Business Office Discoloration and warm to touch found on power strip used at the time clock terminal. The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 147	business office has been removed and staff has been notified that this is not an acceptable practice. Routine audits will be conducted. We have a waiver for the use of the surge protectors. This will be reviewed as part of our ongoing checks and maintenance schedule and will be reviewed in our Continuous Quality Improvement meeting (CQI).	