

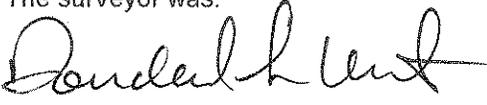
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

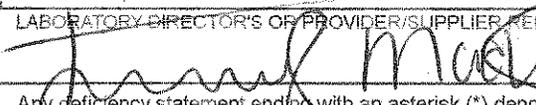
Printed: 10/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505351	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2014
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NAME OF PROVIDER OR SUPPLIER ARLINGTON HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 19192 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Arlington Health & Rehab on 10/28/2014 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>The facility has a total of 76 beds and at the time of this survey the census was 62.</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 single story structure of Type V-A 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 compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:  Donald L West Deputy State Fire Marshal</p>	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/6/14
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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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K 018 SS=D	<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 1¾ 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: 19192 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 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>	K 018	<p>This plan of corrections is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of corrections does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.</p>

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K 018	Continued From page 2 This requirement is not met as evidenced by: Based upon observations and staff interviews on 10/28/2014 between approximately 1015 and 1230 hours the facility 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. The findings include, but are not limited to: 1. The door to the RCM office failed to close and latch. 2. The door to the storage room #213 has no self closing device, this room was a resident room that has been changed into a storage room. 3. The door to the storage room #214 has no self closing device, this room was a resident room that has been changed into a storage room. The above was discussed and acknowledged by the facility Administrator.	K 018	K 018 Specific The door to the RCM office was fixed on 10.29.2014. We put a self-closing device on our two new storage rooms 213 and 214 on 10.31.2014 Similar The rest of the doors in the facility have been checked to assure they close and latch without impediments. Measures In-Serviced the staff to make the Maintenance Director aware of any doors that are not properly closing In-Serviced the Maintenance Director that self-closers are needed on residents rooms that are turned into non-resident rooms or storage rooms. Monitoring The Maintenance Director will do random audits on a monthly basis x 3 months to assure all needed doors close and latch. Dates when the corrective action will be completed: November 21 st , 2014	
K 023 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2 This Standard is not met as evidenced by: Surveyor: 19192 Smoke barriers are provided to form at least two smoke compartments on every sleeping room	K 023	Title of the person responsible to ensure corrections: Maintenance Director and Administrator	

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K 023	<p>Continued From page 3 floor for more than 30 patients. 19.3.7.1, 19.3.7.2</p> <p>This requirement is not met as evidenced by:</p> <p>Based upon observations and staff interviews on 10/28/2014 between approximately 1015 and 1230 hours the facility has failed to maintain the fire separation doors in the building. This could result in the passage of smoke from one smoke compartment into another smoke compartment thereby exposing residents, staff and/or visitors to the toxic products of combustion.</p> <p>The findings include, but are not limited to:</p> <p>1. The cross corridor fire separation doors by the physical therapy room failed to close and latch.</p> <p>The above was discussed and acknowledged by the facility Administrator.</p>	K 023	<p>K 023</p> <p>Specific The corridor fire doors by the physical therapy room were fixed on 10.29.2014 and are properly closing.</p> <p>Similar All other corridor fire doors have been checked to assure they are properly closing with no findings.</p> <p>Measures The Maintenance Director has been in-Serviced on making sure the corridor fire doors are properly working.</p> <p>Monitoring The Maintenance Director will do random audits on a monthly basis x 3 months to assure the corridor fire doors are working properly.</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 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</p> <p>This requirement is not met as evidenced by:</p>	K 062	<p>Dates when the corrective action will be completed:</p> <p>November 21st, 2014</p> <p>Title of the person responsible to ensure corrections:</p> <p>Maintenance Director</p>	

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K 062	Continued From page 4 Based upon observations and staff interviews on 10/28/2014 between approximately 1015 and 1230 hours the facility has failed to maintain the fire sprinkler system as required. 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: 1. During review of the facility fire sprinkler system confidence test report it was observed that the facility needs to supply spare sprinkler heads for the newer portion of the building. 2. The five year tests are due. The above was discussed and acknowledged by the facility Administrator.	K 062	K 062 Specific The 5 year tests for the sprinkler system will be performed on 11.17.2014 by Commercial Fire Protection. At the time of the sprinkler testing Commercial Fire protection will bring spare sprinkler heads for the newer portion of the building that will be stored in the Maintenance office. Similar An Audit has been done to assure all needed Maintenance System tests are completed or scheduled on time. Measures The Maintenance Director has been in-serviced to assure the 5-year sprinkler tests are done timely. Monitoring The Administrator will audit the Maintenance Directors books at random to assure all tests have been done or are scheduled.
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Surveyor: 19192 Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144	Dates when the corrective action will be completed: November 21 st , 2014 Title of the person responsible to ensure corrections: The Administrator and Maintenance Director

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K 144	Continued From page 5 accordance with NFPA 99. 3.4.4.1. This requirement is not met as evidenced by: Based upon record review and staff interviews on 10/28/2014 between approximately 1015 and 1230 hours the facility has failed to have annual testing and maintenance conducted on the emergency generator. This could result in a failure of the emergency power system which would leave the facility without egress and work lighting in the event of a power failure which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. The facility has not had the generator inspected and tested by a certified technician since July 2012. The above was discussed and acknowledged by the facility Administrator.	K 144	K144 Specific The Generator test and inspection has been done by a certified technician on 11.5.2014. Similar An Audit has been done to assure all needed Maintenance System tests are completed or scheduled on time. Measures The Maintenance Director has been in-serviced to assure the Annual Generator tests are completed by a certified technician. Monitoring The Administrator will audit the Maintenance Directors books at random to assure all tests have been done or are scheduled. Dates when the corrective action will be completed: November 21 st , 2014	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This Standard is not met as evidenced by:	K 154	Title of the person responsible to ensure corrections: The Administrator and Maintenance Director	

Jm
11/6/14

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K 154	<p>Continued From page 6 Surveyor: 19192 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This requirement is not met as evidenced by:</p> <p>Based upon record review and staff interviews on 10/28/2014 between approximately 1015 and 1230 hours the facility has failed to have a written procedure for instituting as approved fire watch in the event of a failure of the fire sprinkler system. This could result in an inadequate fire watch which may result in a delay of fire detection and suppression, endangering residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to:</p> <ol style="list-style-type: none"> 1. The facility needs to update the existing policy for sprinkler outage to meet the requirements. <p>The above was discussed and acknowledged by the facility Administrator.</p>	K 154	<p>K154</p> <p>Specific We updated our existing policy for sprinkler outage to meet the current requirements.</p> <p>Similar We did an Audit of our Emergency policies to assure they were correct and up to date.</p> <p>Measures We in-serviced the staff on the updated policy</p> <p>Monitoring The Administrator will make changes to the policy as necessary</p> <p>Dates when the corrective action will be completed: November 21st, 2014</p> <p>Title of the person responsible to ensure corrections: Administrator and Maintenance Director</p>	
K 155 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p>	K 155		

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K 155	<p>Continued From page 7</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>This requirement is not met as evidenced by: Based upon record review and staff interviews on 10/28/2014 between approximately 1015 and 1230 hours the facility has failed to have a written procedure for instituting as approved fire watch in the event of a failure of the fire alarm system. This could result in an inadequate fire watch which may result in a delay of fire detection and suppression, potentially endangering residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to:</p> <ol style="list-style-type: none"> 1. The facility needs to update the existing policy for fire alarm outage to meet the requirements. <p>The above was discussed and acknowledged by the facility Administrator.</p>	K 155	<p>K155</p> <p>Specific We updated our existing policy for fire alarm outages to meet the current requirements.</p> <p>Similar We did an Audit of our Emergency policies to assure they were correct and up to date.</p> <p>Measures We in-serviced the staff on the updated policy</p> <p>Monitoring The Administrator will make changes to the policy as necessary.</p> <p>Dates when the corrective action will be completed: November 21st, 2014</p> <p>Title of the person responsible to ensure corrections: Administrator and Maintenance Director</p>

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11/6/14