

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

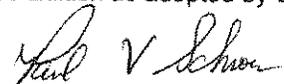
Printed: 08/27/2013
FORM APPROVED
OMB NO. 0938-0391

1348

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505393	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2013
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NAME OF PROVIDER OR SUPPLIER NORTH CASCADES HEALTH AND REHABILIT	STREET ADDRESS, CITY, STATE, ZIP CODE 4680 CORDATA PARKWAY BELLINGHAM, WA 98226
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K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Life Safety Code Survey was conducted at North Cascades Health and Rehabilitation Center, Bellingham, Washington, on August 27, 2013 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 122 bed facility with a census of 76, consisted of a Type V-111, 2 story structure, built in 1999 with no basement. 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 is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p> Deputy State Fire Marshal</p>	K 000	<p>DISCLAIMER CLAUSE</p> <p>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>	
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 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</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brook K. Thornton</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/5/13</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.

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K 018	Continued From page 1 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This Standard is not met as evidenced by: Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment. Findings include: During the facility tour on August 27, 2013 from 0830 to 1330 it was observed that the following doors did not close, latch or open properly when tested: 1. Clean linen storage room by Res Rm 239 - tissue in door latching assy 2. Res Rm 242 - failed to latch 3. Director of Nursing - failed to latch 4. 1st floor Rehab Area - failed to latch 5. Kitchen Rear Door - hard to open These findings were acknowledged by the facility Maintenance Director.	K 018	<p><i>1. How was corrective action accomplished for the identified residents?</i></p> <p><i>The doors have been tested, repaired, and latch on the following rooms:</i></p> <p><i>1. Clean linen storage by Rm 239</i></p> <p><i>2. Rm 242</i></p> <p><i>3. DNS door</i></p> <p><i>4. 1st floor rehab area</i></p> <p><i>5. Kitchen rear door</i></p> <p><i>2. How you will identify other residents with the potential of being affected by the same practice?</i></p> <p><i>A walkthrough has been conducted and doors checked for latching.</i></p> <p><i>3. Address what measures will be put in place to ensure deficient practice will not recur.</i></p> <p><i>A monthly walkthrough will be done by maintenance checking and repairing doors that fail to latch.</i></p> <p><i>4. How will the plan be monitored to ensure the solutions are sustained?</i></p> <p><i>Findings to be brought to COI for further review and evaluation.</i></p>	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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.	K-050		

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K 050	Continued From page 2 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 This Standard is not met as evidenced by: Based on record review, the facility failed to assure that the LTC staff was adequately trained to respond to fires. This potentially exposed residents to smoke and fire in the facility. Findings include: An examination of the facility 's fire drill records on August 27, 2013 at 1145 revealed that the fire drill records were missing for: 1. day shift, 2nd qtr, 2013 These findings were acknowledged by the Maintenance Director.	K-050 K050	5. <i>The Plant Supervisor is responsible for compliance by Oct 1, 2013.</i> 1. <i>How corrective action accomplished for the identified residents?</i> <i>No residents identified.</i> 2. <i>How you will identify other residents with the potential of being affected by the same practice?</i> <i>Fire drills are conducted quarterly on each shift.</i> 3. <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> <i>Safety committee to review monthly fire drills.</i> 4. <i>How will the plan be monitored to ensure the solutions are sustained?</i> <i>Findings to be brought to CQI for further review and evaluation.</i> 5. <i>The Plant Supervisor is responsible for compliance by Oct 1, 2013</i>	
K 064 SS=D	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 This Standard is not met as evidenced by: Based on observation and record review, the facility failed to assure fire extinguishers are properly maintained. This potentially delays a quick response to contain a fire from spreading, exposing residents to fire in the environment.	K-064		

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K 064	Continued From page 3 During the facility tour on August 27, 2013 from 0830 to 1330 observed fire extinguishers in the following locations where the top of the extinguisher was more than five feet above the floor: 1. Class K extinguisher in kitchen 2. Multi purpose extinguisher in the laundry The Maintenance Director acknowledged the findings.	K 064	1. How corrective action accomplished for the identified residents? <i>Fire extinguishers in the following locations were lowered:</i> 1) Class K in kitchen 2) Multi purpose extinguisher in the laundry.	
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: Based on observation and staff interview, the facility failed to assure that exit egress remained clear and unobstructed. This potentially prevents residents from exiting a fire/smoke environment. Findings include: During the facility tour on August 27, 2013 from 0830 to 1330 observed that the following items were impeding full use of the exit corridors: 1. Hoyer lift, 2nd floor, by resident room 206 2. 2nd floor employee corridor area - bed frame 3. 1st floor by beauty shop - wheelchairs and a luggage cart 4. Hoyer lift, 1st floor, by resident room 111	K 072	2 How you will identify other residents with the potential of being affected by the same practice? <i>No residents were identified.</i> 3 Address what measures will be put in place to ensure deficient practice will not recur. <i>Monthly rounds by maintenance will check fire extinguisher placement.</i> 4 How will the plan be monitored to ensure the solutions are sustained? <i>Findings to be brought to CQI for further review and evaluation.</i> 5. The Plant Supervisor is responsible for compliance by Oct 1, 2013	

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K 072	Continued From page 4 This finding was acknowledged by the Maintenance Director.	K 072	1 How corrective action accomplished for the identified residents?	
K 076 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This Standard is not met as evidenced by: Based on observation and staff interview the facility failed to maintain medical gas storage in accordance to NFPA 99, 4-3.1.1.2. This has the potential for a fire and explosive hazard exposure to the residents. This potentially exposed residents to a missile hazard during fire conditions. Findings include: During the facility tour on August 27, 2013 from 0830 to 1330 it was observed that: 1. Supply Room 2nd floor by nurses station - Cylinder improperly stored (in bag hanging on a single cylinder portable cart with a cylinder in it) These findings were acknowledged by the facility Maintenance Director.	K 076	1) Corridors have been cleared by resident room 206 and 111. Parking spaces have been marked for lifts that are not in the hallway. 2) 2nd floor employee corridor has been cleared. 3) Wheelchairs and luggage cart have been removed from 1st floor hall.	
K 141	NFPA 101 LIFE SAFETY CODE STANDARD	K 141	2 How you will identify other residents with the potential of being affected by the same practice? No residents were identified. 3 Address what measures will be put in place to ensure deficient practice will not recur. Informal rounds will be conducted by managers to ensure clear hallways. 4 How will the plan be monitored to ensure the solutions are sustained?	

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K 141 SS=C	Continued From page 5 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: Based on observations and staff interview the facility failed to post " Oxygen in use. No smoking " signs for resident rooms using oxygen in accordance with NFPA 99, 8-3.1.11.3 and * -6.4.2. This has the potential for exposing residents to a fire or explosive environment. During the facility tour on August 27, 2013 from 0830 to 1330, observed no " Oxygen in use. No smoking " signs posted for: 1. Supply room 2nd floor by the nurses station These observations were acknowledged by the Maintenance Director.	K141 K076	<i>Findings to be brought to CQI for further review and evaluation.</i> 5. <i>The Administrator is responsible for compliance by Oct 1, 2013</i> 1 <i>How corrective action accomplished for the identified residents?</i> <i>Cylinder was removed and placed in storage closet.</i> 2 <i>How you will identify other residents with the potential of being affected by the same practice?</i> <i>No residents were identified.</i> 3 <i>Address what measures will be put in place to ensure deficient practice will not recur. Informal rounds conducted by managers will check for out of place items.</i> 4 <i>How will the plan be monitored to ensure the solutions are sustained?</i> <i>Findings to be brought to CQI for further review and evaluation.</i> 5. <i>The DNS is responsible for compliance by Oct 1, 2013.</i>	
K 147 SS=C	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 August 27, 2013 from 0830 to 1330 the following deficiencies were found:	K147		

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K 141 SS=C	Continued From page 5 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: Based on observations and staff interview the facility failed to post "Oxygen in use, No smoking" signs for resident rooms using oxygen in accordance with NFPA 99, 8-3.1.11.3 and "6.4.2. This has the potential for exposing residents to a fire or explosive environment. During the facility tour on August 27, 2013 from 0830 to 1330, observed no "Oxygen in use, No smoking" signs posted for: 1. Supply room 2nd floor by the nurses station These observations were acknowledged by the Maintenance Director.	K 141	<ol style="list-style-type: none"> 1 <i>How corrective action accomplished for the identified residents?</i> <i>No residents identified.</i> <i>A sign was posted on supply room by nurse's station, "Oxygen in use, no smoking."</i> 2 <i>How you will identify other residents with the potential of being affected by the same practice?</i> <i>No residents were identified.</i> 3 <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> <i>Informal rounds by managers to check for compliance.</i> 4 <i>How will the plan be monitored to ensure the solutions are sustained?</i> <i>Findings to be brought to CQI for further review and evaluation.</i> 5 <i>The DNS is responsible for compliance by Oct 1, 2013</i> 	
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K 147	<p>Continued From page 6</p> <ol style="list-style-type: none"> 1. Activity Office - multi plug adapter hanging by cord 2. Activity Office - power cord running under carpet walkway <p>These findings were acknowledged by the Maintenance Director</p>	K 147	<ol style="list-style-type: none"> 1 <i>How corrective action accomplished for the identified residents?</i> <ol style="list-style-type: none"> 1) <i>The multi plug adapter has been remove from the activity office.</i> 2) <i>The power cord has been remove from the activity office.</i> 2 <i>How you will identify other residents with the potential of being affected by the same practice?</i> <i>No residents were identified.</i> 3 <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> <i>Informal rounds by managers to check for compliance.</i> 4 <i>How will the plan be monitored to ensure the solutions are sustained?</i> <i>Findings to be brought to CQI for further review and evaluation.</i> 5 <i>The Plant Supervisor is responsible for compliance by Oct 1, 2013</i> 	