

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

Printed: 09/18/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505349 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 09/18/2013 |
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| NAME OF PROVIDER OR SUPPLIER WILLAPA HARBOR HEALTH AND REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 1100 JACKSON STREET RAYMOND, WA 98577 |
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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 29197 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Wilapa Harbor Care Center on 9/18/2013 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 60 beds and at the time of this survey the census was 39.</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 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. Smoke detectors are present in all resident rooms. 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>Deputy State Fire Marshal</p> | K 000 | | |
| 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</p> | K 018 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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>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: 29197 Based upon observations and staff interviews on 9/18/13 between approximately 1000 and 1300 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.</p> <p>The findings include, but are not limited to: The door that opens to the corridor in Room #16 (currently used as an office) did not have a self closer installed. The room door that opens to the corridor in the Office across from the Social Services office did not fully close and latch.</p> | K 018 | | |

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| K 018 | Continued From page 2 | K 018 | | |
| K 029 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Surveyor: 29197 Based upon observations and staff interviews on 9/18/13 between approximately 1000 and 1300 hours the facility has failed to maintain doors to hazardous areas as self or automatic closing. This could result in the spreading of the toxic products of combustion into the corridor in the event of a fire which would endanger residents, staff and/or visitors. The findings include, but are not limited to: The latch on the laundry room door that opens to the corridor was missing / broken.</p> <p>The above was discussed and acknowledged by the Director of Maintenance.</p> | K 029 | | |
| K 050 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each</p> | K 050 | | |

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| K 050 | <p>Continued From page 3</p> <p>shift. The staff is familiar with procedures and is aware that drills are part of established routine. 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</p> <p>This Standard is not met as evidenced by: Surveyor: 29197 Based upon record review and staff interviews on 9/18/13 between approximately 1000 and 1300 hours the facility has failed to activate the fire alarm as required during fire drills conducted between 0600 and 2100. This could potentially result in the staff not responding in a coordinated manner in the event of a fire or other emergency and endangering residents, staff and/or visitors.</p> <p>The findings include, but are not limited to: The facility did not activate the fire alarm as required during fire drills conducted between 0600 and 2100.</p> <p>The above was discussed and acknowledged by the Director of Maintenance.</p> | K 050 | | |
| K 062 SS=F | <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:</p> | K 062 | | |

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| K 144 | Continued From page 5 the Fire Safety Code. This could result in conditions that would result in the failure of the emergency generator that would not be detected by staff in a timely manner which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: The generator status panel displayed a "Critical High Fuel" trouble alarm. The above was discussed and acknowledged by the Director of Maintenance. | K 144 | | |
| 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: 29197 Based upon observations and staff interviews on 9/18/13 between approximately 1000 and 1300 hours the facility has failed to restrict the use of multi-plug outlets (power strips) to providing power to permitted electrical equipment. 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: There were multi-plug adaptors not equipped with over-current protection in resident rooms 9 and 23. There was a powerstrip connected to the aquarium next to the Nurse's utility room. The extension cord connected to a portable air-conditioner extended through the door of the therapy office. | K 147 | | |

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| K 147 | Continued From page 6 The above was discussed and acknowledged by the Director of Maintenance. | K 147 | | |

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| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 505349 | DATE SURVEY COMPLETE: 09/18/2013 |
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K 012 NFPA 101 LIFE SAFETY CODE STANDARD

Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1

This Standard is not met as evidenced by:

Surveyor: 29197

Based upon observations and staff interviews on 9/18/13 between approximately 1000 and 1300 hours the facility has failed to maintain fire resistive construction of the building capable of resisting the passage of smoke and fire into other compartments. This could allow the toxic product of combustion to move out of a room and into the exit access corridor and the smoke compartment which would endanger the residents, staff and/or visitors within the facility.

The findings include, but are not limited to: An uncovered penetration was observed in the corridor wall above the janitor's closet.

The above was discussed and acknowledged by the Director of Maintenance.

K 064 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:

Surveyor: 29197

Based upon record review and observation on 9/18/13 between approximately 1000 and 1300 hours the facility has failed to assure proper maintenance of the facilities portable fire extinguishers. 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: The portable extinguisher in the laundry room was mounted so that the top of the extinguisher was over 5 feet in height from the floor.

The above was discussed and acknowledged by the Director of Maintenance.

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.

The above isolated deficiencies pose no actual harm to the residents