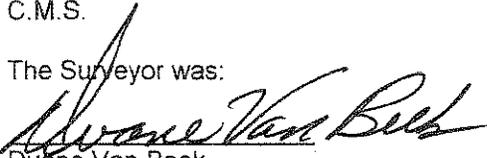


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
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NAME OF PROVIDER OR SUPPLIER <b>AVALON CARE CENTER - PULLMAN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>NORTHWEST 1310 DEANE PULLMAN, WA 99163</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>This report is a result of an unannounced a Fire and Life Safety re-certification survey conducted at the Avalon Care Center of Pullman on 09-19-12 by a representative of the Washington State Fire Marshal. The survey was conducted in concert with the Washington State Department of Social and Health Services (DSHS) health survey team.</p> <p>Avalon Care Center of Pullman has a total of 48 beds and at the time of this survey the census was 25.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70.</p> <p>This facility is a one story structure of type V (III) Construction with exits to grade. The facility is protected by a Type 13 Fire Sprinkler system through out 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 Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The Surveyor was:  Duane Van Beek Deputy State Fire Marshal Nursing Home Surveyor 15826</p>	K 000		<p style="text-align: center;"><b>RECEIVED</b> <b>OCT 11 2012</b> <b>FIRE PROTECTION BUREAU</b></p>
K 017 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only</p>	K 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>10/3/12</b>
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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 017	Continued From page 1 required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5  This Standard is not met as evidenced by: Based upon observations and staff interviews during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to maintain corridor walls so that they will resist the passage of smoke. This could allow the toxic products of combustion to move out of a room and into the exit access corridor and the smoke compartment which would endanger all of the residents, staff and visitors within the compartment.  The findings include:  1. At approximately 0951 observed two unsealed penetrations of the wall from the Medication Room into the nurses station which is open to the corridor. This was pointed out to and acknowledged by the director of maintenance.	K 017	<u><b>K 017 Corridor walls will resist the passage of smoke. 19.3.61.1, 19.3.6.2.1, 19.3.6.5.</b></u>  The two unsealed penetrations were sealed with 3M fire barrier sealant 09/20/2012.  Maintenance Supervisor to monitor and insure that any penetrations in the walls in the corridor areas are sealed with fire barrier sealant.  Administrator to monitor corridors for penetrations semiannually for compliance through the QA process.	09/26/2012
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
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K 018	<p>Continued From page 2</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: Based upon observations and staff interviews during survey rounds between 0840 and 1400 Avalon Care Center of Pullman 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 the toxic products of combustion getting out of the room and into the exit access corridor and endanger all of the residents, staff and visitors within the smoke compartment.</p> <p>The findings include:</p> <p>1. At approximately 0919 hours observed a</p>	K 018	<p><u><b>K 018 Failure to maintain doors without impediments to their closing and latching. 19.3.6.3</b></u></p> <p>1- Door wedge to the beauty shop was removed immediately on 09/19/2012. 2- Resident room 20 door was fixed to allow free movement of door on 09/20/2012. 3- Exercise weight in therapy room was removed immediately 09/19/2012. 4- Door wedge to the Administrators office was removed immediately 09/19/2012.</p> <p>All staff and contracted agencies will be in-serviced on 09/28/2012 regarding the fire safety policy and door impediments.</p> <p>Maintenance Supervisor to monitor and insure doors are free from impediments.</p> <p>Administrator to monitor doors for impediments semiannually for compliance through the QA process.</p>	09/26/2012
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K 018	Continued From page 3 wedge being used to keep the door to the beauty shop open.  2. At approximately 0927 observed that the door to resident room 20 was dragging on the floor which made it difficult to pull the door closed.  3 At approximately 0940 observed a 10lb exercise weight on the floor by the door into the Therapy room. The door is equipped with a self closer. Interviews with the speech pathologist indicated the the weight was used to hold the door open. She removed the weight and returned it to the rack.  3. At approximately 1338 hours observed a wedge being used to hold open the administrators door.  The above violations were discussed with and acknowledged by the administrator and the maintenance director	K 018		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This Standard is not met as evidenced by: Based upon observations and staff interviews	K 027		

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K 027	Continued From page 4 with the director of maintenance during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to maintain smoke barrier doors so that they would close and resist the passage of smoke. Avalon Care Center of Pullman has two sets of smoke barrier doors at the time of the survey both sets of smoke barrier doors failed to close. This would allow for the toxic products of combustion to spread throughout the entire building and would not provide for the opportunity to evacuate from one compartment into another.  The findings include:  1. At approximately 0911 observed that the cross corridor smoke barrier in the service corridor had two rated doors as the smoke barrier doors. The doors were held open by magnetic hold open devices and one of the doors was equipped with an astragal. A door coordinator was also installed on the door. Upon release from the hold open device the door coordinator prevented the doors closing.  2. At approximately 0915 observed that the cross corridor smoke barrier in the North corridor had two rated doors as the smoke barrier doors. The doors were held open by magnetic hold open devices and one of the doors was equipped with an astragal. A door coordinator was also installed on the door. Upon release from the hold open device the door coordinator prevented the doors closing.  This was observed an acknowledged by the director of maintenance who made repairs prior to the conclusion of the survey.	K 027	<u><b>K 027 Failure to maintain smoke barrier doors to close. 19.3.7.5, 19.3.7.5, 19.3.7.7.</b></u>  1- Door coordinator in service corridor was adjusted to work properly on 09/19/2012. 2- Door coordinator in North corridor was adjusted to work properly on 09/19/2012.  Maintenance Supervisor to monitor and insure door coordinators are working properly.  Administrator to monitor door coordinators are functioning properly semiannually for compliance through the QA process.	09/26/2012
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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

Printed: 09/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
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K 029 SS=E	<p>Continued From page 5</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: Based upon observations and staff interviews during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to maintain doors to hazardous areas self or automatic closing. This could result in the toxic products of combustion entering into the exit access corridor in the event of a fire. This could place the residents, staff and guests in peril in the event of a fire.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. At approximately 0857 observed a door wedge being used to prevent the door to the room which houses the water boilers, emergency generator and maintenance office closing. This was acknowledged by the maintenance director who stated the door was too small to get larger equipment into the room.</li> <li>2. At approximately 0937 observed that the door to the linen storage closet near resident room 8. This was observed and acknowledged by the</li> </ol>	K 029	<p><u><b>K 029 Failure to maintain doors to hazardous areas self or automatic closing. 19.3.2.1</b></u></p> <p>1- Door wedge to maintenance office was immediately removed on 09/19/2012.</p> <p>2- Door to linen closet latch was repaired and working properly on 09/20/2012.</p> <p>Maintenance Supervisor to monitor and insure doors to hazardous areas self or automatic closing are free of impediments and working properly.</p> <p>Administrator to monitor hazardous area doors are free from impediments and working properly semiannually for compliance through the QA process.</p>	09/26/2012

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K 029	Continued From page 6 director of maintenance.	K 029		
K 046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This Standard is not met as evidenced by: The specific standard at Section 7.9.3 of NFPA 101 the Life Safety Code 2000 edition as adopted by CMS states: " Periodic Test of Emergency Lighting" A functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less that 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be full operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction."</p> <p>The standard is not met:</p> <p>Based upon a record review at 1130 and staff interviews with the Director of Maintenance during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to maintain records of testing for the emergency battery back-up lighting. This could result in the failure of the battery powered back-up lighting in the event of a power outage and render the means of egress dark. This could result in tripping and falling injuries.</p> <p>The findings include:</p> <p>1. Interviews with the director of maintenance</p>	K 046	<p><b><u>K 046 Failure to maintain records of testing for the emergency battery back-up lighting. 19.2.9.1.</u></b></p> <p>1- Testing of battery back-up Emergency lighting was immediately done on back-up emergency lighting in Emergency Generator room and means of egress in two dining rooms on 09/20/2012 and recorded.</p> <p>Maintenance Supervisor to do monthly and annual testing of battery back-up Emergency lighting and monitor and insure battery back-up Emergency lighting is working properly.</p> <p>Administrator to monitor battery back-up Emergency lighting testing semiannually for compliance through the QA process.</p>	09/26/2012

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K 046	Continued From page 7 indicated that monthly and annual testing was not conducted and they did not have any records of such testing.  2. Observed Battery-Back up emergency lighting in the Emergency Generator room,  3. Observed Battery Back-up emergency lighting above the means of egress door in two dining rooms.	K 046		
K 052 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This Standard is not met as evidenced by: Based upon a record review and staff interviews with the director of maintenance at approximately 1120 hours Avalon Care Center of Pullman has failed to have appropriate testing of the fire alarm system. This could result in the failure of the fire alarm system to operate properly which would result in the failure to notify staff of a water supply problem to the fire sprinkler system.  The findings include:  1. A record review of the fire alarm test report for	K 052	<u><b>K 052 Failure to have appropriate testing of the fire alarm system. 9.6.1.4.</b></u>  1- Tamper switches are tested annually and were tested on 01/19/2012 by Simplex Grinnell. IDR will be submitted at same time as this POC.  Maintenance Supervisor to monitor and insure that records for tamper switch testing are updated and available for further inspection.  Administrator to monitor and insure that records for tamper switch testing are updated and available for further inspection semiannually for compliance through the QA process.  2- Central Station Interconnection and code transmitters are tested daily by Moon Security. IDR will be submitted at same time as this POC.  Maintenance Supervisor to monitor and insure that records for Central Station Interconnection and code transmitters are updated and available for further inspection.  Administrator to monitor and insure that records for Central Station Interconnection and code transmitters are updated and available for further inspection semiannually for compliance through the QA process.	09/26/2012

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K 052	Continued From page 8	K 052		
	the test conducted on 03-28-12 by Moon Security indicated that the tamper switches for the fire sprinkler system were not tested.			
	2. The test report also does not indicate that the Central Station Interconnection and the code transmitters were also not tested.			
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 054	<b><u>K 054 Failure to provide documentation for fire alarm sensitivity testing. 9.6.1.3.</u></b>	
	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3		1- Moon security does annual testing of alarm sensitivity and tested sensitivity on 03/28/2012. Documentation from Moon Security will be submitted with IDR at same time as this POC.	
	This Standard is not met as evidenced by: Based upon a record review and staff interviews with the director of maintenance at approximately 1120 hours Avalon Care Center of Pullman has failed to provide documentation to show that the smoke detectors in the building have had sensitivity testing completed as required. This could result in the failure of the smoke detectors to operate properly which could result in a delay in detecting a fire.		Maintenance Supervisor to monitor and insure that records for alarm system sensitivity testing are updated and available for further inspection.	
	The findings include: 1. During this record review I did find a test report for sensitivity testing however, there is no property name or address or another identifying indicators and there is no date on the form to show what date the testing was conducted.		Administrator to monitor and insure that records for alarm system sensitivity testing are updated and available for further inspection semiannually for compliance through the QA process.	09/26/2012
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		
	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested			

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K 062	Continued From page 9 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This Standard is not met as evidenced by: Based upon observations, record reviews and staff interviews with the director of maintenance during survey rounds between the hours of 0840 and 1400 Avalon Care Center of Pullman has failed to maintain the fire sprinkler system as required. This could result in the failure of the sprinkler system to operate in the event of a fire and allow the fire to gain in size and intensity which would endanger the residents, staff and guests  The findings include:  1. Observed several items being stored on the sprinkler piping in the boiler room.  2. Observed a electric type light switch on the sprinkler system which appeared to be connected to valves or tamper switches on the system.  3. During a record review at 1200 there were no records of quarterly sprinkler testing and in 2011 records indicated only two quarters of sprinkler testing.  4. Observed that a folding chair was placed in front of the Fire Department Connection (FDC) so that the FDC was not observable.  5. Observed an electrical cord wrapped around the sprinkler piping in the Laundry room above the entrance door.	K 062	<b><u>K 062 Failure to maintain the fire sprinkler system as required. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5.</u></b>  1- Stored items on sprinkler piping were immediately removed on 09/19/2012. 2- Electric type switch on sprinkler system is for natural gas shutoff in kitchen. Switch was marked and labeled for use on 09/20/2012. 3- Testing was scheduled on 09/24/2012 and will be done quarterly. 4- Folding chair in front of FDC was immediately removed on 09/19/2012. 5- Electrical cord wrapped around the sprinkler piping in laundry room was removed immediately on 09/19/2012.  All Staff will be in-serviced regarding keeping fire sprinkler equipment free from impediments and cables on 09/28/2012.  Maintenance Supervisor to monitor and insure fire sprinkler system is tested quarterly, maintained, free from any obstructions, hanging objects, and storage.  Administrator to monitor fire sprinkler system is tested and maintained as required semiannually for compliance through the QA process.	
K 066	NFPA 101 LIFE SAFETY CODE STANDARD	K 066		09/26/2012

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>AVALON CARE CENTER - PULLMAN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>NORTHWEST 1310 DEANE PULLMAN, WA 99163</b>		
(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 066	<p>Continued From page 10</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This Standard is not met as evidenced by: Based upon observations, record review and staff interviews with the director of maintenance during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to provide the proper equipment at the approved staff smoking area. This could result in the ignition of the dried grass abutting the staff smoking area.</p> <p>The findings include:</p> <p>1. The smoking policy presented to this surveyor</p>	K 066	<p><u><b>K 066 Failure to provide proper equipment at the approved staff smoking area. 19.7.4</b></u></p> <p>The resident No Smoking policy is given and signed on admission by our residents.</p> <p>The designated staff smoking area has been cleaned on 09/26/2012 and ashtray and metal container with a self closing lid present will be available on 10/01/2012.</p> <p>Maintenance Supervisor to monitor and insure the designated staff smoking area is clean and ash trays and metal container with self closing lid are being used and maintained.</p> <p>Administrator to monitor staff smoking area for compliance semiannually for compliance through the QA process.</p>	09/26/2012

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K 066	Continued From page 11 indicated that staff was permitted to smoke in designated area.  2. Director of maintenance indicated that the facility was a no smoking facility and the Director of Nursing stated that smoking was permitted by staff only. There is not a written smoking policy for residents available at the time of this survey.  3. Observed at the designated staff smoking area there were no ashtrays present.  4. Observed that there was not a metal can with a self closing lid present to dispose of the contents of ashtrays.  5. Observed numerous cigarette butts and other smoking material in the dried grass abutting the smoking area.  6. Observed a plastic milk container with discarded smoking material in it.	K 066		
K 072 SS=E	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 upon observations and staff interviews with the director of maintenance during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to maintain the exit access corridors free of obstructions and	K 072		

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K 072	Continued From page 12 impediments to full and instant use in the event of an emergency. This could result in delays in conducting smoke compartment evacuation or full evacuation of the building due to a fire or other emergency.  The findings include:  1. AT 0840 observed two (2) Hoyer lifts being stored in the corridor near resident rooms 29 and 33. The lifts did not move and were still in the corridor at the same location at 1008 hours and at 1400 hours. Interviews with Health Survey team members indicated that they were stored in the corridor yesterday as long as the surveyors were in the building.  2. Observed wall mounted computers in the corridor at three locations. At two of the three locations the key boards were left in the down position which extended 13 inches into the corridor when measured by the director of maintenance.  3. The wall mounted computer near resident room 5 was in the down position from first observation at 0845 through 1400 hours.  4. The wall mounted computer near the Captivity Director's office was in the down position from 0845 and still down at 1338.	K 072	<u><b>K 072 Failure to maintain the exit access corridors free of obstructions and impediments to full and instant use in the event of an emergency. 7.1.10.</b></u>  1- Hoyer lifts were moved out of corridor on 09/20/2012. 2-4 Wall mounted computers keyboards were immediately put in the up position for compliance on 09/19/2012.  Staff will be trained and in-serviced on 09/28/2012 regarding the obstruction and impediments code 7.1.10.  Maintenance Supervisor to monitor and insure the exit access corridors are free from obstructions and impediments.  Administrator to monitor exit access in corridors semiannually for compliance through the QA process.	
K 144 SS=F	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.	K 144		09/26/2012

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K 144	Continued From page 13  This Standard is not met as evidenced by: Based upon a record review and staff interviews with the director of maintenance at approximately 1135 hours Avalon Care Center of Pullman has failed to have annual and 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 lighting and work lighting in the event of a power failure.  The findings include:  1. The Maintenance Director was unable to locate a current test report for the emergency generator the last report was dated 2010.	K 144	<u><b>K 144 Failure to have annual testing and maintenance conducted on an emergency generator. 3.4.4.1.</b></u>  I- Annual emergency generator test was performed by M&M Harrison Electric on 09/20/2012.  Maintenance Supervisor to monitor and insure annual testing and service is completed.  Administrator to monitor annual generator testing and service is done semiannually for compliance through the QA process.	09/26/2012
K 146 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1  This Standard is not met as evidenced by: Based upon observations and staff interviews with the director of maintenance during survey rounds between 0840 and 1400 Avalon Care Center of Pullman has failed to restrict the use of multi-plug outlets (power strips) to providing power to limited electrical equipment such as	K 146		

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K 146	Continued From page 14 computer related equipment. This could result in a fire due to the overheating of the plug strip due to the heavy power draw.  The findings include:  1. In the office of the Director of Nursing, Assistant Director of Nursing observed that a window air conditioning unit was plugged into a 6 outlet plug strip.	K 146	<u><b>K 146 Failure to restrict use of multi plug outlets to provide power to limited electrical equipment. NFPA 99, 3.6.3.1.1</b></u>  1- Window air conditioning unit was unplugged immediately on 09/19/2012. A new outlet will be installed to accommodate unit if appropriate for that room.  The maintenance supervisor will inspect each power tap device in building to insure proper protocols are followed.  An in-service and safety policy review will also be completed on 09/28/2012.  Administrator to monitor compliance of facility with electrical wiring code semiannually for compliance through the QA process.	09/26/2012

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