

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

1361
Printed: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505246	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2013
NAME OF PROVIDER OR SUPPLIER AVALON CARE CENTER - PULLMAN			STREET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST 1310 DEANE PULLMAN, WA 99163	
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>This inspection report is the result of an unannounced Fire and Life Safety Re-certification Survey conducted at Avalon Care Center - Pullman, located at 1310 NW Deane St. Pullman Washington. The Fire and Life Safety Survey commenced on 10/30/13 at approximately 1230 hours and ended on 10/30/13 at approximately 1600 hours. During this Survey I was accompanied by the facility maintenance director and at times the facility administrator, who witnessed any deficiency noted during this Survey.</p> <p>The existing section of the 2000 Life Safety Code (NFPA 101) was used in accordance with 42 CFR 483.70. This facility is a one story structure of type V-1 Hour Construction with exits to grade and is protected by a Type 13 Fire Sprinkler System and an Automatic/Manual Fire Alarm System with corridor detection, resident room and common areas are equipped with Single Station Smoke Alarms. The facility is approximately 15,200 square feet in size and is licensed for 48 residents with a current census of 26.</p> <p>The Fire and Life Safety Survey was conducted in conjunction with the Health Survey Team from Department of Social and Health Services.</p> <p>The facility fails to meet this standard based upon deficiencies noted during this Survey.</p> <p>The Surveyor was: ██████████ Deputy State Fire Marshal Nursing Home Surveyor 20225</p> <p>The Surveyor was from:</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **MAINTENANCE DIRECTOR** (X6) DATE **11/07/2013**

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 000	Continued From page 1 Washington State Patrol Office of the State Fire Marshal Fire Prevention Bureau PO Box 19130 Spokane WA 99219-9130 Telephone: (509) 227-6567 Fax: (509) 227-6639  DSFM	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: During this Fire and Life Safety Survey conducted on 10/30/13 between the hours of 1230 to 1600 while accompanied by facility staff we observed three out of four exit doors equipped with 15 second delayed egress were difficult to initiate the delayed egress process, had to push extremely hard on the doors and once that point was reached then the process was initiated with the alarm. Would be difficult for some individuals to activate the delayed egress process without using the code to open the doors. Difficulty of these doors to open could cause an undo delay in exiting the building in the event of a fire or other emergency placing residents, staff and visitors at risk of possible harm.	K 038	<u>K 038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1</u> The three doors that were difficult to initiate the delayed egress process were immediately adjusted and are now easy to operate as required. Maintenance Supervisor to monitor monthly and insure that all four doors with delayed egress process are easy to operate. Administrator to monitor delayed egress process for all four doors quarterly for compliance through the QA process.	10/31/13
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		

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K 046	Continued From page 2 This Standard is not met as evidenced by: Based upon observations made during the Survey conducted on 10/30/13 between the hours of 1230 to 1600 while accompanied by facility staff we observed the Emergency Egress Light located in the Dayroom did not work on Battery Backup. Emergency Egress Lights are required to work on Battery Backup for up to 90 minutes. Facility is also required to test these devices on a Monthly Basis for 30 Seconds and once a Year for 90 Minutes and maintain documentation available for review. Failure to provide proper illumination in the event of an emergency could place residents, staff or visitors at risk of possible harm.	K 046	<u>K 046 Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9 19.2.9.1</u> The battery was replaced for the emergency egress light located in the dayroom on 10/31/2013. Maintenance Supervisor to monitor monthly and insure that all emergency lighting throughout the facility are working properly and replace batteries as needed. Administrator to monitor emergency lighting monitoring quarterly for compliance through the QA process.
K 050 SS=F	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. 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 upon observations, documentation review and staff interviews during the Survey conducted on 10/30/13 between the hours of 1230 to 1600 while accompanied by facility staff we observed that the facility was lacking documentation to show that fire drills were being conducted on	K 050	<u>K 050 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. Responsibility of planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms. 19.7.1.2</u> Month to Month Fire Drill coordination form was created and implemented on 11/04/13.

10/31/13

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K 050	Continued From page 3 each shift at least once quarterly: 1. Facility was lacking documentation for a Swing Shift Fire Drill during the First Quarter of 2013 2. Facility was lacking documentation for a Night Shift Fire Drill during the Second Quarter of 2013 3. Facility was lacking documentation for a Swing Shift Fire Drill during the Third Quarter of 2013 Failure to conduct the required number of fire drills to ensure staff training and knowledge to ensure the prompt response and action in the event of a fire could place residents, staff and visitors at risk of possible harm.	K 050	Maintenance Supervisor to monitor and insure Fire Drill times and varying condition requirements are followed monthly. Administrator to monitor fire drill coordination semiannually for compliance through the QA process.	11/4/13
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based upon observations and staff interviews during this Fire and Life Safety Survey conducted on 10/30/13 between the hours of 1230 to 1600 the facility was unable to provide documentation to show that the Single Station Smoke Alarms in resident rooms and common areas were being tested Monthly and batteries replaced at least Annually. Maintenance staff indicated that they had tested and replaced battery's in approximately 20 detectors but did not have documentation to show that this was done. Failure to ensure the proper operation of these Smoke Alarms could place residents, staff and visitors at risk of possible harm.	K 054	<u>K 054 All required smoke detectors, including those activating door hold-open devices are approved, maintained and tested in accordance with manufacturers specifications. 9.6.1.3</u> All single station smoke detectors were inspected and tested on 10/31/13. Checklist implemented on 11/1/13 for proof of compliance. Maintenance Supervisor to inspect and test single smoke stations monthly and change batteries at least annually. Administrator to monitor single station smoke alarm monitoring and testing semiannually for compliance through the QA process.	11/1/13
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 073		

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K 073	Continued From page 4 No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This Standard is not met as evidenced by: Based upon observations and staff interviews during this Fire and Life Safety Survey conducted on 10/30/13 between the hours of 1230 to 1600 while accompanied by facility staff we observed some Holiday Decorations that were of highly combustible material located throughout the facility and at the Main Entrance to the facility. Facility was displaying imitation spider webs that the package that they come in advised against having to close to open flame and also had a Decoration made of Cornstalks positioned at the Main Entrance. In addition they had the artificial spider webs and a string of decorative lights on the handrail by the nurses station that made the handrail unusable. Decorations of highly combustible material are prohibited in our Health Care facilities unless they are fire retardant, failure to ensure this Standard could place residents, staff and visitors at risk of possible harm due to fire.	K 073	<u>K 073 No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</u> All Halloween Holiday decorations that were not in compliance were removed immediately on 10/30/13. In-Service was done with Activities Coordinator and Maintenance Director about not using flammable holiday decorations. Maintenance Supervisor to monitor and insure that any holiday or other decorations or furnishings are not of a highly flammable character. Administrator to monitor flammability of holiday and any other decorations semiannually for compliance through the QA process.	10/30/13
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	<u>K 0144 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1</u> Annual generator test was ordered on 10/30/13 and performed on 11/1/13. Maintenance Supervisor to monitor and insure annual generator test is completed before expiration occurs.	

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K 144	Continued From page 5 This Standard is not met as evidenced by: Based upon observations, staff interviews and documentation review the facility was unable to provide documentation of a current Annual Inspection and Testing of their Emergency Generator. The last Inspection Report available for review was for 9/21/12 and Staff did not believe the Inspection and Testing had been done. Failure to ensure proper operation of the Emergency Generator could place residents, staff and visitors at risk of possible harm.	K 144	Administrator to monitor generator tested and maintained as required semiannually for compliance through the QA process.	11/1/13
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: Based upon observations made during the Fire and Life Safety Survey conducted on 10/30/13 between the hours of 1230 to 1600 while accompanied by facility staff we observed two locations where multi-plug power strips with flexible cords were being used for Electrical Items other than Computer Equipment. CMS has made a determination the multi-plug power strips with flexible cords are only allowed for Computer Equipment and no other Electrical Devices: 1. Multi-plug power strip with flexible cord was being used for TV Equipment in the Dayroom 2. Multi-plug power strip with flexible cord was being used for Appliances (Refrigerator and Vending Machine) in the Employee Break Room Appliances are to be plugged directly into an approved electrical outlet. Failure to ensure the proper use of Electrical Equipment and Wiring could place residents, staff and visitors at risk of	K 147	<u>K 147 electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2</u> All multi-plug power strips with flexible cords were removed on 11/04/13. Maintenance Supervisor to monitor and insure that multi plug power strips with flexible cords are not used throughout building except for use with computer equipment. Administrator to monitor that multi plug power strips with flexible cords are not being used, except for use with computer equipment semiannually through the QA process.	11/4/13

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K 147	Continued From page 6 possible harm due to overheating or electrical shock.	K 147		
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