

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

Printed: 03/27/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505513</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>STAFFORD HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2800 SOUTH 224TH STREET. DES MOINES, WA 98198</b>
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K 000

INITIAL COMMENTS

K 000

Surveyor: 19192  
This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Stafford Healthcare located at 2800 South 224th Street Des Moines Wa, 98198 on 3/27/2014 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.  
The facility is a two story structure with a basement of Type V-A construction. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. Exits are through rated stairwell enclosures from the upper floors and to grade with paved exit discharges to the public way.  
  
The facility has a total of 165 beds and at the time of this survey the census was 92.  
The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 48  
  
The facility is in compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.

  
Donald L. West  
Deputy State Fire Marshal

K 050  
SS=F

NFPA 101 LIFE SAFETY CODE STANDARD

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 for planning and conducting drills

**RECEIVED**  
**APR 04 2014**  
**Tacoma WSP**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Kenn S. Fletcher</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>4/4/14</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 050	<p>Continued From page 1</p> <p>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: 19192</p> <p>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</p> <p>Based upon record review and staff interviews on 3/27/2014 between approximately 0800 and 1145 hours the facility has failed to provide fire drill records reflecting drills being conducted on all shifts for the past 12 months. 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:</p>	K 050	<p>K 050</p> <p>(1) Future fire drills will be done in compliance with the NFPA 101 Standard that requires conducting at least one drill per shift each quarter at varying times each shift to ensure all employees are adequately trained and practice emergency procedures.</p> <p>(2) The Maintenance Director will develop a schedule for all shifts of employees to participate in quarterly fire drills by individual shifts, rather than combining two shifts into one drill as practiced by previous Maintenance Director.</p> <p>(3) The Maintenance Director will report on staff performance in fire drills at facility Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee will review the monthly drills that ensure quarterly compliance of drills on all shifts.</p> <p>(4) The Maintenance Director will ensure compliance.</p>	4/18/14

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K 050	Continued From page 2 1. There are no drill reports to review for the swing shift in the first quarter of 2014. 2. There are no drill reports to review for the day shift in the second quarter of 2013. 3. There are no drill reports to review for the night shift in the fourth quarter of 2013.  The above was discussed and acknowledged by the facility maintenance director at the time of the survey.	K 050		
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: Surveyor: 19192 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This requirement is not met as evidenced by: Surveyor 19192  Based upon record review and observation on 3/27/2014 between approximately 0800 and 1145 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:	K 064		

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K 064	Continued From page 3  1. The K-class extinguisher in the kitchen is mounted to high, the extinguisher shall be mounted no more than 3 1/2 feet off the floor.  The above was discussed and acknowledged by the facility maintenance director at the time of the survey.	K 064	K 064  The K-Class extinguisher in the kitchen was removed and re-mounted to regulation height the same date identified by the State Fire Marshal.	3/27/14
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 accordance with NFPA 99. 3.4.4.1.  This requirement is not met as evidenced by: Surveyor 19192  Based upon observations and staff interviews on 3/27/2014 between approximately 0800 and 1145 hours the facility has failed to have the emergency generator meet the requirements of 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	K 144	K 144  (1) Future generator tests conducted will meet requirements for general tests and load tests to ensure readiness of equipment to function in emergency power outages to protect residents.  (2) A generator test log will be implemented that will record the start time and end time, and will indicate whether it was a load test or not. The total elapsed time of tests under load will be documented on load tests.  (3) The Maintenance Director will review generator performance and provide a copy of the generator test log for review at the QAPI committee meeting monthly for three months to ensure proper function of equipment.  (4) The Maintenance Director will ensure compliance.	4/11/14

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K 144	<p>Continued From page 4 within the facility.</p> <p>Based upon record review and staff interviews on 3/27/2014 between approximately 0800 and 1100 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.</p> <p>The findings include, but are not limited to:</p> <p>1. Upon review of the facility generator logs it was determined that the facility is not identifying the start and end time of the monthly load test and there is no total run time for the load test identified.</p> <p>The above was discussed and acknowledged by the facility maintenance director at the time of the survey.</p>	K 144		
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This requirement is not met as evidenced by: Surveyor 19192</p> <p>Based upon observations and staff interviews on</p>	K 147	<p>K 147</p> <p>(1) The facility staff will use approved methods of supplying power to all equipment used in the course of their work duties to ensure safety of residents.</p> <p>(2) The power strip identified during inspection of the office area in the therapy gym was immediately removed from use at the time of the Life Safety inspection.</p>	

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K 147	<p>Continued From page 5</p> <p>3/27/2014 between approximately 0800 and 1145 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.</p> <p>The findings include, but are not limited to:</p> <p>1. In the therapy gym there was an extension cord in use at the desk by the door next to the file cabinet. (THIS FINDING WAS CORRECTED AT THE TIME OF THE SURVEY)</p> <p>The above was discussed and acknowledged by the facility maintenance director at the time of the survey.</p>	K 147	<p>(3)</p> <p>Department leadership members and therapy team members will be re-inserviced on regulations addressing power supply chords that are allowable and not allowable in the skilled nursing facility environment.</p> <p>(4)</p> <p>Weekly rounds of office work areas will be conducted to ensure compliance.</p> <p>(5)</p> <p>The Maintenance Director will ensure compliance.</p>	4/11/14
K 211 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul>	K 211		

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K 211	<p>Continued From page 6</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>· The corridor is at least 6 feet wide</li> <li>· The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>· The dispensers have a minimum spacing of 4 ft from each other</li> <li>· Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>· Dispensers are not installed over or adjacent to an ignition source.</li> <li>· If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul> <p>This requirement is not met as evidenced by: Surveyor 19192</p> <p>Based upon observations and staff interviews on 3/27/2014 between approximately 0800 and 1145 hours the facility has failed to properly install alcohol based hand rub dispensers. Dispensers installed improperly could result in hand rub coming in contact with an electrical source resulting in a fire causing potential endanger to 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"> <li>1. In the therapy gym there was a hand sanitizer dispenser too close to the light switch. (THIS DEFICIENCY WAS CORRECTED AT THE TIME OF THE SURVEY)</li> </ol>	K 211	<p>K 211</p> <p>The alcohol gel dispenser identified to be too close to the light switch was removed, and relocated to an alternate location at the time of survey.</p> <p>A full inspection of the facility gel dispensers was conducted to ensure no others were located in a manner that would create a fire hazard.</p>	3/27/14

*KSP*

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K 211	Continued From page 7  The above was discussed and acknowledged by the facility maintenance director at the time of the survey..	K 211		