

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

FORM APPROVED  
OMB NO. 0938-0391

1371

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505216</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>FIDALGO CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1105 27TH STREET ANACORTES, WA 98221</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced Life Safety Code Survey was conducted at Fidalgo Care Center, Anacortes, Washington, on September 6, 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 44 bed facility with a census of 37, consisted of a Type V-111, 1 story structure housing the residents, as well as a 2 story, Type V-111 structure that houses the administration offices, environmental services and rehabilitation, built in 1995 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> <i>Paul V. Schra</i> Deputy State Fire Marshal</p>	K 000		
K 018 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joe Stutik</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>9/16/13</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 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  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 September 6, 2013 from 11:30 AM to 2:00 PM it was observed that the following doors did not close, latch or open properly when tested:  1. Garden dining room - door obstructed by resident 2. Baker dining room - east door wedged.  These findings were acknowledged by the facility Maintenance Director.	K 018	Resident was moved from a position of obstructing the closure of the fire door in the Garden Dining Room. The floor wedge was removed from under Mt. Baker dining room door the day of the inspection. Staff was in-serviced on why the fire doors are to be free of obstructions. Doors will be observed on facility safety tours of the Skilled Nursing per the facility Safety Committee and Maintenance Director. These safety reviews will be reviewed by the facility QA committee. Facility Maintenance Director (M.D. will monitor and Executive Director (E.D.) will oversee compliance.	10/13/13
K 050 SS=E	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	<p>Continued From page 2</p> <p>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: 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:</p> <p>An examination of the facility 's fire drill records on September 6, 2013 at 12:40 PM revealed that the fire drill records were missing for the month, quarter and shift as follows:</p> <p>Jan/Feb/Mar 2013 - no record of fire drills conducted Apr/May/Jun 2013 - no record of drills for 2nd or 3rd shift Jul/Aug/Sept 2013 - no record of fire drills conducted Oct/Nov/Dec 2012 - no record of drills for 2nd shift</p> <p>These findings were acknowledged by the Maintenance Director.</p>	K 050	<p>Facility will conduct quarterly fire drills at random times a minimum of once each shift. Future fire drills will be and have been scheduled in the monthly safety committee meeting held 9/15/13. Drill records will be reviewed for compliance at both the monthly safety committee and Quality Assurance meetings. Fire drills will be conducted by the facility M.D. or their designee. M.D. will monitor and Executive Director oversee compliance.</p>	10/13/13
K 062 SS=E	<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>	K 062		

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K 062	<p>Continued From page 3</p> <p>This Standard is not met as evidenced by: Based on observations, the facility failed to maintain the proper operational condition of the sprinkler system. This has the potential of having a non-functional sprinkler system that would expose residents to a fire or smoke environment. The findings are as follows:</p> <p>During the facility tour on May 29, 2008, from 10:45 AM to 1:00 PM, the following deficiencies were found:</p> <p>1. On September 6, 2013 at 12:30 PM while checking sprinkler documentation, it was observed that the facility has no documentation for conducting quarterly sprinkler inspections for the following periods.:</p> <p>a. 2nd qtr - 2013 b. 3rd qtr 2013 c. 4th qtr 2012</p> <p>Also the documentation seen has the inspection completed but no date indicating when completed.</p> <p>These findings were acknowledged by the Maintenance Director.</p>	K 062	<p>Facility will conduct sprinkler inspections on a quarterly basis per the regulation. Log will be reviewed at both monthly Safety and Quality Assurance Committee meetings. Sprinkler inspection was conducted by the facility maintenance department and completed on September 11, 2013. M.D. will monitor and E.D. will oversee compliance and safety.</p>	10/13/13
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>	K 064		

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K 064	<p>Continued From page 4</p> <p>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.</p> <p>During the facility tour on September 6, 2013 at 1:10 PM documentation review was conducted and the following deficiency was observed:</p> <ol style="list-style-type: none"> <li>1. No documentation for 12 months of monthly inspections (missing may, Jun, Jul, Aug, sep 2013)</li> <li>2. Extinguisher in the kitchen is directly behind the grill which impedes quick action if needed.</li> <li>3. Extinguisher in the laundry room - top of unit is more than 5 feet above the floor.</li> </ol> <p>The Maintenance Director acknowledged the findings.</p>	K 064	<p>Fire extinguishers will be inspected per regulatory requirements and date of inspection noted in log. Fire extinguishers were inspected by facility Maintenance Department. Log book will be reviewed at both monthly Safety Committee meeting and Quality Assurance meeting for compliance.</p> <p>Fire extinguisher located in laundry Room was moved to a height under the five foot requirement. The facility Maintenance Department checked all other fire extinguishers for compliance with height requirement.</p> <p>Fire extinguisher in the Kitchen was moved to location that does not impede its use in an emergency and is under the five foot height requirement.</p>	10/13/13
K 072 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>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.</p>	K 072	M.D. will monitor and E.D. will oversee compliance.	

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K 072	<p>Continued From page 5</p> <p>Findings include:</p> <p>During the facility tour on September 6, 2013 from 11:30 AM to 2:00 PM observed that the exit egress by the:</p> <ol style="list-style-type: none"> <li>Admin Building - Rear stairwell - motorized wheel chair being stored</li> <li>Admin Building - Front stairwell - popcorn machine being stored</li> </ol> <p>This finding was acknowledged by the Maintenance Director.</p>	K 072	<p>Motorized wheelchair and popcorn machine were removed from stairwells on 9/7/13. Maintenance Department will conduct weekly rounds of building stairwells for prevention of similar situations as listed in citation. M.D. will monitor and E.D. will oversee compliance.</p>	10/13/13 & On-going
K 144 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This Standard is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that emergency power was available during primary power outage in accordance with NFPA 99, 3-4.4.2 requiring documentation of testing, maintenance and repairs of the generator. This potentially affected all residents to loss of illumination of exit egress, fire and smoke alarms during a power outage.</p> <p>Findings include:</p> <p>During a record review of the generator maintenance log on September 6, 2013 at 12:55</p>	K 144		

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K 144	<p>Continued From page 6</p> <p>PM, the facility failed to maintain a proper log showing that the generator had been placed under a load in the past 12 months for : (month/year)</p> <p>1. Jan, Mar, Apr, May, Jun, Jul, Aug 2013 2. Sep, Nov 2012</p> <p>During a record review of the generator maintenance log on September 6, 2013 at 12:55 PM, the facility failed to maintain a proper log showing that the generator had been inspected weekly for the past 12 months for: (month/year)</p> <p>1. Jul, Aug, Sep 2013</p> <p>During the record review of the generator maintenance log on September 6, 2013 at 12:55 the log book showed that the facility failed to have the annual service conducted on the generator. Last service conducted: (8-1-2012)</p> <p>These findings were acknowledged by the maintenance staff.</p>	K 144	<p>During the inspection the annual service/inspection documentation was not readily available. See attached annual inspection documentation conducted 7/23/13.</p> <p>The facility generator will be placed under load on a monthly basis. Load test was conducted on 9/14/13. Facility generator will be inspected weekly and proper log with month and year will be maintained by facility Maintenance Department. Logs will be reviewed at both Safety Committee and Quality Assurance meetings for completion. M.D. will monitor and E.D. will oversee compliance.</p>	10/13/13 & On-going
K 147 SS=C	<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: 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:</p> <p>During the facility tour on September 6, 2013 from 11:30 AM to 2:00 PM the following</p>	K 147		

*[Handwritten Signature]*  
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K 147	<p>Continued From page 7 deficiencies were found:</p> <ol style="list-style-type: none"> <li>1. Rehab area IT room - multi plug adapter hanging by cord</li> <li>2. Rehab area - treatment room - broken electrical cover plate</li> </ol> <p>These findings were acknowledged by the Maintenance Director</p>	K 147	<p>Multi-plug adapter was secured on 9/7/13. Outlet cover was replaced on 9/9/13. Service Building will be included by facility Maintenance Department on monthly building rounds. Documentation and findings from the building tour will be reviewed at monthly Safety Committee meeting. M.D. will monitor and E.D. will oversee compliance.</p>	10/13/13 & On-going

*[Handwritten Signature]*  
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