

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

1374 ✓

Printed: 07/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505327</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/09/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>AVAMERE OLYMPIC REHABILITATION OF SE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 5TH AVENUE SOUTH SEQUIM, WA 98382</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 32862 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at the Avamere Olympic Rehabilitation of Sequim on 07/09/13 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>Olympic Rehabilitation of Sequim has a total of 125 beds and at the time of this survey the census was 81.</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 5 (111) construction with exits to grade. The facility is protected by a Type 13 sire sprinkler system throughout 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 2000 Life Safety Code as adopted by the Centers for Medicare &amp; Medicaid Services.</p> <p><i>Melissa Blann</i> Deputy State Fire Marshal</p> <p><i>[Signature]</i> Deputy State Fire Marshal</p>	K 000	<p>The filing of this plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's effort to comply with the requirements of Medicare and Medicaid participation and to continue to provide a high quality of resident care.</p>	
K 012 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Building construction type and height meets one</p>	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> Heather Jeffers	TITLE Administrator	DATE 7/19/2013 (X6)
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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 012	Continued From page 1 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: 32862 Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim 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: Gap between sheetrock and sprinkler pipe over the kitchen hood Gap between sheetrock and wiring in Resident Care Manager Office Gap between sheetrock and sprinkler pipe in the Med Room Hole in ceiling lid above ceiling tiles near Resident Room 101 Gap between sheetrock and wiring/electrical conduit above the fire separation doors by the MDS Coordinator's Office/Greywolf Way Gap between sheetrock and wiring in the linen closet by Room 106 Gap between sheetrock and wiring in the Shower West room Gap between sheetrock and wiring/breach in sheetrock Oxygen Storage closet Breaches in sheetrock in the Medical Records Room	K 012	K012:  1. Areas listed will be repaired. 2. Resident rooms and common areas will be audited to validate that no other areas need repaired. 3. Routine audits of rooms by Maintenance rounds and Caring Partners to include any breach in walls, ceilings, sheetrock and will be reported in stand up and maintenance requisition. 4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6: Maintenance Director & Administrator to ensure compliance.	

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K 012	Continued From page 2 Gap between sheetrock and wiring in the IT Room Gap between sheetrock and wiring/breach in sheet room in the Clean Linen Dungeness Court Gap between sheetrock and wiring/breach in sheet room in the Main Electrical Room Breach in sheetrock in the Main Boiler Room Gap between sheetrock and wiring in the laundry room Gap between sheetrock and wiring House Keeping Manager's Office Breach in wall and ceiling in the House Keeping Manager's Office Missing sheetrock on the ceiling of Room 315 Wiring run through sheetrock between the lobby desk and office Gap between sheetrock and wiring above the corridor fire doors near the Beauty Salon Wall installed in the Physical Therapy Office - no evidence this wall was approved by Department of Health Construction Review Missing sheetrock in the computer room of the Cyprus Dining Room Gap between sheetrock and sprinkler pipes in the Resident Care Manger's office  The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 012		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 018	K018:  1. Door of Room 111 latched repaired on 7/19/13. 2. Doors in facility checked and replaced latches as identified. 3. Ongoing monitoring and auditing of door latches will be added to preventative maintenance program and routine maintenance rounds.	

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K 018	Continued From page 3 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: Surveyor: 32862 Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim 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.  The findings include, but are not limited to: Resident room door 111 difficult to open and close in the latching position The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 018	K018 Continued:  4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6. Maintenance Director & Administrator to ensure compliance.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 029		

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K 029	<p>Continued From page 4</p> <p>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: 32862 Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim 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.</p> <p>The findings include, but are not limited to: Baker Dining Room doors not latching in the closed position Cyprus Dining Room doors not latching in the closed position Kitchen storage room doors not latching in the closed position Doctor's office not equipped with latching hardware (key pad dead-bolt device only) Lobby fire doors not latching not latching in the closed position Classroom near Dungeness Drive does not have a self closer Health Information room does not have a self closer Activities room does not have a self closer The above was discussed and acknowledged by the Facility Director and Maintenance Director.</p>	K 029	<p>K029:</p> <ol style="list-style-type: none"> <li>Doors mentioned have been adjusted for closing speed and latching speed. Hardware changed to latching hardware where needed. Self closers installed where indicated.</li> <li>Doors will be added to fire drill check list to verify closure.</li> <li>Audit of doors latching added to fire drill check off.</li> <li>Routine auditing of doors added to preventative maintenance schedule. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter.</li> <li>Date of completion: 8/10/13</li> <li>Maintenance Director &amp; Administrator to ensure compliance.</li> </ol>	

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K 052 K 052 SS=F	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD  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: Surveyor: 32862 Based upon record review and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim has failed to have appropriate testing of the fire alarm system which could result in the failure of system endangering the residents, staff and/or visitors within the facility.  The findings include, but are not limited to: The fire alarm system has not received an annual inspection since 2/21/12 The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 052 K 052	K052:  1. Fire Alarm system received last annual inspection on 7/23/12 to 7/24/12. Documentation of this was provided to surveyor on 7/9/13. 2. Next Annual fire alarm inspection was already scheduled for 7/30/13 and will be completed as scheduled. 3. Annual fire alarm inspection is on preventative maintenance schedule. 4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6. Maintenance Director to ensure ongoing compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 062		

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K 062	Continued From page 6  This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim has failed to conduct testing of the fire sprinkler system as required. Space around the fire sprinkler riser obstructed with storage. This could result in the failure of the fire sprinkler system to operate properly in the event of a fire which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Storage of vacuums and filing cabinets obstructing the sprinkler riser Sprinkler Riser Room is not labeled on the corridor. Fire sprinkler inspection report does not indicate fire department connection back flush or internal pipe inspection has been conducted within the past 5 years Fire sprinkler escutcheon missing in the Social Director's office The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 062	<b>K062:</b>  1. Annual Fire Sprinkler System was tested on 7/23/12. Documentation was provided to surveyor on 7/9/13. Next annual testing is scheduled for 7/20/12 and will be completed as scheduled. This will also include fire department connection back flush and internal pipe inspection. Vacuums relocated to different storage area. Filing cabinets relocated. Sprinkler Riser Room labeled in corridor with appropriate signage. Fire sprinkler escutcheon replaced in SSD office. 2. Sprinkler riser rooms added to maintenance rounds schedule to validate areas stay cleared. 3. Item added to preventative maintenance schedule to ensure ongoing compliance. 4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6. Maintenance Director responsible for compliance.	
K 064 SS=E	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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:	K 064		

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K 064	Continued From page 7 Surveyor: 32862 This requirement is not met as evidenced by:  Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim 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: Extinguisher in the kitchen blocked by cooking equipment Extinguisher in the maintenance shop has not been inspected on an annual or monthly basis Extinguisher in the Laundry Room has not been inspected on an annual or monthly basis Extinguisher in the Main Electrical Room mounted above 5 feet at the top of the extinguisher  The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 064	<b>K064:</b>  1. Cooking equipment relocated away from fire extinguisher. Extinguisher in Maintenance shop inspected and is current. Extinguisher in Laundry has been inspected and is current. Extinguisher in main electrical room lowered to meet regulatory distance from floor. 2. Maintenance will maintain complete list of extinguishers to ensure annual and monthly inspections are completed. 3. Maintenance of fire extinguishers added to monthly preventative maintenance program; as well as annual inspections. 4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6. Maintenance Director to ensure compliance.	
K 072 SS=F	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:	K 072		

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K 072	Continued From page 8 Surveyor: 32862 This requirement is not met as evidenced by:  Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim has failed to maintain the exit access corridors free of obstructions and impediments to full and instant use in the event of an emergency. This could result in the delays in smoke compartment evacuations or full evacuation of the building due to a fire or other emergency which would endanger the residents, staff and/or visitors within the facility.  The findings include, but are not limited to: Copy machine stored on corridor by Human Resource/Business Office Candy Machine on corridor near Human Resource/Business Office powered by powerstrip Medical carts stored on corridor by nurses station unit #2 Lifts stored on corridor by room 301 and 309. Gate to propane storage tanks not marked with "not an exit" sign The first gate leading to the exit discharge from the Dungeness Court does not swing in the direction of exit travel. Both gates leading to the exit discharge from the Dungeness Court have locking devices Storage of carts, pallets, beds, helium tank, boxes and other items located in the exit discharge area near the outside detached storage  The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 072	K072:  1. Power strip on candy machine removed. Copy machine and candy machine moved out of corridor. Waiver for medical carts & lifts stored obtained. Sign posted on gate to propane storage tanks "NOT AN EXIT". Gate leading to exit discharge from Dungeness Court altered to open in direction of travel. Locking devices on gates removed. Items stored in exit discharge area near outside detached storage removed/relocated. 2. Signs posted in exit discharge area to indicate no storage. Staff to be in-serviced on keeping hallways clear and proper storage areas. 3. Routine maintenance rounds to include monitoring of storage area for obstructions and will monitor items stored or blocking egress corridors. 4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6. Maintenance Director to ensure compliance.	
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Draperies, curtains, including cubicle curtains,	K 074		

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K 074	<p>Continued From page 9</p> <p>and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>This Standard is not met as evidenced by: Surveyor: 32862 Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim has failed to ensure that hanging curtains are rated as flame resistant. This could result in the rapid spread of smoke and fire in the event of ignition which could potentially endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to: Curtains in the front lobby do not have tags indicating their flame resistant Curtains in across from Room 322 do not have tags indicating they are flame resistant The above was discussed and acknowledged by the Facility Administrator and Maintenance</p>	K 074	<p>K074:</p> <ol style="list-style-type: none"> <li>1. Documentation is available to validate the drapes in the lobby and across from 322 are flame resistant. Will audit other drapes to be sure met the flame resistant standard.</li> <li>2. New items obtained will meet the requirement and documentation will be maintained to validate the product meets the requirement.</li> <li>3. Routine preventative maintenance rounds will include monitoring fabrics/drapes to assure are in compliance. Will document on preventative maintenance logs.</li> <li>4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter.</li> <li>5. Date of completion: 8/10/13</li> <li>6. Maintenance Director to ensure compliance.</li> </ol>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505327</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/09/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>AVAMERE OLYMPIC REHABILITATION OF SE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 5TH AVENUE SOUTH SEQUIM, WA 98382</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 074	Continued From page 10 Director.	K 074		
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: 32862 Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim has failed to provide emergency lighting for the emergency generator transfer switch. This could result in conditions where lighting may not be provided if the generator fails to operator endangering the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Emergency lighting not provided for the emergency generator transfer switch in the Main Electrical Room The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.	K 144	K 144:  1. Emergency lighting has been installed in main electrical room, for emergency generator transfer switch. 2. N/A 3. The lighting will be monitored during regular generator test, and included in the preventative maintenance log. 4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter. 5. Date of completion: 8/10/13 6. Maintenance Director will oversee ongoing compliance.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	<p>Continued From page 11</p> <p>This Standard is not met as evidenced by: Surveyor: 32862</p> <p>This requirement is not met as evidenced by:</p> <p>Based upon observations and staff interviews on 07/09/13 between approximately 10:00 and 16:00 hours Avamere Olympic Rehabilitation of Sequim has failed to restrict the use of multi-plug outlets, power strips, extension cords, cords run through walls, and wiring outside of conduit to providing power to permitted electrical equipment. This facility has also failed to maintain clearance between heat producing equipment and combustibles. This could result in a fire from overheating of the electrical system due to the heavy power draw and/or combustibles being too close to heat producing equipment endangering the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to: Cord run through wall in the kitchen walls to the corridor Kitchen electrical panel missing breaker cover for slot #58 Panel C in the IT Room #39 and #41 Cyprus Wiring showing for wander guard system on corridor near the Human Resource/Business Office Wiring to the magnetic hold open device in the Fire Sprinkler Riser Room not in conduit Extension cord in use in the Director of Nursing Extension cord in use to power a refrigerator in the House Keeping Office Multi-plug adapter with no over-current protection and reset in use in the Oxygen/Clean Utility Multi-plug adapter with no over-current protection and reset in use in the House Keeping Office Power strip plugged into another power strip in the Resident Care Manager's Office</p>	K 147	<p>K147:</p> <ol style="list-style-type: none"> <li>1. Cord through wall in kitchen removed and holes in wall repaired. <ul style="list-style-type: none"> <li>-Breaker cover for slot #58 replaced in kitchen electrical panel.</li> <li>-Wiring for wander guard system covered.</li> <li>-Conduit replaced on wiring to the magnetic hold open device in Fire Sprinkler Riser Room.</li> <li>-Extension cords listed have been removed.</li> <li>-Multi-plug adapters in Oxygen/Clean Utility room &amp; Housekeeping office replaced with a multi-plug adapters with reset.</li> <li>-Removed power strip from RCM office and hall outside resident tub/bath room on unit 3.</li> <li>-Power strip in MDS office has been corrected to include over current protection when in use.</li> <li>-Cover installed on junction box in Activity Office &amp; Electrical Rooms.</li> <li>-Multi-plug adapter removed from room 201, RCM office at unit 2.</li> <li>-Cover plate placed on junction box under reception desk in lobby.</li> <li>-Dresser in room 113 moved away from baseboard heater.</li> <li>-Baseboard heaters in Madrona Dining Room located by piano &amp; in lobby near chairs have been disconnected as they are not used.</li> </ul> </li> <li>2. An audit will be completed to determine that power strips and/or multiple routine electrical inspections of facility. Maintenance Rounds will be completed to assure wires are properly contained; and that items are not too close to baseboard heaters.</li> <li>3. Electrical boxes, wiring enclosures, baseboard heater clearance and power strips/multi-plug adapters will be included in the preventative maintenance program and documented on the logs.</li> </ol>	

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K 147	<p>Continued From page 12</p> <p>Power strip with no over-current protection in use in the MDS Coordinator's Office</p> <p>No cover on the junction box in the Activities office</p> <p>No cover on the junction boxes in the Electrical Room</p> <p>Multiplug adaptors with no over-current protection in resident room 201</p> <p>Multiplug adaptors with no over-current protection in ARC Unit #2</p> <p>Extension cord in use at Unit #2 nurses station</p> <p>Extension cord in use in Resident Room 312</p> <p>Power strip in use in the Resident Tub and Bath by Room 314</p> <p>Electrical wiring and computer wiring under desk in lobby no junction boxes.</p> <p>Dresser in Room 113 placed against the baseboard heater</p> <p>Piano placed against the baseboard heater in the Madrona Room</p> <p>Chairs placed too close to baseboard heater in the lobby</p> <p>The above was discussed and acknowledged by the Facility Administrator and Maintenance Director.</p>	K 147	<p>K147 Continued:</p> <p>Staff will be in-serviced on proper placement of furniture in relation to the baseboard heaters, as well as the requirement and proper use of power strips/multi-plug adapters.</p> <p>4. Results from preventative maintenance review will be reviewed by facility Quality Assurance Committee (QAC) for 3 months and then periodically thereafter.</p> <p>5. Date of completion: 8/10/13</p> <p>6. Maintenance Director will be responsible to oversee ongoing compliance compliance.</p>	