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

Printed: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	505327		10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE OLYMPIC REHABILITATION OF SEC	1000 5TH AVENUE SOUTH SEQUIM, WA 98382

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K 000	INITIAL COMMENTS Surveyor: 35231 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at the Avamere Olympic Rehabilitation on 10/07/2015 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 has a total of 110 beds and at the time of this survey the census was 85. The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. The facility is a single story structure of Type 5 construction with exits to grade. The facility is protected by a Type 13 fire 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. The facility is not in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Nicholas D. Wolden Deputy State Fire Marshal	K 000	RECEIVED OCT 20 2015 FIRE PREVENTION DIVISION	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/16/15

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 This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 10/07/2015 between approximately 13:15 and 17:00 hours the facility 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: The facility failed to maintain fire resistive construction in boiler room. Holes were found in the wall around sprinkler piping and various water valves. The Maintenance Director acknowledged the violation and confirmed what holes need to be repaired. Outside room 314 multiple holes with an approximate size of 1 inch by 3 inches were found in the interstitial space. The Maintenance Director stated that he sees what I am taking about. Two holes were found in the interstitial space above the Administrators office. The maintaince director states that he would estimate the size to be 2 inches by 6 inches and 5 inches by 5 inches. The above was discussed and acknowledged by the Administrator.	K 012	K 012: 1.Areas listed will be repaired. 2.Holes in boiler room wall around sprinkler piping and various water valves will be repaired with fire stop putty. 3. Maintenance will inspect all rooms in building to ensure similar problems do not exist. 4. Multiple holes found in interstitial space by room 314 and Administrators office will be covered with 5/8 sheet rock. 5. Maintenance will inspect the interstitial spaces in hallways to ensure similar problems do not exist. 6. Repairs will be completed by 11/10/2015. 7. Maintenance will complete repairs. 8.Maintenance Director and Administrator to ensure compliance.	11/10 2015
K 019 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Vision panels in corridor walls or doors are fixed window assemblies in approved frames. (In fully sprinklered buildings, there are no restrictions in the area and fire resistance of glass and frames.)	K 019	K 019: 1. Fire resistant glass was installed in Madrona Dining Room door on 10/9/2015. 2. Maintenance completed work. 3. Maintenance Director and Administrator verified work was completed.	10/9 2015

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K 054	Continued From page 3 This Standard is not met as evidenced by: Surveyor: 35231 Based upon record review and staff interviews on 10/07/2015 between approximately 13:15 and 17:00 and 10/08/2015 between approximately 07:30 and 10:00 hours the facility has failed to have appropriate testing of the smoke detectors in the building as required. This could result in failure of the smoke detectors to operate properly which could result in a delay in the detecting of fire and could endanger residents, staff and/or visitors within the facility. The findings include, but are not limited to: Document review of smoke detectors show that sensitivity testing was completed on 7/23/2012. Discrepancies portion of the report states "Smoke detectors failed sensitivity, ceased testing awaiting resolution. When reviewing the fire alarm report dated July 30, 2015. Discrepancies portion of the report states: Smoke detectors failed sensitivity last year and there has been no resolution so sensitivity retesting has yet to be preformed. Work order dated 7/2/2015 states: Sensitivity not completed contact office for more info see reports for deficiencies. The facility was unable to provide any paperwork associated with a follow up. I contacted the fire alarm vendor to attempt to obtain documentation of a possible follow up. When speaking with the testing agency I was told that there was a mass failure of sensitivity testing and the facility started to replace smoke detectors. They further stated that were unable to replaced all of the smoke detectors because the current fire alarm panel lack functionality and began to have open circuits and shorts.	K 054	K 054: See waiver.	

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K 054	Continued From page 4 The facility immediately started a fire watch when notified. The above was discussed and acknowledged by the Administrator.	K 054	K 054: See waiver.	
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 This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 10/07/2015 between approximately 13:15 and 17:00 hours the facility has failed to conduct testing of the fire sprinkler system as required. 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: The facility failed to conduct a quarterly fire sprinkler inspection during the second quarter of 2015. The Maintenance director states that the vendor came 1 month early. Documents show that during the first quarter of 2015 the facility conducted 2 quarterly inspections. A total of 4 quarterly inspections were conducted in throughout that past calendar year. The above was discussed and acknowledged by the Administrator.	K 062	K 062: 1. Maintenance Director scheduled fire sprinkler inspections quarterly and required PSI to conduct inspections as scheduled. 2. Quarterly fire sprinkler inspections scheduled as follows, October 23 2015 January 29 2016 April 30 2016 August 1 2016 3. Maintenance Director scheduled quarterly fire sprinkler inspections on 10/13/2015. 4.Maintenance Director and Administrator to ensure compliance.	10/13 2015
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064		

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K 064	Continued From page 5 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: 35231 Based upon record review and observation on 10/07/2015 between approximately 13:15 and 17:00 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: Fire extinguisher in laundry room blocked by cart. Laundry staff state that they always place the cart in that location. The Maintenance Director states that he knows what I am looking at and references the fire extinguisher. The above was discussed and acknowledged by the Administrator.	K 064	K 064: 1. Director of Maintenance relocated portable fire extinguisher with in the laundry room on 10/8/2015. 2. Director of Maintenance conducted an inservice with laundry and housekeeping staff to ensure portable fire extinguisher in laundry room is not blocked again. Completed on 10/14/2015. 3. Maintenance Director and Administrator to ensure compliance.	10/14 2015
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: Surveyor: 35231 Based upon observations and staff interviews on 10/07/2015 between approximately 13:15 and 17:00 hours the facility has failed to restrict the use of multi-plug outlets (power strips) to	K 147	K 147: 1. Failure to restrict the use of multi-plug outlets was corrected on 10/7/2015 by Director of Maintenance. 2. Director of Maintenance conducted inservice of office staff for restricted use of multi-plug outlets. The was completed on 10/13/2015.	10/15 2015

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K 147	Continued From page 6 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. The findings include, but are not limited to: Powerstrip plugged into powerstrip in health information. Maintenance Director states that he understand that's not allowed and corrected the violation on site. Open junction box was found in the interstitial space above room 314. The Maintenance Director says that he see what I am talking about. The above was discussed and acknowledged by the Administrator.	K 147	3. Open junction box in interstitial space was covered by maintenance on 10/15/2015. 4. Maintenance will inspect the interstitial spaces to ensure there are no other open junction boxes. 5. Maintenance Director and Administrator to ensure compliance.	

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