

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 35231</p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at the Life Care Center of Mount Vernon 06/22/2015 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.</p> <p>The facility has a total of 121 beds and at the time of this survey the census was 88.</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 single story structure of Type V 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.</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. The surveyor was:</p> <p><i>Nicholas D. Wolden</i> Nicholas D. Wolden Deputy State Fire Marshal</p>	K 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> <p><b>K012</b></p> <p><b>Correction as it relates to the resident:</b></p> <p>Hole in ceiling of fire alarm/mechanical room has been covered.</p> <p><b>Action taken to protect residents in similar situations:</b></p> <p>Environmental Services will round in facility to ensure there are no additional holes in ceilings.</p> <p><b>Measures taken or systems altered to ensure the problem does not recur:</b></p> <p>Maintenance Department will be serviced by the Environmental Services Director to check emergency light in generator transfer switch area.</p> <p>Environmental Services will add ceilings to weekly environmental rounds.</p> <p><b>Plans to monitor performance to ensure solution is sustained:</b></p> <p>Negative findings from weekly environmental rounds will be presented by the Environmental Services Director to the facility Performance Improvement Committee for the next three months.</p> <p><b>Date Certain:</b></p> <p>July 15, 2015</p> <p><b>Title of Person Responsible for Compliance:</b></p> <p>Executive Director</p>	
K 012 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p>	K 012	<p>Executive Director</p>	7/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicholas D. Wolden</i>	TITLE Executive Director	(X6) DATE 7/1/15
--	-----------------------------	---------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 012	Continued From page 1  This Standard is not met as evidenced by: Surveyor: 35231  Based upon observations and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 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: Hole in ceiling of fire alarm/mechanical room.  The above was discussed and acknowledged by the Executive Director.	K 012	K046  Correction as it relates to the resident:  Emergency light in generator transfer switch area had the battery replaced and is now functional.  Facility will implement annual inspection of emergency lighting for 90 minutes and monthly inspection for 30 seconds for generator area and emergency transfer switch area.  Action taken to protect residents in similar situations:  An inspection of the facility was completed by the Environmental Services Director and no similar findings were found.  Measures taken or systems altered to ensure the problem does not recur:  Maintenance Department will be inserviced by Environmental Services Director to inspect the emergency light in generator transfer switch area.	
K 046 SS=D	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.  This Standard is not met as evidenced by: Surveyor: 35231  Based upon observations and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 hours the facility has failed to maintain records of testing for the emergency battery backup lighting. This could result in the failure of the battery powered backup lighting in the event of a power outage and render the means of	K 046	The emergency lights in generator transfer switch area and generator area will be added to weekly environmental rounds.  Maintenance Department will be inserviced by Environmental Services Director to conduct annual inspections of the emergency lighting for 90 minutes and monthly inspection for 30 seconds for generator area and emergency transfer switch area.  Plans to monitor performance to ensure solution is sustained:  Negative findings of the annual and monthly inspections will be presented by the Environmental Services Director to the facility Performance Improvement Committee for the next three months and annually.	

*Handwritten signature and date: 7/1/15*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 046	Continued From page 2 egress dark. This could result in tripping and fall injuries to residents, staff and/or visitors.  The findings include, but are not limited to: Emergency light in generator transfer switch area failed to function. Facility failed to provide annual inspection of emergency lighting for 90 minutes and monthly inspection for 30 seconds for generator area and emergency transfer switch area. The above was discussed and acknowledged by the Executive Director.	K 046	Date Certain:  July 15, 2015  Title of Person Responsible for Compliance:  Executive Director  K050	
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: Surveyor: 35231  Based upon record review and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 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.	K 050	Correction as it relates to the resident:  No residents were involved.  Action taken to protect residents in similar situations:  Fire drills will be held once a quarter on each shift.  Measures taken or systems altered to ensure the problem does not recur:  Maintenance Department will be inserviced by Environmental Services Director on requirement to conduct fire drills.  Plans to monitor performance to ensure solution is sustained:  Results of the fire drills will be shared by the Environmental Services Director with the Performance Improvement Committee quarterly.  Date Certain:  July 15, 2015  Title of Person Responsible for Compliance:  Executive Director	

Handwritten signature and date: 7/1/15

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

Printed: 06/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>	
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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
<p>K 050</p> <p>K 052 SS=C</p>	<p>Continued From page 3</p> <p>The findings include, but are not limited to: The facility failed to conduct fire drills as follows: 1st quarter : Missing day shift and night shift 2nd quarter: Missing swing shift 3rd quarter: Missing night shift The above was discussed and acknowledged by the Executive Director.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p><b>This Standard is not met as evidenced by:</b> Surveyor: 35231</p> <p>Based upon record review and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 hours the facility has failed to have appropriate testing of the fire alarm system which result in the failure of notification to staff of a water supply problem to the fire sprinkler system and endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to: Glass rods in Manuel pull station missing near room 104, 204, and Kitchen. The above was discussed and acknowledged by</p>	<p>K 050</p> <p>K 052</p>	<p>K052</p> <p>Correction as it relates to the resident:</p> <p>No residents were involved.</p> <p>Action taken to protect residents in similar situations:</p> <p>Glass rods in manual pull station have been replaced near rooms 104, 204 and kitchen.</p> <p>Audits of all pull stations conducted to ensure compliance.</p> <p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>Maintenance Department will be inserviced by Environmental Services Director to ensure glass rods are in place in manual pull stations and to check for them during weekly environmental rounds.</p> <p>Plans to monitor performance to ensure solution is sustained:</p> <p>Negative findings of weekly environmental rounds will be shared by the Environmental Services Director with the Performance Improvement Committee for the next three months.</p> <p>Date Certain:</p> <p>July 15, 2015</p> <p>Title of Person Responsible for Compliance:</p> <p>Executive Director</p>	<p>7/15/15</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 052	Continued From page 4 the Executive Director.	K 052		
K 054 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>This Standard is not met as evidenced by: Surveyor: 35231</p> <p>Based upon record review and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 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.</p> <p>The findings include, but are not limited to: The facility has failed to conduct testing of the smoke detector for sensitivity. The above was discussed and acknowledged by the Executive Director.</p>	K 054	<p><b>K054</b></p> <p><b>Correction as it relates to the resident:</b></p> <p>Testing of the smoke detectors for sensitivity was done in September of 2011.</p> <p>Facility obtained evidence of sensitivity testing post inspection.</p> <p>Facility is currently in compliance.</p> <p><b>Action taken to protect residents in similar situations:</b></p> <p>Testing of the smoke detectors for sensitivity is scheduled for September of 2015.</p> <p><b>Measures taken or systems altered to ensure the problem does not recur:</b></p> <p>Maintenance Department will be inserviced by Environmental Services Director to ensure the testing of the smoke detector for sensitivity is scheduled on an annual basis.</p> <p><b>Plans to monitor performance to ensure solution is sustained:</b></p>	
K 062 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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> <p>This Standard is not met as evidenced by: Surveyor: 35231</p>	K 062	<p>Results of annual testing will be shared by the Environmental Services Director with the Performance Improvement Committee.</p> <p><b>Date Certain:</b></p> <p>July 15, 2015</p> <p><b>Title of Person Responsible for Compliance:</b></p> <p>Executive Director</p>	

*Handwritten signature and date: 06/24/15*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 062	Continued From page 5  Based upon observations and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 hours the facility has failed to conduct testing of the fire sprinkler system as required, and failed to maintain 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: Kitchen dry storage area has less than 18 inches of clearance from fire sprinkler deflectors. 5 year internal testing not conducted. Fire sprinkler esutcheon loose in fire room. The above was discussed and acknowledged by the Executive Director.	K 062	K062  Correction as it relates to the resident:  No residents were involved  Action taken to protect residents in similar situations:  The kitchen dry storage area has been corrected to be in compliance of 18" clearance from fire sprinkler deflectors.  The 5 year internal testing for the fire sprinkler system has been scheduled.  The fire sprinkler escutcheon has been tightened.  Measures taken or systems altered to ensure the problem does not recur:  Maintenance Department will be inserviced by Environmental Services Director on ensuring the kitchen dry storage area has 18" of clearance from fire sprinkler deflectors, ensuring the internal testing for the fire sprinkler system is done every 5 years and to check the fire sprinkler escutcheons during weekly environmental rounds.  Plans to monitor performance to ensure solution is sustained:  Negative findings of weekly environmental rounds will be shared by the Environmental Services Director with the Performance Improvement Committee for the next three months.  Date Certain:  July 15, 2015  Title of Person Responsible for Compliance:  Executive Director	
K 064 SS=C	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: 35231 Based upon record review and observation on 06/22/2015 between approximately 10:00 and 16:00 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.	K 064		

*Handwritten signature and date: 7/1/15*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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
<p>K 064</p> <p>K 144 SS=F</p>	<p>Continued From page 6</p> <p>The findings include, but are not limited to: Fire extinguisher in central supply greater than 5 feet high. The above was discussed and acknowledged by the Executive Director.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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: Surveyor: 35231</p> <p>Based upon observations and staff interviews on 06/22/2015 between approximately 10:00 and 16:00 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 within the facility.</p> <p>The findings include, but are not limited to: The facility has failed to provide a emergency shut for the generator in a remote location.</p> <p>The above was discussed and acknowledged by the Executive Director.</p> <p>NFPA 110 1999 Edition 3-5.6 All level 1 and 2</p>	<p>K 064</p> <p>K 144</p>	<p><b>K064</b></p> <p><b>Correction as it relates to the resident:</b></p> <p>Fire extinguisher in Central Supply has been removed</p> <p><b>Action taken to protect residents in similar situations:</b></p> <p>All fire extinguishers in facility will be audited to ensure they are not greater than 5ft high.</p> <p><b>Measures taken or systems altered to ensure the problem does not recur:</b></p> <p>Maintenance Department will be inserviced by Environmental Services Director to ensure that all fire extinguishers are not greater than 5ft high during weekly environmental rounds.</p> <p><b>Plans to monitor performance to ensure solution is sustained:</b></p> <p>When a new fire extinguisher is installed, ED will inspect installation to ensure compliance with location.</p> <p><b>Date Certain:</b></p> <p>July 15, 2015</p> <p><b>Title of Person Responsible for Compliance:</b></p> <p>Executive Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 144	Continued From page 7 installations shall have a remote manual stop station of a similar type to a break-glass station located outside the room housing the prime mover, where so installed or located elsewhere on the premises where the prime mover is located outside the building.  A-3-5.5.6 For level 1 and level 2 systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified.	K 144	K144  <b>Correction as it relates to the resident:</b>  No residents were affected.  <b>Action taken to protect residents in similar situations:</b>  Remote manual stop station for the emergency generator has been scheduled for installation.	
K 147 SS=C	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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 06/22/2015 between approximately 10:00 and 16:00 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.  The findings include, but are not limited to: Open electrical junction box labeled fire alarm. Non approved Multi-plug adapter used in interstitial space in dish cleaning area used for fans. Extension cord used as permanent wiring in interstitial space in dish cleaning area used for fans. Power strip plugged into powerstrip in Executive	K 147	<b>Measures taken or systems altered to ensure the problem does not recur:</b>  Maintenance Department will be inserviced by Environmental Services Director on regulations related to manual stops.  <b>Plans to monitor performance to ensure solution is sustained:</b>  Executive Director will validate completion of installation. Environmental Services Director will maintain records to ensure compliance.  <b>Date Certain:</b>  July 15, 2015  <b>Title of Person Responsible for Compliance:</b>  Executive Director	

*Handwritten signature and date: 7/1/15*

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

Printed: 06/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>LIFE CARE CENTER OF MOUNT VERNON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2120 EAST DIVISION STREET MOUNT VERNON, WA 98273</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 147	Continued From page 8 Director office.  The above was discussed and acknowledged by the Executive Director.	K 147	<p><b>K147</b></p> <p><b>Correction as it relates to the resident:</b></p> <p>No residents were affected.</p> <p><b>Action taken to protect residents in similar situations:</b></p> <p>The open electrical junction box has been covered.</p> <p>Power strips and extension cords identified have been removed.</p> <p><b>Measures taken or systems altered to ensure the problem does not recur:</b></p> <p>Maintenance Department will be in serviced by Environmental Services Director to ensure that non approved electrical outlets/equipment are not in use during weekly environmental rounds.</p> <p>Facility audit conducted to ensure no other non-approved items are in place.</p> <p><b>Plans to monitor performance to ensure solution is sustained:</b></p> <p>Negative findings of weekly environmental rounds will be shared by the Environmental Services Director with the Performance Improvement Committee for the next three months to identify further education opportunities.</p> <p><b>Date Certain:</b></p> <p>July 15, 2015</p> <p><b>Title of Person Responsible for Compliance:</b></p> <p>Executive Director</p>	

①-11/15