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

Printed: 10/15/2013
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
	505362		10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENT	5129 HILLTOP ROAD EVERETT, WA 98203

(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	INITIAL COMMENTS An unannounced Life Safety Code Survey was conducted at Forest View Transitional Health Center, Everett, Washington, on October 15, 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. The LTC 70 bed facility with a census of 63, consisted of a Type V-111, 2 story structure, with a basement (used for environmental care purposes) and was built in 1999. 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. The deficiencies identified during this survey are listed below. The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S. Paul V. Schroer Deputy State Fire Marshal	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency Care Center at Forest View does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 050 SS=D	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	K 050	**K050** **Plan to correct identified findings:** An education was performed to the Maintenance Director to ensure Fire Drills are held at unexpected times under varying conditions, at least quarterly on each shift. **Identification similar situation:** An education was performed to the Maintenance Director to ensure Fire Drills are held at unexpected times under varying conditions, at least monthly and on random rotations. **Measures to prevent recurrence:** Maintenance Director has been provided forms for tracking fire drills. The Maintenance Director has been signed up for the TELS program to monitor, track, and trend fire drills. **Monitor to sustain compliance:** The Maintenance Director and/or designee will audit the process of fire drills at unexpected times. Results will be forwarded to Quality Assurance Committee for the next 90 days	11-8-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenny Schaub	Administrator	10-24-13

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	Continued From page 1 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: An examination of the facility ' s fire drill records on October 15, 2013 at 12:40 PM revealed that the fire drill records were not conducted for: 1. 3rd qtr, 2013 (months Jul/Aug/Sept) These findings were acknowledged by the Maintenance Director.	K 050	**K076** **Plan to correct identified findings:** Oxygen Cylinders were immediately secured on second floor and first floor. **Identification similar situation:** An audit was complete of the Oxygen Cylinders in the facility to ensure proper storage. **Measures to prevent recurrence:** An education has been performed to the licensed staff on securing Oxygen Cylinders on the first and second floor. A random audit will be completed by the Maintenance Director and/or designee to ensure proper storage and educate when necessary. **Monitor to sustain compliance:** A random audit will be completed by the Maintenance Director and/or designee to ensure proper storage. Results will be forwarded to the Quality Assurance Committee for the next thirty days..	11-8-13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This Standard is not met as evidenced by: Based on observation and staff interview the facility failed to maintain medical gas storage in accordance to NFPA 99,4-3.1.1.2. This has the	K 076		

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K 076	Continued From page 2 potential for a fire and explosive hazard exposure to the residents. This potentially exposed residents to a missile hazard during fire conditions. Findings include: During the facility tour on October 15, 2013 from 9:30 AM AM to 1:45 PM. It was observed that: 1. 2nd floor oxygen storage room - 3 cylinders unsecured 2. 1st floor oxygen storage room - 4 cylinders unsecured. These findings were acknowledged by the facility Maintenance Director.	K 076	**K130** **Plan to correct identified findings:** CO 2 Detector in hallway of second floor was installed CO2 2 Detector in hallway of first floor was installed CO2 detector in Resident Room 102 was installed **Identification similar situation:** An education will be performed to staff regarding CO2 Detectors installed, the sound and the procedure in case alarms.	11-8-13
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observations, the facility did not have Carbon Monoxide Detectors installed in the building in accordance with NFPA Standard 720 2012 edition. This has the potential of having a leak with no detection that would expose residents, visitors and staff to a hazardous environment. The findings are as follows: During the facility tour on October 15, 2013 from 9:30 AM to 1:45 PM the following deficiencies were found: 1. No CO detector coverage in the hallway of the second floor 2. No CO detector coverage in the hallway of the first floor. 3. No CO detector coverage in Resident Room	K 130	**Measures to prevent recurrence:** Battery Power checks will be performed monthly on CO2 detectors and reported to Quality Assurance Committee for 90days. A random audit will be completed by the Maintenance Director and/or designee to ensure staff education and awareness of CO2 Detectors for the next 30days. **Monitor to sustain compliance:** Battery Power checks will be performed monthly on CO2 detectors and reported to Quality Assurance Committee for 90days. A random audit will be completed by the Maintenance Director and/or designee to ensure staff education and awareness of CO2 Detectors and forwarded .Quality Assurance Committee for the next thirty days.	

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K 130	Continued From page 3 102 These findings were acknowledged by the Maintenance Director.	K 130	**K144** **Plan to correct identified findings:** An education was performed to the Maintenance Director to ensure Emergency Power test monthly are performed. **Identification similar situation:** An education was performed to the Maintenance Director to ensure monthly Emergency Power testing are performed. **Measures to prevent recurrence:** Maintenance Director has been provided forms for tracking Emergency Power Testing.. The Maintenance Director has been sign up for the TELS program to monitor, track and trend. **Monitor to sustain compliance:** The Maintenance Director and/or designee will audit the process of Emergency Power Testing Results will forwarded to Quality Assurance Committee for the next 90 days.	11-8-13
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: 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. Findings include: 1. During a record review of the generator maintenance log on October 15, 2013 at 12:30 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 : May, June, July, August, September 2013 2. During a record review of the generator maintenance log on October 15, 2013 at 12:40 PM, the facility failed to maintain a proper log showing that the generator had been inspected	K 144		