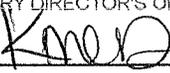


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505362</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>FOREST VIEW TRANSITIONAL HEALTH CEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5129 HILLTOP ROAD EVERETT, WA 98203</b>
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(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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 19192 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Forest View Transitional Health Care on 9/29/2014 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 70 beds and at the time of this survey the census was 54.</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 Two story structure of Type V-A 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 compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare &amp; Medicaid Services.</p> <p>The surveyor was:  Donald L West Deputy State Fire Marshal</p>	K 000	<p>This plan of correction is being submitted in accordance with specific regulatory requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies on the HCFA 2567; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies statements, findings, facts, and conclusions that form the basis of the deficiency.</p> <p style="text-align: right;"><i>10/10/14</i></p>	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE <b>LNCHA</b>	(X6) DATE <b>10/9/14</b>
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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 SS=D	Continued From page 1  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 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: 19192 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 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.	K 018	The result of an unannounced Fire and Life Safety survey on 9/29/2014 found Prefix Tag K 18 to be deficient. The deficiency was located on the door to the MDS office that had a self-closing device removed. 1: There was no harm identified to any residents. 2: The removed self-closing device was immediately replaced to insure compliance with the life safety code. 3: The monthly maintenance schedule has been revised to include checking that all doors in the facility that are equipped with self-closing device pull the door closed to the latched position. 4: The monthly maintenance schedule will be performed by maintenance personnel. The monthly maintenance schedule will be monitored by the director of maintenance services, and reported to Administrator on an annual basis.	10/10/14

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

Printed: 09/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

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K 018	Continued From page 2 This requirement is not met as evidenced by:  Based upon observations and staff interviews on 9/29/2014 between approximately 0915 and 1115 hours the facility 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:  1. The door to Josh's office has had the self closing device removed.  The above was discussed and acknowledged by the facility maintenance director.	K 018		
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This Standard is not met as evidenced by: Surveyor: 19192 Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2.  Based upon observations and staff interviews on <u>9/29/14</u> between approximately <u>0915</u> and	K 032	The result of an unannounced Fire and Life Safety survey on 9/29/2014 found Prefix Tag K 032 to be deficient. The deficiency was located in the Physical Therapy room the second exit is obstructed by a bed and other equipment 1: There was no harm identified to any resident. 2: The equipment was immediately removed from the exit door in the Physical therapy room to too ensure that the residents and staff have a safe evacuation rout. 3: The monthly maintenance schedule has been revised to include checking that all exit doors are not blocked in any manner. 4: The monthly maintenance schedule will be performed by maintenance personnel. The monthly maintenance schedule will be monitored by the director of maintenance services, and reported to Administrator on an annual basis.	10/10/14

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K 032	Continued From page 3 <b>11:30</b> hours the facility has failed to maintain the minimum number of exit from a room, this has the potential for the delay to evacuate the residents and staff in the event of a fire.  This requirement is not met as evidenced by:  1. In the Physical Therapy room the second exit is obstructed by a bed and other equipment.  The above was discussed and acknowledged by the facility maintenance director.	K 032		
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: 19192 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	The result of an unannounced Fire and Life Safety survey on 9/29/2014 found Prefix Tag K 050 to be deficient. The deficiency took place when there were no night shift fire drills for the first and third quarter of 2014.  1: There was no harm identified to the residents 2: The fire drills will be randomly scheduled to ensure that all employees on all shifts are properly trained in case of an active fire. 3: The monthly maintenance schedule has been revised to include checking that the unannounced fire drills are being conducted with-in the proper time allowed. 4: The monthly fire drills will be performed by maintenance personnel. The fire drills will be monitored by the director of maintenance services, and reported to Administrator on a monthly basis.	10/10/14

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K 050	Continued From page 4 This requirement is not met as evidenced by:  Based upon record review and staff interviews on 9/29/2014 between approximately 0915 and 1115 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.  The findings include, but are not limited to:  1. There are no night shift drills for the first and third quarter of 2014.  The above was discussed and acknowledged by the <i>Facility Maintenance Director</i>	K 050		
K 064 SS=E	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: 19192 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This requirement is not met as evidenced by:  Based upon record review and observation on 9/29/2014 between approximately 0915 and 1130 hours the facility has failed to assure proper	K 064		

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K 064	Continued From page 5 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:  1. The portable fire extinguishers in the building have not been checked on a monthly basis, some of the are dated July, and some not at all.  The above was discussed and acknowledged by the facility maintenance director.	K 064	<b>The result of an unannounced Fire and Life Safety survey on 9/29/2014 found Prefix Tag K 064 to be deficient. The deficiency took place when the portable fire extinguishers in the building have not been checked on a monthly basis</b> 1: There was no harm identified to any resident 2: The portable fire extinguishers have been immediately numbered so they can be tracked and checked monthly to ensure they work properly. 3: The monthly maintenance schedule has been revised to include checking each individual portable fire extinguisher monthly 4: The monthly maintenance schedule has been immediately revised and will be performed by maintenance personnel. The monthly maintenance schedule will be monitored by the director of maintenance services, and reported to Administrator on an annual basis.	10/10/14