

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

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Printed: 09/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/06/2013
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NAME OF PROVIDER OR SUPPLIER JOSEPHINE SUNSET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 9901 272ND PLACE NORTHWEST STANWOOD, WA 98292
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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
K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Fire and Life Safety Code Complaint Investigation was conducted at Josephine Sunset Home, Stanwood, Washington, on September 6, 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.</p> <p>The LTC facility, licensed for 160 and a census of 155, consisted of a Type V-1hr, 2 story structure, with no basement. 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.</p> <p>The DSHS Complaint Resolution Unit Intake Number 2870227, received August 30, 2013 was referencing that the generator failed to start upon power failure to the facility.</p> <p>Facility contacted appropriate staff to return to the facility. Staff returned and safety precautions were put into place to ensure the safety of the residents and building were taken care of. A service technician also responded to trouble shoot the problem.</p> <p>It was identified on the panel that the auto EPS switch not auto (meaning if power is loss the generator does not automatically power up).</p> <p>The facility did have the annual generator service conducted on August 26, 2013 without any deficiencies.</p> <p>The facility conducted an investigation and could not find if the generator was left in test mode</p>	K 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul Jacobson DWS</i>	TITLE <i>RD, DWS, LMC, CORD</i>	(X6) DATE <i>9/6/13</i>
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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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during the annual servicing inspection or the power surge that hit the building's electrical system caused a malfunction of the system.

The facility is conducting weekly inspections as well as a monthly load test. Also in place, is when any servicing is done on the generator maintenance staff will conduct an exit interview as well as ensure that all normal and emergency settings are functional.

No staff or residents were injured. Staff followed emergency procedures.

No further actions required.

The facility is in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.

K 000

The surveyor was:



Deputy State Fire Marshal

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