

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

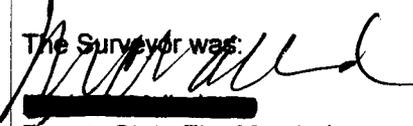
Printed: 06/14/2013
FORM APPROVED
OMB NO. 0938-0391

1458

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2013
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - PARKS	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST EMMA UNION GAP, WA 98903
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K 000	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced Federal Life Safety re-certification survey conducted at Prestige Care & Rehabilitation - Parkside, 308 Emma Street, Union Gap, WA on June 14, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Union Gap Detachment. This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health Services (DSHS).</p> <p>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 Long Term Care 88 bed facility, census of 55 was provided by the Administrator and verified by the Social Services Director. The facility consisted of construction type III (211) one story building with a basement used for physical therapy, laundry, restrooms, and conference room. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade have been provided with an all weather surface and lead to a public way.</p> <p>The facility is not in substantial compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The Surveyor was:  Deputy State Fire Marshal Nursing Home Surveyor 28058</p>	K 000	<p>K000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation-Parkside 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."</p>	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 021		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Adm.

6/27/13

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 021	<p>Continued From page 1</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This Standard is not met as evidenced by: Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment.</p> <p>The findings include, but are not limited to:</p> <p>During the facility tour on June 14, 2013 from the hours of 11:30am and 1:00pm, I observed that the fire doors between the exit corridor and the therapy area did not come to a full close and latch when activated.</p> <p>This finding was observed and discussed with the Maintenance Temp and the Administrator.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 021	<p>K021</p> <ul style="list-style-type: none"> ● Fire door mentioned will be repaired. ● Maintenance will check all other doors. ● All fire doors will be monitored during monthly fire drills. ● Administrator will ensure compliance. 	07/14/13
K 038 SS=D		K 038		

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K 038	<p>Continued From page 2</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: The facility has failed to maintain exits readily accessible at all times. This could allow for residents, visitors, and staff not have a readily available exit and delay evacuation out of the building.</p> <p>The findings include, but are not limited to:</p> <p>During the facility tour on May 14, 2013 between the hours of 11:30 and 1:00pm, I observed yard debris and other miscellaneous combustible items blocking the exit path in the basement south east exit.</p> <p>This finding was observed and discussed with the Maintenance Temp and the Administrator.</p>	K 038	<p>K 038</p> <ul style="list-style-type: none"> • Debris has been removed. • All other exits were checked for debris and none was found. • All staff in-serviced on leaving debris and making sure management was notified if debris is left. • Maintenance will make rounds to assure it is not re-occurring. <p style="text-align: center;">RECEIVED JUN 27 2013 FIRE PROTECTION BUREAU</p>	07/14/13
K 050 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 050	<p>K 050</p> <ul style="list-style-type: none"> • Administrator will check to see all drills are done. • Drills will be done as scheduled. • Compliance will be monitored by administrator monthly. 	07/14/13

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K 050	Continued From page 3 This Standard is not met as evidenced by: The facility has failed to provide the required number of fire drills of one fire drill per quarter per shift. This could allow for staff to not be fully trained and thereby delay emergency response and evacuation of the building. The findings include, but are not limited to: Record review of the facility's fire drill records on June 14, 2013 between the hours of 10:30am and 11:30am revealed the following deficiencies: 1. No record of a swing shift drill in first quarter. 2. No record of day shift drill in third quarter. These findings were observed and discussed with Maintenance Temp and the Administrator.	K 050	<ul style="list-style-type: none"> Administrator will be responsible to see drills are done as scheduled. 	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are	K 066	<p style="text-align: center;">RECEIVED JUN 27 2013 FIRE PROTECTION BUREAU</p> <ul style="list-style-type: none"> K 066 In the process of making the building a smoking facility. A designated smoking area and protective gear will be arranged and purchased. Smoking times and schedule will be in place. Administrator is responsible for monitoring. 	07/14/13

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K 066	Continued From page 4 readily available to all areas where smoking is permitted. 19.7.4 This Standard is not met as evidenced by: The facility has failed to ensure that the smoking practices of residents, visitors, and staff are in compliance with their smoking policy. This could potentially allow for unsafe smoking practices and expose residents, visitors, and staff to the threat of fire. The findings include, but are not limited to: 1. Review of the facilities emergency preparedness plan/disaster plan revealed that the facility has a smoke free environment policy. No smoking is allowed on the premises. 2. Exterior assessment of the facility revealed that the northeast corner of the building was equipped with an illegal ashtray and chairs provided. The ashtray had an a thick layer of cigarette butts and ashes. 3. Same illegal ashtray was found on the north main entrance with just ashes and no butts. 4. Exterior assessment of the building revealed numerous cigarette butts scattered through out. Mostly thrown into the landscaping bark. This finding was discussed with the Administrator	K 066		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

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K 144	Continued From page 5 accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: The facility has failed to maintain the generator weekly inspections and monthly load tests as required. This could allow for the generator to become inoperable and staff not aware. The findings include, but are not limited to: Record review on June 14, 2013 between the hours of 10:30am and 11:30am, revealed that the generator weekly inspection and monthly loads were stopped on 05/05/2013. This was the last time the maintenance director completed. The facility has been without a maintenance director since then. This finding was observed and discussed with the Administrator.	K 144	K 144 ● Maintenance will be responsible for weekly inspection. ● Administrator will monitor it is done for 3 months. ● Bring documentation to QAPI monthly. ● Administrator will ensure compliance.	07/14/13
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: The facility has failed to maintain the premises free of electrical hazards. This could potentially expose residents, visitors, and staff to the threat of an electrical fire.	K 147	K 147 ● Waiver will be obtained and submitted for power strips.	07/14/13

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K 147	<p>Continued From page 6</p> <p>The findings include, but are not limited to:</p> <p>During the facility tour on May 14, 2013 between the hours of 11:30am and 1:00pm, I observed the following electrical hazards:</p> <ol style="list-style-type: none"> 1. At 11:43, I observed a power strip used for power of an electric shave and lamp. 2. At 11:44, I observed a power strip used for powering of an electric charger, cell phone, and another charger. 3. At 12:05, I observed that the maintenance room had an orange extension cord powering a power strip. <p>These findings were observed and discussed with the Maintenance Temp and the Administrator.</p>	K 147	<ul style="list-style-type: none"> • All power strips will be removed until waiver secured. • Maintenance will make rounds to ensure other items are not in resident rooms. • Administrator will monitor for compliance. 	
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