

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

Printed: 10/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505491	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2014
NAME OF PROVIDER OR SUPPLIER EVERETT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 112TH STREET SOUTHWEST EVERETT, WA 98204		
(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>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Everett Center in Everett, Washington on 10/23/14 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. During the physical tour of the facility I was accompanied by the Facility Maintenance Director who witnessed any deficiency noted during this survey.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. This facility is a one story structure with a partial basement of Type V- 1 hour construction with exits to grade and is protected by a Type 13 sprinkler system and an Automatic / Manual Fire Alarm System with corridor smoke detection. The facility is licensed for 100 residents.</p> <p>The facility is not in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The following citations were documented during the survey:</p> <p>The surveyor was:</p> <p>David Rogers Deputy State Fire Marshal Nursing Home Surveyor 32863</p> <p>The surveyor was from: Washington State Patrol Office of the State Fire Marshal Fire Protection Bureau PO Box 19130</p>	K 000		

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

TITLE

(X6) DATE

Jim Rush

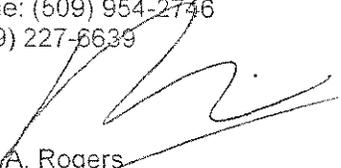
Administrator

10/31/2014

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 000	Continued From page 1 Spokane WA 99219-9130 Telephone: (509) 954-2746 Fax: (509) 227-6639  DSFM D.A. Rogers	K 000		
K 017 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to maintain use areas so that they will resist the passage of smoke from spreading into the corridor. 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 smoke</p>	K 017	<p>The smoke-resistant ceiling tile in the telephone room was replaced on 10/22/14 by the Director of Maintenance.(DM.) The DM will, as part of his daily rounds, check the telephone room and other facility rooms for missing ceiling tiles. Any tiles found to be missing will be replaced by the DM or designee.The DM or designee will audits all rooms with smoke-resistant ceiling tiles for three weeks, then monthly for 2 months to ensure ceiling tiles are in place.</p> <p>The DM will be responsible to ensure correction of this citation. The date of correction will be 11/07/14.</p>	

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K 018	Continued From page 3 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: The cross-corridor door by resident room #120 did not fully latch when closed. The above was discussed and acknowledged by the Maintenance Director.	K 018		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This Standard is not met as evidenced by: Based upon record review and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to maintain a written plan for the protection of all residents, staff and visitors and for their evacuation in the event of an emergency. At a minimum a written care occupancy fire safety plan shall provide for the following: 1. Use of alarms 2. Transmission of alarms to fire department 3. Response to alarms 4. Isolation of the fire 5. Evacuation of the immediate area 6. Evacuation of smoke compartment 7. Preparation of floors and building for evacuation 8. Extinguishment of fire The findings include, but are not limited to: The written fire evacuation policy does not	K 048	The Director of Maintenance (DM), in conjunction with the facility Administrator (Admin), will write the fire policy on partial evacuation of a smoke compartment and include a definition of a smoke compartment. The DM. will educate staff on the policy and when it would apply. The policy will be incorporated into the facility's Fire Safety/Disaster Manual by the DM. The DM. will be responsible to ensure corrective action. The corrective action will be completed by 11/14/14.	

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K 048	Continued From page 4 address partial evacuation of a smoke compartment, or define the facility's smoke compartments as required. The above was discussed and acknowledged by the <u>MAINTENANCE DIRECTOR</u> , <u>DM</u> 4/29/15	K 048		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based upon record review and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to maintain smoke detection devices 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. The findings include, but are not limited to: There is a smoke detector hanging from the ceiling by it's electrical wires in the basement mechanical room / maintenance office The facility does not have the report for the most recent smoke detector sensitivity testing. The above was discussed and acknowledged by the Maintenance Director.	K 054	The facility will contract with AAA Fire and Safety, Inc. to perform the smoke detector sensitivity testing. A bid for testing was accepted by the facility Administrator on 10/29/14. The Director of Maintenance (DM) will ensure the work is completed by the vendor as agreed to. The facility will enter into an agreement with this vendor for regular sensitivity testing of smoke detectors as prescribed by the Life Safety Code. The DM will be responsible to ensure correction. Corrective action will be completed by 11/26/14.	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066		

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K 066	<p>Continued From page 5</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This Standard is not met as evidenced by: Based upon record review and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to provide the required equipment at the designated smoking area(s). This could result in the ignition of the combustible materials adjacent to the staff smoking area which would endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to:</p> <p>All the facility's designated smoking areas are not equipped with a metal container with a self-closing lid.</p>	K 066	<p>The Director of Maintenance (DM) has ordered metal containers equipped with a self-closing lid for the facility designated smoking areas. These containers will be used exclusively for ashes and butts, and will be labeled to this effect. The DM or designee will be responsible for ensuring that these containers are emptied on a regular basis. The Administrator will be responsible for ensuring that staff and residents know of these containers and what their express purpose is. The DM or designee will audit container use and emptying weekly for 3 weeks and then monthly thereafter. The DM will be responsible for correction of this citation. Corrective action will be completed by 11/07/14.</p>	

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K 066	Continued From page 6 The above was discussed and acknowledged by the Maintenance Director.	K 066		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This Standard is not met as evidenced by: Based upon observations and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to prohibit the use of furnishings or decorations of flammable material. This could result in the rapid spread of smoke and fire in the event of ignition which could potentially endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: There were flammable decorations hanging across the ceiling of the activities room. There was a large flammable poster on the door that opens to the corridor in resident room #210. The above was discussed and acknowledged by the Maintenance Director.	K 073	The flammable decorations across the ceiling of the activities room were removed by the Activities Director (AD) on 10/23/14. The large flammable poster on the door that opens to the corridor in room #210 was removed by staff on 10/23/14. All other rooms in the facility were checked on 10/23/14 by the Administrator. The AD has been instructed by the Director of Maintenance on proper use of holiday decorations. The AD, working with the Administrator, will ensure that all holiday decorations are suitable for use in the facility. The Administrator, through his daily rounds, will remove any decorations found not to be in compliance. The Administrator will educate staff on what constitutes an acceptable decoration. The AD or designee will audit weekly for 8 weeks, and monthly thereafter, all seasonal decorations used to ensure compliance with the Life Safety Code. The Administrator will ensure facility compliance with this citation. The facility will be in compliance by 11/01/14.	
K 075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 Usq m). A capacity of 37 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075	The 64-gallon paper recycling containers were removed from both nursing stations on 10/24/14 by facility staff. The containers were replaced by 32-gallon secure containers. The Administrator (AD) will ensure that recycling containers do not exceed 32 gallons unless they are located in a room protected as a hazardous area when not attended. The Administrator will, on his daily rounds, inspect the containers to ensure they are of proper size. The facility will be in compliance by 11/01/14.	

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K 075	Continued From page 7 This Standard is not met as evidenced by: Based upon observations and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to properly maintain trash / recycle receptacles in excess of 32 gallons in a room protected as a hazardous area possibly endangering residents, staff and/or visitors within the facility. The findings include, but are not limited to: There were 64 gallon paper recycling receptacles stored in Nurse's station #1 and Nurse's station #2 that were open to the corridor. The above was discussed and acknowledged by the Maintenance Director.	K 075		
K 144 SS=F	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 upon observations and staff interviews on 10/23/14 between approximately 1100 and 1330 hours the facility has failed to have the	K 144	The vendor to install the emergency stop button for the generator was in the facility on 10/29/14 and met with the Director of Maintenance (DM.) The emergency stop button will be located at the unit 1 nurses station. The DM will oversee the installation of the emergency stop button and verify that it is in working condition. The DM will test the emergency stop button monthly as part of the emergency generator testing procedures. The DM will ensure compliance with this citation. The facility will achieve corrective action by 11/26/14.	

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K 144	<p>Continued From page 8</p> <p>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: There is no emergency stop button installed outside the room with the prime mover in accordance with NFPA 110 3-5.5.6.</p> <p>The above was discussed and acknowledged by the Maintenance Director.</p>	K 144		