

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

Printed: 11/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505024</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/16/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>FRANKLIN HILLS HEALTH &amp; REHAB CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6021 NORTH LIDGERWOOD SPOKANE, WA 99207</b>		
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Franklin Hills Health and Rehabilitation Center in Spokane, Washington on 11/16/15 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 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. Single station smoke detectors are installed in all resident rooms. The facility is licensed for 100 residents.</p> <p>Facility has applied for a waiver extension for K-147.</p> <p>The facility is not in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare &amp; 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>	K 000	<p><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE



Administrator

11/25/15

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 The surveyor was from: Washington State Patrol Office of the State Fire Marshal Fire Protection Bureau PO Box 19130 Spokane WA 99219-9130 Telephone: (509) 954-2746 Fax: (509) 227-6639	K 000		
K 018 SS=D	DSFM <i>D.A. Rogers</i> NFPA 101 LIFE SAFETY CODE STANDARD 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: Based upon observations and staff interviews on 11/16/15 during the physical tour of the facility	K 018	<u>K-018: Door Closures</u>  <u>Individual Residents</u>  No individual residents were identified.  <u>Residents in similar situations</u>  Residents within the facility will not be affected.  <u>Measures to prevent reoccurrence</u>  Facilities Maintenance staff adjusted the kitchen door to ensure proper closure and seal. The break room door latch was replaced to ensure proper latching.	11/18/15

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K 018	Continued From page 2 between 1245 and 1430 hours the facility has failed to maintain doors capable of resisting fire for at least 20 minutes. 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: The installed self-closing device on 1 of 2 doors from the kitchen into the exit corridor did not have enough self-closer force to fully close and latch.  The employee breakroom door that opens to the exit corridor was not equipped with a door latch.  The above was discussed with the Facility Maintenance Director who said he had not previously observed the defective closer on the kitchen and was not aware the breakroom door needed a latch.	K 018	<u>On-going monitoring</u>  The maintenance department will conduct weekly inspections of facility doors to ensure proper closures. Documentation of inspections will be maintained in the TELS preventative maintenance program.  <u>Individual to ensure compliance</u>  Maintenance Director	
K 029 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This Standard is not met as evidenced by:	K 029	<u><b>K 029 – Door Closure</b></u>  <u>Individual residents</u>  No individual residents were identified.  <u>Residents in similar situations</u>  Residents will not be affected.  <u>Measures to prevent reoccurrences</u>  The maintenance department corrected all identified doors to ensure proper closing and latching.	11/18/15

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K 029	Continued From page 3 Based upon observations and staff interviews on 11/16/2015 during the physical tour of the facility between approximately 1245 and 1430 hours the facility has failed to maintain doors of fully sprinklered hazardous areas as self-closing. This could result in the spreading of the toxic products of combustion into the corridor in the event of a fire which would endanger residents, staff and/or visitors.  The findings include, but are not limited to: The Central Supply room greater than 50 square feet did not have a self-closing device installed on the door to the exit corridor.  The above was discussed and acknowledged by the Maintenance Director who said he was not aware that the door needed a self-closer.	K 029	<u>On-going monitoring</u>  The maintenance department will conduct weekly inspections of facility doors to ensure proper operation. Documentation of inspections will be maintained in the TELS preventative maintenance program.  <u>Individual to ensure compliance</u>  Maintenance Director	
K 054 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  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 11/16/15 during the document review of the facility between approximately 1430 and 1515 hours the facility has failed to conduct testing of smoke detectors in the building 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:	K 054	<u>K 054 - Smoke Detectors</u>  <u>Individual Residents</u>  No individual residents were identified  <u>Residents in similar situations</u>  Residents will not be affected, sensitivity testing was completed. Paperwork had to be obtained from testing company.  <u>Measures to prevent reoccurrences</u> Fire and Life Safety documentation will be maintained in the TELS preventative maintenance on-line library.	11/18/15

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K 054	Continued From page 4 The facility was unable to provide documentation of having conducted smoke detector sensitivity testing in the last 5 years.	K 054	<u>On-going monitoring</u>  Facilities Management will utilize TELS preventative maintenance program to monitor when smoke detector sensitivity testing is required.	
K 062 SS=F	The above was discussed and acknowledged by the Maintenance Director who said he believes the testing was done recently but did not have a inspection report copy on site.  NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This Standard is not met as evidenced by: Based upon record review and staff interviews on 11/16/2015 between approximately 1430 and 1515 hours the facility has failed to conduct testing of the fire sprinkler system as required. This could result in the failure of the fire sprinkler system to operate properly in the event of a fire which would endanger the residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  The facility does not have records of having conducted quarterly sprinkler testing for 2nd quarter 2015 and 4th quarter 2014.  The facility was unable to provide documentation of having conducted the 5 year internal pipe inspection in the last 5 years.  The above was discussed and Maintenance	K 062	<u>Individual to ensure compliance</u> Maintenance Director  <u>K 062 – Sprinkler system maintenance</u>  <u>Individual Residents</u>  No individual residents were identified  <u>Residents in similar situations</u>  Residents have the potential to be affected by the practice. Facility will conduct testing to decrease impact.  <u>Measures to prevent reoccurrences</u>  Fire and Life Safety documentation will be maintained in the TELS preventative maintenance on-line library.  <u>On-going monitoring</u>  Facilities Management will utilize TELS preventative maintenance program to monitor when quarterly and annual testing is required.	12/1/15

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K 062	Continued From page 5 Director said they are aware of the missing 2015 quarterly inspection and have already scheduled a make-up inspection.	K 062	<u>Individual to ensure compliance</u>	
K 147 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based upon observations and staff interviews on 11/16/15 during the physical tour of the facility between approximately 1245 and 1330 hours the facility has failed to restrict the use of multi-plug outlets (power strips) to providing power to permitted electrical equipment. This could result in a fire from overheating of the plug strip due to the heavy power draw endangering the residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  There was a powerstrip in use with a tv in resident rooms #61, 59, 60, 54, 83, 89, 11.  The Facility Maintenance Director said they are still in the planning process to re-wire the building, but the facility being recently taken over by new management has set the timeline back. The facility had requested a waiver / time extension from CMS in October, but has not heard back yet.	K 147	<u>Maintenance Director</u>  <u>K 147 – Multi-plug outlet (surge protectors)</u>  <u>Individual Residents</u>  No individual residents were identified  <u>Residents in similar situations</u>  Residents have the potential to be affected by the practice. Waiver request has been submitted to the state.  <u>Measures to prevent reoccurrences</u>  Waiver has been submitted to the state due to financial hardship.  <u>On-going monitoring</u>  Facilities Management will reduce multi-plug outlets when it does not impacted resident needs or comfort.  <u>Individual to ensure compliance</u>  Maintenance Director	