

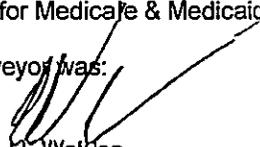
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

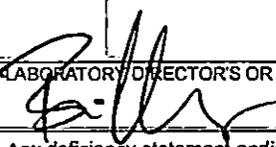
Printed: 06/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505315	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER MIRA VISTA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 18TH STREET MOUNT VERNON, WA 98273
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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>INITIAL COMMENTS</p> <p>Surveyor: 35231 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at the Mira Vista Care Center on 06/01/2015 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 92 beds and at the time of this survey the census was 70.</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 single story structure of Type V 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.</p> <p>The facility is not in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:</p>  Nicholas D. Volten Deputy State Fire Marshal	K 000	<p><i>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed solely because it is required for state licensure and/or for participation in the Medicare/Medicaid program</i></p>	
K 012 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p>	K 012	<p>K012</p> <p>Corrective Action for Residents found to be affected by this deficiency:</p> <p>No residents were listed in this finding.</p>	06/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 6/25/2015
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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 012	Continued From page 1 This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 hours the facility has failed to maintain fire resistive construction of the building capable of resisting the passage of smoke and fire into other compartments. 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 facility. The findings include, but are not limited to: Fire wall separating hall 200 has an approximate 2 foot by 2 foot hole in the interstitial space. Fire wall separating hall 100 has an approximate 2 foot by 2 foot hole in the interstitial space. The facility has failed to maintain fire resistive construction in boiler room around pipes going through the ceiling The above was discussed and acknowledged by the Administrator	K 012	<i>K012 cntd</i> Corrective Action for Residents that may be affected by this deficiency: The fire wall separating 200 and 100 halls has been repaired according to Construction Review's recommendations. The fire resistive construction has been added around the boiler room pipes. Measures that will be implemented to ensure this deficiency does not recur: Maintenance will continue to monitor fire wall barriers and fire resistive construction for compliance. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Problems will be reported to our Quality Assurance Committee.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and	K 038	K038 Corrective Action for Residents found to be affected by this deficiency: No residents were identified in this deficiency. Corrective Action for Residents that may be affected by this deficiency: A sign has been placed on the door in the therapy room clearly stating that it is not meant to be an emergency egress point.	06/30/2015

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K 038	Continued From page 2 15:00 hours the facility has failed to maintain the exit discharge free of obstructions. This could cause an inability or delay in the evacuation of residents in the event of an emergency which would endanger residents, staff and/or visitors. The findings include, but are not limited to: The facility has failed to maintain an impervious surface to the public way outside the physical therapy room. The facility has failed to maintain obstruction free access to emergency exits in the east corridor near Maintenance Directors office. The facility has failed to provide readily accessible exits from courtyard. The facility locks emergency exits with key lock on emergency exit. The above was discussed and acknowledged by the Administrator.	K 038	K038 contd. The east hall corridor hallway has been cleared providing clear access to the emergency exits. Per Construction Review recommendation, the lock on the courtyard gate has been removed. Hinges were switched around so the gate opens out. A new single action latch was installed. Measures that will be implemented to ensure this deficiency does not recur: Maintenance will continue to monitor emergency exits to ensure that they are readily accessible. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Problems will be fixed immediately and reported to the Quality Assurance Committee.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 hours the facility has failed to maintain records of testing for the emergency battery backup lighting. This could result in the failure of the battery powered backup lighting in the event of a power outage and render the means of egress dark. This could result in tripping and fall injuries to residents, staff and/or visitors. The findings include, but are not limited to: Emergency light in electrical room above generator transfer switch shall be tested monthly	K 046	K046 Corrective Action for Residents found to be affected by this deficiency: No residents were identified as being affected by this deficiency. Corrective Action for Residents that may be affected by this deficiency: A log monitoring the testing of emergency lighting in the electrical room for 30 seconds each month and 90 minutes yearly will be kept. Measures that will be implemented to ensure this deficiency does not recur: Administration will review logs monthly with Maintenance. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Problems will be reported to the Quality Assurance Committee.	06/30/2015

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K 046	Continued From page 3 for 30 seconds and yearly for 90 minutes. The above was discussed and acknowledged by the Administrator.	K 046		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Surveyor: 35231 Based upon record review and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 hours the facility has failed to have appropriate documentation of the fire alarm system which result in the failure of notification to staff of a water supply problem to the fire sprinkler system and endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: The facility has failed to maintain Nuisance log as required for zone fire alarm system The above was discussed and acknowledged by the Administrator.	K 052	K052 Corrective Action for Residents found to be affected by this deficiency: No residents were identified in this deficiency Corrective Action for Residents that may be affected by this deficiency: A nuisance log for the zone fire alarm system will be kept by maintenance. Measures that will be implemented to ensure this deficiency does not recur: Administration will monitor nuisance log on a monthly basis. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Problems will be reported to the Quality Assurance Committee.	06/30/2015
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	K062 Corrective Action for Residents found to be affected by this deficiency:	07/02/2015

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K 062	Continued From page 4 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: Surveyor: 35231 This requirement is not met as evidenced by: Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 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 has failed to conduct a 5 year internal pipe testing on sprinkler system. The above was discussed and acknowledged by the Administrator.	K 062	K062 cntd No residents were identified in this deficiency Corrective Action for Residents that may be affected by this deficiency: A five year internal pipe test of the sprinkler system was conducted. Measures that will be implemented to ensure this deficiency does not recur: Maintenance will monitor required sprinkler testing requirements and ensure tests have been completed. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Problems will be reported to the Quality Assurance Committee.	
K 064 SS=D	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: 35231 Based upon record review and observation on 06/01/2015 between approximately 09:00 and	K 064	K064 Corrective Action for Residents found to be affected by this deficiency: No residents were identified in this deficiency. Corrective Action for Residents that may be affected by this deficiency: A type "K" fire extinguisher was placed in the kitchen.	06/30/2015

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K 064	Continued From page 5 15:00 hours the facility has failed to assure proper 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: The facility has failed to provide a type K fire extinguisher in the commercial kitchen that produces grease laden vapors. The above was discussed and acknowledged by the Administrator.	K 064	Measures that will be implemented to ensure this deficiency does not recur: Maintenance will monitor during rounds to ensure a type K fire extinguisher is present in the kitchen. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Discrepancies will be reported to the Quality Assurance Committee.	
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 hours the facility has failed to provide signage where oxygen is in use or stored. 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: The facility has failed to provide provide a precautionary sign in outside oxygen storage room also known as central storage. The above was discussed and acknowledged by the Administrator.	K 141	K141 Corrective Action for Residents found to be affected by this deficiency: No residents were identified in this deficiency. Corrective Action for Residents that may be affected by this deficiency: A no smoking sign was placed on the outside oxygen storage room also know as central storage. Measures that will be implemented to ensure this deficiency does not recur: Maintenance will monitor rooms where oxygen is stored to ensure no smoking signs are present. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency h been corrected and will not recur: Problems will be reported to the Quality Assurance Committee.	06/30/2015
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144	K144 - See next page	06/30/2015

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K 144 SS=D	<p>Continued From page 6</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This Standard is not met as evidenced by: Surveyor: 35231</p> <p>Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 hours the facility has failed to have the 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: The facility has failed to provide a emergency remote stop switch for emergency generator. The above was discussed and acknowledged by the administrator.</p> <p>NFPA 110 1999 Edition 3-5.6 All level 1 and 2 installations shall have a remote manual stop station of a similar type to a break-glass station located outside the room housing the prime mover, where so installed or located elsewhere</p>	K 144	<p>K144</p> <p>Corrective Action for Residents found to be affected by this deficiency:</p> <p>No residents were identified in this deficiency.</p> <p>Corrective Action for Residents that may be affected by this deficiency:</p> <p>An emergency remote stop was installed for the generator per Construction Review's oversight.</p> <p>Measures that will be implemented to ensure this deficiency does not recur:</p> <p>Maintenance will ensure that the emergency remote stop is installed correctly</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Proof that the emergency remote stop was installed will be included in the Quality Assurance Committee notes.</p>	

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K 144

Continued From page 7
on the premises where the prime mover is located outside the building.

A-3-5.5.6 For level 1 and level 2 systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified.

K 144

K 147
SS=F

NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 147

K147
Corrective Action for Residents found to be affected by this deficiency:

No residents were identified in this deficiency.

Corrective Action for Residents that may be affected by this deficiency:

06/30/2015

This Standard is not met as evidenced by:
Surveyor: 35231
Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 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.

Obstructions to the electrical panel in the kitchen have been removed.
Air conditioner is plugged directly in to an outlet in the clinical services office.
Boiler room hot water heater electrical cover was installed.
Open electrical behind conference room on hall 100 was repaired.
Measures that will be implemented to ensure this deficiency does not recur:

The findings include, but are not limited to:
Electrical panel in kitchen shall have proper clearance from blocking obstructions.
Air conditioner shall be plugged directly into outlet in clinical services office.
Boiler room hot water heater open electrical missing electrical cover exposing electrical.
Open electrical behind door in conference room on hall 100.
The above was discussed and acknowledged by the Administrator

Maintenance will regularly monitor the above remedies to ensure compliance.

Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:

Problems will be reported to the Quality Assurance Committee.

K 211
SS=D

NFPA 101 LIFE SAFETY CODE STANDARD
Where Alcohol Based Hand Rub (ABHR)

K 211

K 211 - see next page

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K 211	<p>Continued From page 8</p> <p>dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 06/01/2015 between approximately 09:00 and 15:00 hours the facility has failed to properly install alcohol based hand rub dispensers. Dispensers installed improperly could result in hand rub coming in contact with an electrical source resulting in a fire causing potential endanger to residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to: ABHR in kitchen within 6 inches of light switch electrical outlet.</p> <p>The above was discussed and acknowledged by the Administrator.</p>	K 211	<p>K211</p> <p>Corrective Action for Residents found to be affected by this deficiency:</p> <p>No residents were identified in this deficiency.</p> <p>Corrective Action for Residents that may be affected by this deficiency:</p> <p>The Alcohol Based Hand Rub dispenser was moved away from the light switch in the kitchen.</p> <p>Measures that will be implemented to ensure this deficiency does not recur:</p> <p>Maintenance will monitor ABHR stations in the facility to ensure compliance.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Problems will be reported to the Quality Assurance Committee.</p>	
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