

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

Printed: 04/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

241

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505466</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/03/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>KENNEY, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7125 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 19192 On April 3, 2013 an unannounced fire and life safety code re-certification survey was conducted at The Kenney Nursing and Rehab located at 7125 Fauntleroy Way S Seattle WA, 98136 by a representative of the Washington State Patrol, State Fire Marshal's Office, this survey was conducted using the existing section of the 2000 life safety code in accordance with 42 CFR 483.70.</p> <p>This facility is a Type II- A structure with exiting rated stairwell enclosures and direct to grade, the building is protected throughout by a full NFPA 13 fire sprinkler system and automatic smoke detection in the corridors and common areas.</p> <p>The facility has a licensed capacity of 20 patients with a census today of 20.</p> <p>The following deficiencies are a result of this survey:</p> <p> Deputy State Fire Marshal</p>	K 000		
K 018 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 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</p>	K 018	<p>K018 The spring-hinge on the door has been adjusted to close the door and it is functioning normally. All doors have been inspected for proper closing in Garden Court and Nursing &amp; Rehab. We have implemented a bi-monthly inspection on the doors to ensure this is not a recurring problem and to make any necessary adjustments. Continued compliance to be assured by the Facilities Director.</p>	<p><b>RECEIVED</b> MAY 03 2013 FIRE PROTECTION BUREAU</p> <p>4/15/13 and ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE	(X6) DATE <b>4/16/13</b>
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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 018	Continued From page 1 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: Surveyor: 19192 During the facility tour on April 3, 2013 from 0830 to 1030 it was observed that the facility failed to maintain the fire rated doors in the building capable of self closing and latching tight to the frame, this has the potential for the penetration of smoke throughout the corridor in the event of a fire. This finding was acknowledged at the time of the survey by the facilities manager. The finding was:  1. The door to the nurses station has a self closing hinge but it did not close and latch the door.	K 018		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 050	K050 There is now a monthly check in place to ensure all three fire drills per shift (day, swing and noc) have been conducted per quarter. An assigned date will be given to each drill for the entire calendar year. These dates will be reassigned each year. Continued compliance to be assured by the Facilities Director.	4/30/13 and ongoing

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K 050	Continued From page 2 alarms. 19.7.1.2  This Standard is not met as evidenced by: Surveyor: 19192 During review of the facility fire drill records on April 3, 2013 at 0945 it was observed that the facility failed to conduct the required number of fire drills for the year, this has the potential to delay the evacuation of residents from the building in the event of a fire. These findings were acknowledged at the time of the survey by the facilities director. The findings were:  1. In the first quarter of 2013 there was no NOC shift fire drill recorded. 2. In the third quarter of 2012 there was no DAY shift fire drill recorded.	K 050		
K 062 SS=D	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: Surveyor: 19192 During the facility tour on April 3, 2013 from 0830 to 1030 it was observed that the facility failed to maintain the sprinkler system free of obstructions this has the potential to prevent the sprinklers capable of extinguishing a fire. This finding was acknowledged at the time of the survey by the facilities director. The finding was:  1. In the storage room across from resident	K 062	K062 Storage has been removed from the top shelf. All storage rooms will be checked monthly to ensure proper clearance for sprinkler heads. Staff will be re-educated that no storage is to be within 18 inches of any sprinkler head. Continued compliance to be assured by the Facilities Director	4/16/13

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K 062	Continued From page 3 room N-340 there is storage that is to close to the sprinkler head.	K 062		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on April 3, 2013 from 0830 to 1030 it was observed that the facility failed to maintain the emergency egress corridors free of storage, this has the potential to obstruct the residents from evacuating the facility in the event of a fire These findings were acknowledged at the time of the survey by the facilities director. The findings were:  1. In the corridor by resident room G-338 there is a large linen cart stored in the corridor. 2. In the corridor by resident room N-370 there is a large linen cart stored in the corridor.	K 072	K072 The facility does not consider our movable linen carts, with wheels, to be "storage" as defined in the code. These carts are moved periodically and in the event of a fire alarm or similar emergency they are to be removed from the egress hallways into vacated units or the dining area according to facility policy. Staff need easy access to these linen carts as they are moved periodically up and down the hallway throughout the day. There is insufficient "storage" space on the resident care wing to accommodate these mobile linen carts. If they were removed from the corridors to a remote storage location, this would significantly impede the staff's ability to provide immediate and effective care to residents. We view (K072 continued on next page)	4/16/13
K 147 SS=B	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: Surveyor: 19192 During the facility tour on April 3, 2013 from	K 147	K147 In Garden Court #337 the power strip was removed. A new surface mounted electric outlet was installed near items that needed power. In Nursing & Rehab #342 the power strip was removed and the power cord was plugged directly into a wall outlet. (Continued on page 5 of 5)	4/8/13 and ongoing

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K 062	Continued From page 3 room N-340 there is storage that is to close to the sprinkler head.	K 062		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on April 3, 2013 from 0830 to 1030 it was observed that the facility failed to maintain the emergency egress corridors free of storage, this has the potential to obstruct the residents from evacuating the facility in the event of a fire These findings were acknowledged at the time of the survey by the facilities director. The findings were:  1. In the corridor by resident room G-338 there is a large linen cart stored in the corridor. 2. In the corridor by resident room N-370 there is a large linen cart stored in the corridor.	K 072	(K072 continued from previous page) this as being no different than the mobile medication and treatment carts which also occupy space in the egress corridors. There will be ongoing checks each fire drill to make sure carts are being removed from egress hallways. Continued compliance to be assured by the Facilities Director and the Director of Health Services.	4/16/13
K 147 SS=B	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: Surveyor: 19192 During the facility tour on April 3, 2013 from	K 147		

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K 147	Continued From page 4 0830 to 1030 it was observed that the facility failed to maintain the building free of the use of power strip devices, this has the potential for the circuits to become over loaded. This finding was acknowledged at the time of the survey by the facility maintenance director. The finding was:  1. In the following resident rooms there were power strip devices in use.  a. G-337. b. N-342.	K 147	(Continued from page 4 of 5) Maintenance will conduct bi-monthly inspections to make sure no more power strips or extension cords are used. In addition, residents and residents' families will be advised of the standard. In the event that more outlets are needed a 6 outlet plug with a breaker will be plugged directly into a wall outlet. Staff have been notified that no more power strips can be used in resident rooms. Continued compliance to be assured by the Facilities Director and the Director of Health Services.	4/8/13 and ongoing

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