

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

Printed: 02/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505099	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPOKANE VAL		STREET ADDRESS, CITY, STATE, ZIP CODE EAST 17121 EIGHTH AVENUE SPOKANE VALLEY, WA 99016		
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K 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Good Samaritan Society in Spokane Valley, Washington on 2/22/16 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 were 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 97 residents. The current census is 79 residents.</p> <p>The memory care wing has been approved by the Spokane Valley Fire Department to have 30 second delayed egress doors.</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</p>	K 000	<p>K 018 SS = D</p> <p>It is the policy of the facility to ensure that the Medical Records door fully closes and latches as required.</p> <p><u>Part 1: Individual Corrective Action</u></p> <p>No individual resident identified. No individual resident door identified.</p> <p>Corrective action will include repairs to and/or replacement of the Medical Records door to ensure that the self-closer provides enough force to fully close and latch the door when closed.</p> <p><u>Part 2: Identifying Residents at Risk</u></p> <p>To protect residents from similar situations, the Environmental Services Director and/or designee will conduct a room by room audit to ensure all doors close and latch as required. Any door identified as not meeting the requirement, including hardware necessary to properly close and latch the door, will be adjusted, repaired or replaced if necessary in order to meet the requirement.</p> <p><u>Part 3: Systemic Changes</u></p> <p>To ensure that the problem does not recur, Environmental Services and Housekeeping Staff will be provided education and training by March 14, 2016. All Staff will be</p>	3/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Steve A. Allitto* TITLE *Administrator* (X6) DATE *2/29/16*

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 32863 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  DSFM D.A. Rogers	K 000	provided education and training by March 14, 2016. Education and training will include facility procedures for identifying, reporting and repairing doors that do not close and latch properly. <u>Part 4: Assurance of On-Going Compliance</u> The Environmental Services Director and/or designee will conduct routine focus audits to ensure doors close and latch as required.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This Standard is not met as evidenced by: Based upon observations and staff interviews on 2/22/16 during the physical tour of the facility between 1130 and 1430 hours the facility has failed to maintain doors capable of resisting fire	K 018	Concerns/trends will be reported to the facility Quality Assurance Performance Improvement Committee and the facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Housekeeping Supervisor, Administrator to ensure correction. K 050 SS = F It is the policy of the facility to ensure swing shift fire drills are conducted quarterly and ensure that documentation of swing shift fire drills takes place and is available for review. <u>Part 1: Individual Corrective Action</u> No individual resident identified. Corrective action will include conducting an	3/14/16

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K 018	Continued From page 2 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 Medical Records door that opens into the corridor did not have enough self-closer force to fully close and latch. The above was discussed with the Maintenance Director who said they periodically check all fire doors but that he had not previously observed this door failing to close and latch properly.	K 018	extra swing shift fire drill during the first quarter of 2016. Each swing shift fire drill will be documented. Documentation will be available for review upon request. <u>Part 2: Identifying Residents at Risk</u> To protect residents from similar situations, the Environmental Services Director and/or designee will review fire drill documentation during the final month of each quarter to determine if the requirement has been met. If not met, fire drills will be conducted and documented to meet the requirement.		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This Standard is not met as evidenced by: Based upon record review and staff interviews on 2/22/16 during document review between approximately 1430 and 1515 hours the facility has failed to provide fire drill records reflecting drills being conducted on all shifts for the past 12 months. This could potentially result in the staff not responding in a coordinated manner in the event of a fire or other emergency and	K 050	<u>Part 3: Systemic Changes</u> To ensure that the problem does not recur, Environmental services Staff will be provided education and training by March 14, 2016. All staff will be provided education and training by March, 14, 2016. Education and training will include fire drill requirements. <u>Part 4: Assurance of On-Going Compliance</u> The Environmental Services Director and/or designee will conduct routine focus audits to ensure fire drills take place as required. Concerns/trends will be reported to the facility Quality Assurance Performance Improvement Committee and the facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Administrator to ensure correction.		

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K 050	Continued From page 3 endangering residents, staff and/or visitors. The findings include, but are not limited to: The facility did not have any documentation indicating they had conducted a swing shift fire drill for the 3rd quarter 2015. The above was discussed and acknowledged by the Maintenance Director who said he knew he had conducted three drills that quarter but did not realize the swing shift was missed.	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: Based upon observations and staff interviews on 2/22/16 during the physical tour of the facility between 1130 and 1430 hours the facility has failed to maintain the fire sprinkler system as required. This could result in a delay of sprinkler activation in the event of a fire allowing the fire to increase in size and intensity which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: The soldered disc on 1 of 4 sprinkler heads in the station #3 mechanical room had paint on it. The frangible bulb on 1 (above the resident room door to the corridor) of 3 sprinkler heads in resident room # 359 had paint on it. The above was discussed and acknowledged by the Maintenance Director who said he had not	K 062 SS = D	It is the policy of the facility to continuously maintain in reliable operating condition the automatic sprinkler system and ensure that it is inspected and tested periodically. <u>Part 1: Individual Corrective Action</u> No individual resident identified. One resident room identified. Corrective action will include: 1) the soldered disk on 1 sprinkler head in the Station #3 mechanical room will be cleaned of paint and/or replaced if needed; 2) the frangible bulb on 1 sprinkler head in resident room #359 will be cleaned of paint and/or replaced if needed. <u>Part 2: Identifying Residents at Risk</u> To protect residents from similar situations, the Environmental Services Director and/or designee will conduct both a corridor and a room by room audit to ensure that all sprinkler head soldered disks and all sprinkler frangible bulbs are free of paint. Any identified with paint on them will be cleaned of paint and/or replaced if needed to meet the requirement.	3/14/16

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K 062	Continued From page 4 previously observed the paint on the heads.	K 062	<p><u>Part 3: Systemic Changes</u></p> <p>To ensure that the problem does not recur, Environmental Services and Housekeeping staff will be provided education and training by March 14, 2016. All staff will be provided education and training by March 14, 2016. Education and training will include facility procedures for identifying, reporting and maintaining sprinkler heads free of paint.</p> <p><u>Part 4: Assurance of On-Going Compliance</u></p> <p>The Environmental Services Director and/or designee will conduct routine focus audits to ensure sprinkler heads are free of paint. Concerns/trends will be reported to the facility Quality Assurance Performance Improvement Committee and the facility Safety Committee until a lesser frequency is deemed appropriate. Environmental Services Director, Housekeeping Supervisor, Administrator to ensure correction.</p>	