

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

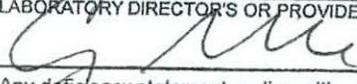
Printed: 07/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505291	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW LUTHERAN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1841 EAST UPRIVER DRIVE SPOKANE, WA 99207
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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 the Riverview Lutheran Care Center in Spokane, Washington on 7/21/15 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 with a full basement of Type V-A 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 75 residents with a current census of 69.</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</p>	K 000		
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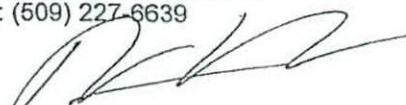
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Maintenance Director</i>	(X6) DATE <i>8/24/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting 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.

*received 7/30/15
approved 7/30/15
[Signature]*

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K 000	Continued From page 1 Fire Protection Bureau PO Box 19130 Spokane WA 99219-9130 Telephone: (509) 954-2746 Fax: (509) 227-6639  DSFM D.A. Rogers	K 000	The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found in this document.	
K 025 <u>SS=D</u>	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by: Based upon observations and staff interviews on 7/21/15 between approximately 0930 and 1230 hours the facility has failed to maintain smoke barrier walls to the required one hour fire resistive rating. This could result in the passage of the products of combustion from one smoke compartment into another smoke compartment thereby exposing residents, staff and/or visitors to the toxic products of combustion. The findings include, but are not limited to: There was a penetration in the barrier above the cross-corridor smoke barrier doors by room #312	K 025	The penetration will be sealed with fire rated foam. A work order will be created to check for penetrations in the smoke barriers on a monthly basis. This work will be completed by August 21, 2015. The Director of Maintenance will make sure the work has been completed.	

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K 025	Continued From page 2	K 025		
K 062 <u>SS=E</u>	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on 7/21/15 between approximately 0930 and 1230 hours the facility has failed to maintain 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 and allow the fire to increase in size and intensity which would endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to: In the Restorative Office there was one sprinkler head with a missing escutcheon plate and two sprinkler heads with gaps between the escutcheon plates and the ceiling tiles which could allow heat to bypass the sprinkler heads.</p> <p>There was a gap in the ceiling panel around the corridor sprinkler head near the North nurse's station.</p> <p>The above was discussed and acknowledged by the Maintenance Director.</p>	K 062	<p>The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found in this document.</p> <p>Riverview will contact Western States Fire Protection to add escutcheon plates where needed and raise the escutcheon plates where they have dropped. A work order will be created to check all sprinkler heads on a monthly basis.</p> <p>The Director of Maintenance will ensure that the work has been completed. This work will be completed by August 21, 2015.</p>	
K 070 <u>SS=D</u>	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in</p>	K 070		

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K 070	<p>Continued From page 3</p> <p>all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This Standard is not met as evidenced by: Based upon record review and staff interviews on 7/21/15 between approximately 0930 and 1230 hours the facility has failed to prohibit the use of portable electric heaters within the facility to approved areas. This could result in a fire due to the ignition of combustible materials that would place residents, staff and/or visitors in danger.</p> <p>The findings include, but are not limited to:</p> <p>There was a portable heater in use in resident room # 106. (Removed immediately during inspection).</p> <p>The above was discussed and acknowledged by the Facility Maintenance Director.</p>	K 070	<p>The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found in this document.</p> <p>The heater noted was removed and the family will be notified that portable heaters are not allowed in resident rooms. A policy will be written to give to incoming residents and families stating that portable heaters are not allowed in our facility.</p> <p>A work order will be created to check all rooms for portable heaters on a weekly basis.</p>	
K 074 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p>	K 074	<p>This work will be completed by August 21, 2015. The Director of Maintenance will ensure all work is completed.</p>	

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K 074	Continued From page 4 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This Standard is not met as evidenced by: Based upon observations and staff interviews on 7/21/15 between approximately 0930 and 1230 hours the facility has failed to ensure that hanging fabrics are rated as flame resistant. 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 is a hanging curtain in the Staff Education office over the window that is not manufactured to be flame resistance and has no documentation indicating is has been treated to be flame-resistant. The above was discussed and acknowledged by the Facility Maintenance Director.	K 074	The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found in this document. The noted window covering will be removed, sprayed with fire retardant spray, tagged and reinstalled. A work order will be created to check all areas of the Care Center for untreated items on a monthly basis. A policy will be written for staff stating that all items brought into the nursing home must come already fire retardant or must be sprayed and tagged with a fire retardant spray. This will be completed by August 21, 2015. The Director of Maintenance will ensure that these items are completed.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based upon observations and staff interviews on 7/21/15 between approximately 0930 and 1230	K 130		

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K 144	<p>Continued From page 6</p> <p>failure to shut off the emergency generator in the event of a fire at the generator 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 remote emergency stop button installed separate of the facility's automatic generator in accordance with NFPA 110 3-5.5.6.</p> <p>The above was discussed and acknowledged by the Maintenance Director.</p>	K 144	<p>The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found in this document.</p> <p>Riverview will contact Legacy Power Systems to install an emergency shut off valve at least seven feet away from the generator.</p> <p>This work will be completed by August 21, 2015. The Director of Maintenance will ensure that the work is completed.</p>	