

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

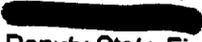
Printed: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391

1196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT TOWNSEND	STREET ADDRESS, CITY, STATE, ZIP CODE 751 KEARNEY STREET PORT TOWNSEND, WA 98368
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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>An unannounced Life Safety Code Survey was conducted at Life Care Center of Port Townsend, Port Townsend, Washington, on August 9, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Oak Harbor Detachment. The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care.</p> <p>The LTC 94 bed facility with a census of 49, consisted of a Type V-111, 1 story structure with no basement. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and have an all weather surface and lead to a public way.</p> <p>The deficiencies identified during this survey are listed below.</p> <p>The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p> Deputy State Fire Marshal <i>Paul V. Schwa</i></p>	K 000	<p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>K012</p> <ol style="list-style-type: none"> No residents identified. Four areas identified were repaired on the date of visit 8/9/2013. Daily building rounds completed by Maintenance Director or designee to ensure properly maintained walls. Executive Director will do building rounds with Maintenance Director once a month for 3 months to ensure compliance. <p>Date of compliance - 8/29/2013</p>	
K 012 SS=D	<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> <p>This Standard is not met as evidenced by: Based upon observations the facility has failed to maintain the construction requirements for the classification of construction. The facility has a</p>	K 012	<p>K018</p> <ol style="list-style-type: none"> No residents identified. Two areas identified were adjusted on date of visit 8/9/2013. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 8/19/13
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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	<p>Continued From page 1 type 5 1 hour separation classification by the Building and Fire Codes.</p> <p>During the tour on August 9, 2013 from 1100 to 1400 the following areas were observed to be deficient:</p> <ol style="list-style-type: none"> 1. Wheelchair closet - 2 ft by 3 ft area needing to repaired 2. Wheelchair closet - 1 inch hole needing to be repaired 3. Admin closet in dining room - multiple holes in sheet rock 4. Attic space above freezer room - missing cover inn attic space <p>These findings were acknowledged by the maintenance director.</p>	K 012	<ol style="list-style-type: none"> a. Social Services Door - door kick removed from door b. Conference Room Door - mag was placed on door <ol style="list-style-type: none"> 3. Daily building rounds completed by Maintenance Director or designec to ensure all doors close, latch or open properly when tested. 4. Executive Director will do building rounds with Maintenance Director once a month for 3 months to ensure compliance. <p>Date of compliance - 8/29/2013</p> <p>K064</p> <ol style="list-style-type: none"> 1. No residents identified. 2. Three areas identified were adjusted to appropriate heighth on date of visit 8/9/2013. <ol style="list-style-type: none"> a. Kitchen b. Laundry Room c. Mechanical Room 3. Executive Director will do building rounds with Maintenance Director once a month for 3 months to ensure compliance. <p>Date of compliance - 8/29/2013</p>	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505306	DATE SURVEY COMPLETE: 08/09/2013
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 018 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 on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment. Findings include:

During the facility tour on August 9, 2013 from 1100 to 1400 it was observed that the following doors did not close, latch or open properly when tested:

1. Social Services Directors Office - door blocked open by door kick
2. Conference Room - missing mag on door.

These findings were acknowledged by the facility Maintenance Director.

K 064 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:

Based on observation and record review, the facility failed to assure fire extinguishers are properly maintained. This potentially delays a quick response to contain a fire from spreading, exposing residents to fire in the environment.

During the facility tour on August 9, 2013 from 1100-1400 observed fire extinguishers in the following locations that the tops were more more than five feet from the floor:

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505306	DATE SURVEY COMPLETE: 08/09/2013
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K 064

Continued From Page 1

1. Kitchen
2. Laundry Room
3. Mechanical Room

The Maintenance Director acknowledged the findings.

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