

RECEIVED

NOV 20 2013

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

FIRE PROTECTION
BUREAU

Printed: 10/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER TOPPENISH NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 802 WEST THIRD STREET TOPPENISH, WA 98946		
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced Fire and Life Safety Complaint Fire Investigation conducted on October 31, 2013 at Toppenish Nursing Rehab Center, 802 West 3rd Street, Toppenish, WA by a representative of the Washington State Fire Marshal's Office.</p> <p>The complaint from the Department of Social and Health Services, (Complaint Resolution Unit) has an Intake ID number of 2884288, which states: There was a minor fire in the kitchen. Plastic cup got stuck somehow on the element and it caused a minor little fire. It was extinguished immediately. There were no residents at risk for harm. No excess smoke, it was put out right away. Nobody was at risk for further harm. Toppenish Nursing and Rehab - Toppenish Provider #50 5086 .</p> <p>Based on record observation and interviews with the DNS and the Maintenance Director, Toppenish Nursing and Rehab Center is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The Surveyor was:  Deputy State Fire Marshal Nursing Home Surveyor 28058</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau 2715 Rudkin Road</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *John T. Buehly* TITLE *Administrator* (X6) DATE *11-13-13*

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.

Printed: 10/31/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER TOPPENISH NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 802 WEST THIRD STREET TOPPENISH, WA 98946		
(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
K 000	Continued From page 1 Union Gap, WA. 98903-1795 Telephone: (509) 576-2190 FAX: (509) 576-3002	K 000		
K 048	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This Standard is not met as evidenced by: The facility has failed to implement the written plan that is in place for the protection of all residents and for their evacuation in the event of an emergency. The kitchen staff upon seeing flames and smoke did not follow the RACE process that this facility has in place. This could have placed the residents, visitors, and staff at risk of smoke, heat, and fire. The findings include, but are not limited to: 1. I asked the DNS and the Maintenance Director to provide their written plan for discovering a fire. They provided their written plan that has RACE as what is practiced here. Rescue, Alarm, Confine, and Evacuate. 2. Upon kitchen staff seeing flames the staff member did not grab a fire extinguisher. He used the pre rinse water hose to extinguish the fire. It cut the fire for a little bit and then reignited he used the hose again. There was a fire extinguisher within about 30 feet of the dishwasher. No fire extinguishers were used. 3. The kitchen staff did not activate the fire alarm to ensure that other areas of the facility are aware that there is a fire threat. Activating the fire alarm	K 048	1. This tag impacts all residents. Staff will be in-serviced on our Fire Safety Policy and Procedure which includes R.A.C.E.R. by the Administrator or Maintenance Director. Documentation of the in-service will be maintained. The Maintenance Director will provide refresher training on R.A.C.E.R. immediately after the next 3 fire drills and bi-annually thereafter. Documentation of the in-service will be maintained in the facility in-service log. 2. This tag impacts all residents. Immediately after the next 3 fire drills, P.A.S.S. training will be given including "mimicked" use of a fire extinguisher by the Administrator or the Maintenance Director. Documentation of the in-service will be maintained in the facility in-service log.	11-25-13 11-25-13

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

Printed: 10/31/2013
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER TOPPENISH NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 802 WEST THIRD STREET TOPPENISH, WA 98948		
(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	
K 048	<p>Continued From page 2</p> <p>would have shut doors and air handling units and confined the fire and smoke to the kitchen had this gotten out of control.</p> <p>4. RACE instructs to use a fire extinguisher to extinguish the fire. This could have easily escalated to an electrical fire, and the water hose would have been useless and would have exposed him to other electrical dangers.</p> <p>5. The sprinkler system did not activate as the fire was extinguished and did not reach temperatures hot enough to trigger the activation of the sprinkler system.</p> <p>6. The fire alarm system did not activate as no one pulled a pull station and the smoke did not get concentrated enough to set off the fire alarm system.</p> <p>7. No residents were evacuated. Staff felt that they had eliminated the threat of fire and elected not to disrupt the entire facility. This decision was made by the Administrator.</p> <p>8. No residents or staff were injured as a result of this fire.</p> <p>9. Everything turned out fine in this instance. However, staff needs to be followed-up with fire extinguisher training and to follow the fire emergency policy that they have in place.</p> <p>These findings were acknowledged and discussed with the DNS and the Maintenance Director.</p>	K 048	<p>3. This tag impacts all residents. A hands on in-service with return demonstration on the proper use of fire extinguishers will be conducted by the local Fire Department or other qualified organization by November 25, 2013. Documentation of the in-service will be maintained in the facility in-service log. The Maintenance Director trains all new hires on P.A.S.S. which is documented in the new hire orientation file.</p>	11-25-13	