

1377

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505154</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/22/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>REGENCY AT TACOMA REHABILITATION CE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2102 SOUTH 96TH STREET TACOMA, WA 98444</b>	
(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	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 19192 On February 22, 2013 an unannounced fire and life safety code re-certification survey was conducted at Regency At Tacoma Rehab located at 2102 South 96th Street Tacoma WA, 98444 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 single story type V-A structure with exiting direct to grade level, the building is protected throughout by a full NFPA 13 fire sprinkler system and an automatic smoke detection system in the corridors and common areas.</p> <p>The facility has a total capacity of 150 patients with a census today of 95.</p> <p>The following are the deficiencies cited as a result of this survey:</p> <p><i>Donalish C...</i> Deputy State Fire Marshal</p>	K 000	<p>This plan of Correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor contents should be construed as an admission by this provider of the validity of any findings or citations contained herein.</p> <p><u>Immediate action for cited areas K18</u></p> <p>The door into the clean side of the laundry was repaired to close properly.</p> <p><u>Similar Situations</u></p> <p>An audit was completed to identify and repair doors that may not have closed and latched properly.</p> <p><u>System Measures</u></p> <p>Maintenance director will continue to do regular environmental rounds to assure doors properly close and latch.</p> <p><u>On Going Compliance</u></p>	3/8/13
K 018 SS=E	<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 1/4 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</p>	K 018	<p>Administrator will continue to audit environmental rounds and preventative maintenance logs monthly to ensure compliance. Administrator will include summary of findings in scheduled QA meeting.</p> <p><u>To Ensure Compliance</u></p> <p>Administrator</p>	<p><b>RECEIVED</b> MAR 08 2013 <b>FIRE PROTECTION BUREAU</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE *Administrator* (X6) DATE *2/26/13*

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.

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K 018	<p>Continued From page 1 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on February 22, 2013 from 0815 to 1215 it was observed that the facility failed to maintain the fire rated doors on the corridor capable of self closing and latching tight to the frame, this has the potential for the passage of smoke throughout the corridors in the event of a fire. This finding were acknowledged at the time of the survey by the facility maintenance director. The finding was:</p> <p>1. The door into the clean side of the laundry failed to close and latch. (this deficiency was corrected at the time of the survey)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>	K 018	<p><u>Immediate action for cited areas K64</u></p> <p>The fire extinguisher in the laundry was placed in the correct mounting.</p> <p><u>Similar Situations</u></p> <p>An audit was completed to identify and correct fire extinguishers that may be mounted incorrectly.</p> <p><u>System Measures</u></p> <p>Maintenance director will continue to do regular environmental rounds to assure fire extinguishers are mounted correctly.</p> <p><u>On Going Compliance</u></p> <p>Administrator will continue to audit environmental rounds and preventative maintenance logs monthly to ensure compliance. Administrator will include summary of findings in scheduled QA meeting.</p> <p><u>To Ensure Compliance</u></p> <p>Administrator</p>	3/8/13
K 064 SS=B		K 064		

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K 064	Continued From page 2  This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on February 22, 2013 from 0815 to 1215 it was observed that the facility failed to maintain the portable fire extinguishers in the building, this finding was acknowledged at the time of the survey by the facility maintenance director. The finding was:  1. The fire extinguisher in the laundry was mounted tot he wrong mount and was hanging by the pressure gauge. (this deficiency was corrected at the time of the survey)	K 064	<u>Immediate action for cited areas K147</u>  In resident room #20 power strips were removed and an approved cordless six plug wall mounted surge protector was installed.  In resident room #92 power strips were removed and an approved cordless six plug wall mounted surge protector was installed.  In resident room #63 power strips were removed and an approved cordless six plug wall mounted surge protector was installed.	3/8/13
K 147 SS=E	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 February 22, 2013 from 0815 to 1215 it was observed that the facility failed to maintain the building free of the use of power strip devices in resident sleeping areas, this has the potential to over load the circuit, these findings were acknowledged at the time of the survey by the facility maintenance director. The findings were:  1. In resident room #20 there were two power strip devices plugged into each other. 2. In resident room #92 there is a power strip device in use at bed #1. 3. In resident room #63 there is a power strip device in use at bed #2.	K 147	<u>Similar Situations</u>  An audit was completed to identify and remove any power strips in use in resident rooms and an approved cordless six plug wall mounted surge protector was installed as needed.  <u>System Measures</u>  Maintenance director will continue to do regular environmental rounds to assure power strips are not in use in resident rooms.  <u>On Going Compliance</u>  Administrator will continue to audit environmental rounds and preventative maintenance logs monthly to ensure compliance. Administrator will include summary of findings in scheduled QA meeting.  <u>To Ensure Compliance</u>  Administrator	

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