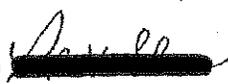


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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505154	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CE		STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444		
(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	INITIAL COMMENTS An unannounced Life Safety Code Survey was conducted at Tacoma Nursing and Rehabilitation Center, Tacoma, Washington, on January 22, 2014 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. The LTC 150 bed facility with a census of 98, consisted of a Type V-111, 1 story structure built in 1962 and has a partial basement area that is used as the boiler room. 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. The deficiencies identified during this survey are listed below. The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.  Deputy State Fire Marshal	K 000	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. <u>Immediate action for cited areas K12</u> Penetration in resident room has been patched and painted. 4 penetrations in central supply ceiling have been patched and painted. Penetration around wiring and conduit in fire alarm panel room has been sealed. <u>Similar Situations</u> An audit was completed to identify, patch and paint penetrations. <u>System Measures</u> Maintenance director will continue to do regular environmental rounds to identify, patch and paint penetrations.	2/14/14
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This Standard is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the integrity of smoke	K 012	<u>On Going Compliance</u> Administrator will continue to audit environmental rounds, TELs and preventative maintenance logs monthly to ensure compliance. Administrator will include summary of findings in scheduled QA meeting. <u>To Ensure Compliance</u> Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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	Continued From page 1 barriers. This potentially allows the spread of smoke to other areas of the facility, exposing residents to a smoke or fire environment. The findings are as follows. During the facility tour on January 22, 2014 from 10:00 AM to 4:00 PM penetrations were observed in the following location(s) 1. Resident room - around wiring 2. Central supply office - 4 holes in the ceiling 3. Fire alarm control panel room - around wiring and conduit These findings were acknowledged by the Maintenance Director.	K 012	<u>Immediate action for cited areas K18</u> PSFP closet door has been replaced. C wing exit door has been repaired. Exit door by O2 storage room has been repaired. <u>Similar Situations</u> An audit was completed to identify and repair exit doors and hallway closet doors.	2/14/14
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 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 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.	K 018	<u>System Measures</u> Maintenance director will continue to do regular environmental rounds to assure exit doors and hallway closet doors are repaired. <u>On Going Compliance</u> Administrator will continue to audit environmental rounds, TELs 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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K 018	Continued From page 2 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 January 22, 2014 from 10:00 AM to 4:00 PM it was observed that the following doors were damaged: 1. PSFP closet door 2. C wing exit door missing hardware 3. Exit door by O2 storage not aligned These findings were acknowledged by the facility Maintenance Director.	K 018	<u>Immediate action for cited areas K38</u> Pallets have been removed from exit path outside the restorative area. <u>Similar Situations</u> An audit was completed to assure exits were clear. <u>System Measures</u> Maintenance director will continue to do regular environmental rounds to assure exits are clear. <u>On Going Compliance</u> Administrator will continue to audit environmental rounds, TELs and preventative maintenance logs monthly to ensure compliance. Administrator will include summary of findings in scheduled QA meeting. <u>To Ensure Compliance</u> Administrator	2/14/14
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that exit egress remained clear and unobstructed. This potentially prevents residents from exiting a fire/smoke environment. Findings include: During the facility tour on January 22, 2014 from 10:00 AM to 4:00 PM, observed that the exit egress by the: 1. Exit path from the exit door at the restorative	K 038		

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K 038	Continued From page 3 rehab area was obstructed by pallets This finding was acknowledged by the Maintenance Director.	K 038	<u>Immediate action for cited areas K62</u> Laundry room sprinkler head will be replaced by contractors on 2/6/14.	2/14/14
K 062 SS=E	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 on observations, the facility failed to maintain the proper operational condition of the sprinkler system. This has the potential of having a non-functional sprinkler system that would expose residents to a fire or smoke environment. The findings are as follows: During the facility tour on January 22, 2014 from 10:00 AM to 4:00 PM, the following deficiencies were found: 1. Laundry Room folding area - painted sprinkler head in the skylight area 2. Corridor by the kitchen entrance - damaged sprinkler head 3. On January 22, 2014 at 2:00 PM while checking sprinkler documentation, it was observed that the facility has no documentation for conducting the annual sprinkler test. These findings were acknowledged by the Maintenance Director.	K 062	<u>Sprinkler head in corridor by kitchen will be replaced by contractors on 2/6/14.</u> <u>Annual sprinkler test will be completed 2/6/14.</u> <u>Similar Situations</u> Sprinkler heads will be audited to assure they are not damaged. <u>System Measures</u> Maintenance director will continue to do regular environmental rounds to assure sprinkler heads are not damaged. Communication about the annual sprinkler testing will include on-site verification of testing and e-mail of typed sprinkler testing results will be forwarded to administrator.	
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 064	<u>On Going Compliance</u> Administrator will continue to audit environmental rounds, TELs 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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K 064	Continued From page 4 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	<u>Immediate action for cited areas K04</u> Fire extinguisher tag will be serviced and punched by contractor on 2/6/14. <u>Similar Situations</u> An audit was completed to assure fire extinguisher tags are correctly punched. <u>System Measures</u> Maintenance director will continue to do regular environmental rounds to assure fire extinguisher tags are correctly punched.	2/14/14
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is	K 066	<u>On Going Compliance</u> Administrator will continue to audit environmental rounds, TELs 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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K 066	Continued From page 5 permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This Standard is not met as evidenced by: Based upon record review along with observations and staff interviews, the facility failed to adhere to the written smoking procedures for the facility. This has the potential to cause a fire to occur due to staff, visitors and possibly residents smoking in areas not equipped with ashtrays and approved containers. During the facility tour on January 22, 2014 from 10:00 AM to 4:00 PM findings include: 1. At the smoking canopy as well as throughout the courtyard there were cigarette butts on the ground. 2. The annex dining hall patio was being used as a smoking area and had cigarette butts on the ground. 3. The annex dining hall patio was being used as a smoking area and within 25 feet of a potential flammable source. (natural gas lines on the ceiling that were closed at the valve). These findings were acknowledged by the Maintenance Director.	K 066	<u>Immediate action for cited areas K.66</u> Cigarette butts have been cleaned up around the canopy area. The annex dining hall patio is no longer used for smoking. The closed gas lines in the ceiling of the annex dining hall patio have been removed. <u>Similar Situations</u> Housekeeping has done clean up in smoking area. <u>System Measures</u> Housekeeping will do scheduled rounds during the day to assure cigarette butts are cleaned up regularly. <u>On Going Compliance</u> Administrator will do random rounds of smoking area to ensure compliance. Administrator will include summary of findings in scheduled QA meeting. <u>To Ensure Compliance</u> Administrator <u>Immediate action for cited areas K.147</u> Multi plug for annex dining hall has been secured. Annex dining hall patio conduit has been removed. Liquid hand cleaner has been moved away from the electrical source in resident room 78.	2/14/14
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	K 147		

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K 147	Continued From page 6 This Standard is not met as evidenced by: Based on observations, the facility failed to maintain proper electrical conditions per NFPA 70, National Electrical Code. This has the potential to expose staff and patients to a fire environment. The findings are as follows: During the facility tour on January 22, 2014 from 10:00 AM to 4:00 PM the following deficiencies were found: 1. Annex dining hall - multi plug adapter hanging by cords 2. Annex dining hall patio - electrical conduit not secured to wall 3. Resident room ● - liquid hand cleaner above electrical source 4. Resident room ● - liquid hand cleaner above electrical source 5. Resident room ● - liquid hand cleaner above electrical source 6. Resident room ● - liquid hand cleaner above electrical source 7. Resident room ● - liquid hand cleaner above electrical source These findings were acknowledged by the Maintenance Director	K 147	Liquid hand cleaner has been moved away from the electrical source in resident room ● Liquid hand cleaner has been moved away from the electrical source in resident room ● Liquid hand cleaner has been moved away from the electrical source in resident room ● Liquid hand cleaner has been moved away from the electrical source in resident room ● <u>Similar Situations</u> An audit was completed to assure multi plugs are secured. An audit was completed to assure conduits are secured. An audit was completed to assure that liquid hand cleaner is not near an electrical source. <u>System Measures</u> Maintenance director will continue to do regular environmental rounds to assure continued placement of liquid hand cleaner is not near an electrical source. <u>On Going Compliance</u> Administrator will continue to audit environmental rounds, TELs and preventative maintenance logs monthly to ensure compliance. Administrator will include summary of findings in scheduled QA meeting. <u>To Ensure Compliance</u> Administrator	2/14/14

* Should be cited under
K211 Not K147
DM 3/25/14
CDSFM