

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

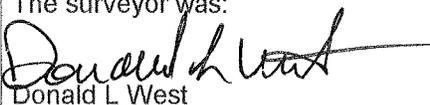
Printed: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

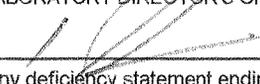
1397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505483	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER ALASKA GARDENS HEALTH AND REHABILIT	STREET ADDRESS, CITY, STATE, ZIP CODE 6220 SOUTH ALASKA STREET TACOMA, WA 98408
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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>Surveyor: 19192 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Alaska Gardens Health & Rehab located at 6220 South Alaska Street Tacoma WA, 98408 on 5/7/2014 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.</p> <p>The facility has a total of 123 beds and at the time of this survey the census was 113.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70.</p> <p>The facility is a single story structure of Type V-A construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way.</p> <p><i>SUBSTANTIAL</i></p> <p>The facility is in compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:  Donald L. West Deputy State Fire Marshal</p>	K 000	<p><i>MURPHY CDSFM 5-15-14</i></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Director of Maintenance</i>	(X8) DATE <i>5/7/2014</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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505483	DATE SURVEY COMPLETE: 05/07/2014
NAME OF PROVIDER OR SUPPLIER ALASKA GARDENS HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 6220 SOUTH ALASKA STREET TACOMA, WA. 98408	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 147

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

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This requirement is not met as evidenced by:

Based upon observations and staff interviews on 5/7/2014 between approximately 0815 and 1015 hours the facility has failed to restrict the use of extension cords to providing power to permitted electrical equipment. This could result in a fire from overheating of the plug strip due to the heavy power draw endangering the residents, staff and/or visitors within the facility.

The findings include, but are not limited to:

1. In resident room #306 at the bed near the window there was an unapproved extension cord in use.
THIS DEFICIENCY WAS CORRECTED AT THE TIME OF SURVEY.

The above was discussed and acknowledged by the facility maintenance director..

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.

The above isolated deficiencies pose no actual harm to the residents