

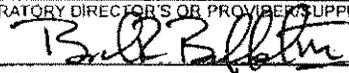
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
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NAME OF PROVIDER OR SUPPLIER AVAMERE HERITAGE REHABILITATION OF TA	STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE 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
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 Avamere Heritage Tacoma on 11/5/2014 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 89 beds and at the time of this survey the census was 65.</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>The facility is not 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		
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,</p>	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11-14-14
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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	Continued From page 1 19.3.5.1 This Standard is not met as evidenced by: Surveyor: 19192 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 requirement is not met as evidenced by: Based upon observations and staff interviews on 11/5/2014 between approximately 0830 and 1115 hours the facility has failed to maintain fire resistive construction of the building capable of resisting the passage of smoke and fire into other compartments. This could allow the toxic product of combustion to move out of a room and into the exit access corridor and the smoke compartment which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. In resident room #407 above the wardrobe there is a penetration in the wall where a cable goes thru, this wall is adjacent to the corridor. The above was discussed and acknowledged by the facility Administrator and Maintenance director.	K 012	K 012 The penetration in room 407 was fixed on 11-5-14 by the maintenance director. An audit of the facility was completed to ensure that there were no other penetrations. Rounds of the facility will be completed monthly to monitor for penetrations. The Maintenance Director will be responsible. Results of the rounds will be submitted to the facility Quality Assurance Committee monthly for 3 months, then periodically thereafter. Compliance Date 11-26-14	
K 018 SS=E	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	K 018		

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K 018	<p>Continued From page 2</p> <p>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</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 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This requirement is not met as evidenced by: Based upon observations and staff interviews on 11/5/2014 between approximately 0815 and 1115 hours the facility has failed to maintain doors</p>	K 018	<p>K 018 The door to the Kitchen was fixed during the tour with the fire marshal. The door to the admissions office was fixed during the tour with the fire marshal.</p> <p>An audit of the facility was completed to ensure that doors in the facility closed properly.</p> <p>Rounds of the facility will be completed monthly to assure that doors close properly.</p> <p>Results of the rounds will be submitted to the facility QA committee monthly for 3 months, then periodically thereafter.</p> <p>The Maintenance Director will be responsible.</p> <p>Compliance Date 11-26-14</p>	

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K 018	Continued From page 3 without impediments to their closing and latching. This could result in a delay in getting the door to the room closed in the event of a fire. This could result in toxic products of combustion getting into the room and into the exit corridor which would endanger the residents, staff and/or visitors within the smoke compartment. The findings include, but are not limited to: 1. The door to the kitchen from the corridor was found to not close and latch. 2. The door to the Admissions office failed to close and latch. NOTE: THESE DEFICIENCIES WERE CORRECTED AT THE TIME OF THE SURVEY. The above was discussed and acknowledged by the facility Administrator & Maintenance director.	K 018		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by: Surveyor: 19192 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This requirement is not met as evidenced by: Based upon record review and staff interviews on 11/5/2014 between approximately 0830 and 1115 hours the facility has failed to maintain the smoke	K 054	K 054 The facility had a fire and security systems out on Friday 11-14-14 and the report is as follows: All Smoke Detectors are in complence and the report is attached.	

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K 054	Continued From page 4 detectors in the building as required. This could result in failure of the smoke detectors to operate properly which could result in a delay in the detecting of fire and could endanger residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. Based on review of the annual confidence test report it was observed that the contractor identified 17 smoke detectors that failed the sensitivity test. The above was discussed and acknowledged by the facility Administrator and Maintenance director.	K 054		