

1408

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505436</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/15/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>MANOR CARE OF GIG HARBOR WA, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3309 45TH STREET COURT NORTHWEST GIG HARBOR, WA 98335</b>
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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><b>INITIAL COMMENTS</b></p> <p>Surveyor: 19192 On May 15, 2013 an unannounced fire and life safety code recertification survey was conducted at Manor Care Gig Harbor located at 3309 45 th Court NW Gig Harbor WA, 98335 by a representative of the Washington State Patrol, State Fire Marshal's Office.</p> <p>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 throughout.</p> <p>The facility has a total licensed capacity of 120 residents with a census today of 88.</p> <p>The facility is not in compliance at this time.</p> <p> Deputy State Fire Marshal</p>	K 000		
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 1¾ 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</p>	K 018	see next page for POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>5/24/13</b>
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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.

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

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FORM APPROVED  
OMB NO. 0938-0391

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K 018	Continued From page 1 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.  This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on May 15, 2013 from 0830 to 1130 it was observed that the facility failed to maintain the fire rated doors in the building 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. These findings were acknowledged at the time of the survey by the facility maintenance director and the regional director. The findings were:  1. The door to the Occupational Therapy room failed to close and latch. 2. The double doors into the sports cafe failed to close and latch when the coordinator was used to close the doors. 3. The double doors into the memory care dining room failed to close and latch when the coordinator was used to close the doors.	K 018	<i>K 018 This standard has been met. 1) All three closures have been replaced 2) All closures have been inspected 3) Closures will be routinely inspected by maintenance and contracted fire services 4) Concerns/trends will be reported to QAA committee responsible: Maintenance Director 5/24/13</i>	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

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K 069	Continued From page 2  This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on May 15, 2013 from 0830 to 1130 it was observed that the facility failed to maintain the range hood suppression system in accordance with NFPA 96, this has the potential for the suppression system to fail in the event of a fire, this finding was acknowledged at the time of the survey by the facility maintenance director and the regional director. The finding was:  1. The range hood suppression system is past due for confidence testing, the last test was conducted on 1/10/2012.  NOTE: The range hood is in the process to be replaced in the near future.	K 069	K069 This standard has been met. 1) Hood inspection was completed on 1/17/13 2) missing tag was posted for the 1/17/13 inspection on 5/16/13 3) Annual inspections will continue to be performed. 4) maintenance Dir. will monitor + report to QAA committee	5/29/13
K 147 SS=B	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 May 15, 2013 from 0830 to 1130 it was observed that the facility failed to maintain the building free of the use of power strip devices in resident room, this has the potential for overloading of the electrical system, and also presents a trip hazard, these findings were acknowledged at the time of the survey by the facility facility maintenance director and regional director. The findings were:  1. In resident room #313 there is a power strip in use.	K 147	K 147 Standard has been met. 1) Power strips removed 2) All other rooms inspected 3) All staff educated and new reminder will be given to new admission families. 4) Routine room inspections trends will be reported to QAA - maintenance Director responsible	5/24/13

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K 147	Continued From page 3 2. In resident room #406 there is a power strip in use.	K 147		
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K 147