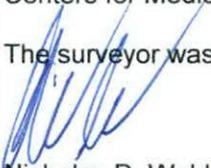
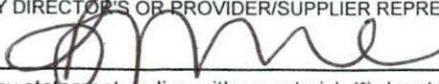


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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: 35231 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at the Life Care Center Of Port Orchard on 11/09/2015 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 117 beds and at the time of this survey the census was 107.</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 five 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 substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:  Nicholas D. Wolden 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, 19.3.5.1</p>	K 012		

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



TITLE

Administrator

(X6) DATE

11/18/15

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 DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 012	Continued From page 1 This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 11/09/2015 between approximately 11:30 and 12:15 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: The facility failed to maintain fire resistive construction in fire sprinkler riser room. Approximate 2 inch by 2 inch hole in ceiling. Maintenance states that the fire caulking fell out. Maintenance repaired during inspection. The above was discussed and acknowledged by the Administrator.	K 012	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 11/09/2015 between approximately 11:00 and 12:00 hours the facility has failed to maintain records of testing for the emergency battery backup lighting. This could result in the failure of	K 046		

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

Printed: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 046	Continued From page 2 the battery powered backup lighting in the event of a power outage and render the means of egress dark. This could result in tripping and fall injuries to residents, staff and/or visitors. The findings include, but are not limited: The facility failed to conduct annual emergency light testing of the emergency light in the laundry room area. This is one of three areas provided with emergency lights. Plant Services Manager states that they have no records of testing. The above was discussed and acknowledged by the Administrator.	K 046	<p>K 012</p> <ol style="list-style-type: none"> No residents identified. Maintenance/Director of Plant Services repaired during inspection on 11/09/2015. Rounds 2x/week completed by Maintenance Director or designee to ensure properly maintained walls and results turned into Executive Director. Maintenance/Director of Plant Services to turn in building rounds to Executive Director x 3 months. Results forwarded to PI x 3 months. Date of compliance 12/11/2015. Executive Director to ensure ongoing compliance. <p>K 046</p> <ol style="list-style-type: none"> No residents identified. Area identified was corrected on 11/09/2015. Area identified added to weekly TELS to verify function for 90 minutes. 	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Surveyor: 35231 Based upon record review and staff interviews on 11/09/2015 between approximately 10:00 and 11:00 hours the facility has failed to provide fire drill records reflecting drills being conducted on all shifts for the past 12 months. This could potentially result in the staff not responding in a coordinated manner in the event of a fire or other emergency and endangering residents, staff and/or visitors.	K 050		

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

Printed: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 050	Continued From page 3 The findings include, but are not limited to: The facility failed to conduct fire drills as follows: First quarter 2015 Swing shift and Night shift. Second quarter of 2015 missing swing shift and night shift. Fourth quarter of 2014 missing days shift swing shift night shift. Plant Services Manager states that this was caused due to a lapse in employment of a Maintenance Director. The required minimum amount of fire drills for the Calendar year is 12. The above was discussed and acknowledged by the Administrator.	K 050	<ol style="list-style-type: none"> 4. Maintenance/Director of Plant Services to turn in weekly TELS report to verify compliance x 3 months. Results forwarded to PI x 3 months. 5. Date of compliance 12/11/2015. 6. Executive Director to ensure ongoing compliance. <p>K 050</p>	
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: Surveyor: 35231 Based upon observations and staff interviews on 11/09/2015 between approximately 10:00 and 11:00 hours the facility has failed to conduct testing of the fire sprinkler system as required and failed to maintain the fire sprinkler system as required. This could result in the failure of the fire sprinkler system to operate properly in the event of a fire which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Facility fails to provide quarterly fire sprinkler inspections during the second quarter of 2015 and the fourth quarter of 2014. The Plant Services Manager states that this is was due to a</p>	K 062	<ol style="list-style-type: none"> 1. No residents identified. 2. Education provided with associates regarding fire drill procedures. Evening and noc shift fire drills scheduled for December 2015. 3. Director of Plant Services and Executive Director completed a schedule for all fire drills to be conducted in the next 13 months to meet the minimum standard. 4. Maintenance/Director of Plant Services to turn in copies of inservices for fire drills monthly x 4 months to ensure compliance. 5. Date of compliance 12/11/2015. 6. Executive Director to ensure ongoing compliance. 	

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

Printed: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 062	Continued From page 4 lapse in employment of a Maintenance Director. The facility fails to provide a 5 year inspection for the fire sprinkler system. The Plant Services Manager states that she was not aware of the testing requirements. The facility fails to correct the violations listed in the fire sprinkler inspection as follows: Two fire sprinkler heads are closer than 6 in the north day dining area... need to remove one Dry heads are over 10 years old and need sample testing or replacement Dry heads by the garbage area door are painted Some area have standard response heads as same area as quick response. The Plant Services Manager states that this was due to the schedule problems associated with the sprinkler system vendor. The above was discussed and acknowledged by the Administrator.	K 062	K 062 1. No residents identified. 2. Testing of the first sprinkler system completed on 11/19/2015. Quarterly fire sprinkler inspection scheduled and completed on 11/19/2015. Five year inspection for the fire sprinkler system completed 11/19/2015. Fire sprinkler head in north day dining corrected 11/19/2015. Requesting waiver for an additional 43 days (2/1/16) to complete the following work: dry heads over 10 years needing replacement, dry head that is painted and the standard response heads in the same area as quick response heads. 3. Quarterly sprinkler inspections added to TELS and marked on planning calendar for Director of Plant Services. Executive Director to convene with Director of Plant Services quarterly to review for ongoing compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Surveyor: 35231 Based upon record review and staff interviews on 11/09/2015 between approximately 10:00 and 10:45 hours the facility has failed to have annual testing and maintenance conducted on the	K 144		

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

Printed: 11/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 144	Continued From page 5 emergency generator. This could result in a failure of the emergency power system which would leave the facility without egress and work lighting in the event of a power failure which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: The facility fails to provide weekly and monthly generator inspection during the months of Oct 2014 through June 2015. The Plant Services Director states that this was due to a lapse in employment of a Maintenance Director. The above was discussed and acknowledged by the Administer.	K 144	4. Maintenance/Director of Plant Services to turn invoice of completion. This will be reviewed in PI x3 months. Scheduled 5 year review with consultant company for 2020. Executive Director to convene with Director of Plant Services quarterly to review for ongoing compliance.	
K 147 SS=F	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: 35231 Based upon observations and staff interviews on 11/09/2015 between approximately 10:00 and 12:00 hours the facility has failed to restrict the use of multi-plug outlets (power strips) 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: Powerstrip plugged into powerstrip in Maintenance office. Powerstrip plugged into powerstrip in physical therapy gym. Extension cord used to charge crash cart by Med	K 147	5. Date of compliance 12/11/2015. 6. Executive Director to ensure ongoing compliance. K 144 1. No residents identified. 2. Maintenance/Director of Plant Services corrected July 2015 and testing has been completed. 3. Maintenance/Director of Plant Services have been in compliance as of July 2015. Area identified with change of leadership and has been corrected moving forward. 4. Maintenance/Director of Plant Services to turn in monthly TELS report to verify compliance x 3 months. Results forwarded to PI x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2015	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD		STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 147	Continued From page 6 C South. Extension cord on crash cart in activities room. Staff states that they will be ordering surge protectors and that the use of extension cords were debated. All above listed violations were corrected during inspection. The above was discussed and acknowledged by the Administrator.	K 147	<ol style="list-style-type: none"> 5. Date of compliance 12/11/2015. 6. Executive Director to ensure ongoing compliance. <hr/> <p style="text-align: center;">K 147</p> <ol style="list-style-type: none"> 1. No residents identified. 2. Maintenance/Director of Plant Services corrected during inspection on 11/09/2015. 3. Daily building rounds completed by Maintenance Director or designee to ensure appropriate use of multi-plug outlets in the facility. 4. Maintenance/Director of Plant Services to turn in copies of rounds verifying appropriate use of multi-plug outlets monthly x 4 months to ensure compliance. 5. Date of compliance 12/11/2015. 6. Executive Director to ensure ongoing compliance. 	

RECEIVED

DEC 21 2015

**FIRE PREVENTION
DIVISION**