

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

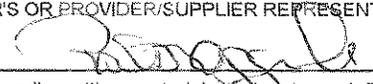
Printed: 06/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505435	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER TACOMA LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N HIGHLANDS PARKWAY TACOMA, WA 98406
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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 Tacoma Lutheran Home located at 1301 North Highlands Park Way on 6/24 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>This facility has a total of 170 beds and at the time of this survey the census was 147.</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 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 7/1/14
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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 018 SS=D	<p>Continued From page 1</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 1¼ 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 Standard is not met as evidenced by: Surveyor: 19192</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 1¼ 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>	K 018	<p>K 018</p> <p>1. How will the nursing home correct the deficiency as it relates to the residents? No residents were affected by this deficient practice.</p> <p>2. How the nursing home will act to protect residents in similar situations? No residents were affected by this deficient practice.</p> <p>3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The door found in violation will be repaired or adjusted to accomplish proper closure of the door. All Health Center doors will be assessed by Maintenance staff to assure proper/closure/function.</p> <p>4. How will the nursing home plan to monitor its performance to make sure that the solution is maintained? Monthly and random fire drill/alarm report forms direct and reflect assessment of proper closure of doors. These reports will be reviewed by the Director of Maintenance to identify and ensure repair of any areas of malfunction identified. Additionally, all staff will be directed to immediately notify maintenance personnel of any doors found not to function properly. Any deficiencies identified will be promptly repaired as able and communicated to the Administrator. Education and repairs will be completed by July 24, 2014.</p>	
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K 018	Continued From page 2 This requirement is not met as evidenced by: Based upon observations and staff interviews on 6/24/2014 between approximately 0900 and 1330 hours the facility has failed to maintain doors 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 Med room at the end of the 600 hall failed to close and latch. The above was discussed and acknowledged by the facility maintenance director.	K 018		
K 023 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2 This Standard is not met as evidenced by: Surveyor: 19192 Smoke barriers are provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2 This requirement is not met as evidenced by: Based upon observations and staff interviews on	K 023	K 023 1. How will the nursing home correct the deficiency as it relates to the residents? No residents were affected by this deficient practice. 2. How the nursing home will act to protect residents in similar situations? No residents were affected by this deficient practice. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The cross corridor fire separation door found in violation will be repaired or adjusted to properly close and latch. All Health Center cross corridor fire separation doors will be assessed by Maintenance staff to assure that they properly close and latch. 4. How will the nursing home plan to monitor its performance to make sure that the solution is maintained? Monthly and random fire drill/alarm report forms direct and reflect assessment of cross corridor fire separation doors. These reports will be reviewed by the Director of Maintenance to identify and ensure repair of any areas of malfunction identified. Additionally, all staff will be directed to immediately notify maintenance personnel of any cross corridor fire separation doors found not to function properly. Any deficiencies identified will be promptly repaired as able and communicated to the Administrator. Education and repairs will be completed by July 24, 2014.	

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K 023	Continued From page 3 6/24/2014 between approximately 0900 and 1330 hours the facility has failed to maintain the fire separation doors in the building. This could result in the passage of smoke from one smoke compartment into another smoke compartment thereby exposing residents, staff and/or visitors to the toxic products of combustion. The findings include, but are not limited to: 1. The cross corridor fire separation doors in the 1000 hall by the Salon failed to close and latch. The above was discussed and acknowledged by the facility maintenance director.	K 023		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Surveyor: 19192 Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system	K 056	K 056 1. How will the nursing home correct the deficiency as it relates to the residents? No residents were affected by this deficient practice. 2. How the nursing home will act to protect residents in similar situations? No residents were affected by this deficient practice. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? A sprinkler head, connected to our approved, supervised automatic sprinkler system, will be installed in the exterior overhang to the courtyard off of the 1200 hall. Until that is accomplished, frequent observation and monitoring of the area will occur by both maintenance and security personnel. Additionally, this entry and courtyard is a heavy traffic area and easily and frequently viewed from many areas of the facility. 4. How will the nursing home plan to monitor its performance to make sure that the solution is maintained? Once the sprinkler head, connected to our approved, supervised automatic sprinkler system is installed, the entire system will be inspected every six months to assure that the fire alarm/sprinkler system functions as it was intended.. The installation will be completed by <u>July 24, 2014</u> .	

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K 056	<p>Continued From page 4</p> <p>in accordance with section 9.7. Required sprinkler systems are equipped with flow and tamper switches which are electrically interconnected to the building fire alarm. In type 1 and II construction, alternative protection measures shall be substituted for sprinkler protection in specific areas where State or Local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NFPA 13</p> <p>This requirement is not met as evidenced by:</p> <p>Based upon observations and staff interviews on 6/24/2014 between approximately 0900 and 1330 hours the facility has failed to provide fire sprinkler protection to all required areas of the facility. This could result in a fire not being contained to the area of origin and could endanger residents, staff and/or visitors.</p> <p>The findings include, but are not limited to:</p> <ol style="list-style-type: none"> 1. The exterior overhang to the courtyard off the 1200 hall is not protected by a sprinkler head. <p>The above was discussed and acknowledged by the facility maintenance director.</p>	K 056		