

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

Printed: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2014
NAME OF PROVIDER OR SUPPLIER ROO-LAN HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTHEAST CARPENTER ROAD LACEY, WA 98503		
(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	INITIAL COMMENTS Surveyor: 29197 This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Roo-Lan Healthcare on 02/18/14 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. The facility has a total of 96 beds and at the time of this survey the census was 93. The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. The facility is a one story structure of Type V (111) 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. The facility is not in substantial compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.  Dan Young Deputy State Fire Marshal	K 000	K000 The submission of this plan of correction does not constitute admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. Please accept this submission of the plan of correction as our allegation of substantial compliance effective, March 21, 2014.	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system;	K 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X6) DATE 2/18/14

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 021	Continued From page 1 b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This Standard is not met as evidenced by: Surveyor: 29197 Based upon observations and staff interviews on 02/18/14 between approximately 1330 and 1700 hours the facility has failed to maintain the ability of doors to be held open only by devices arranged to automatically close such doors upon activation of the fire alarm. This could result in the passage of smoke or fire one compartment into another compartment thereby exposing residents, staff and/or visitors to the toxic products of combustion. The findings include, but are not limited to: The smoke corridor door by resident room 2 was observed to take over 30 seconds to close. The above was discussed and acknowledged by the Maintenance Director.	K 021	K021 Correction as it relates to the resident: A new door closer was installed and is working properly. Action taken to protect residents in similar situations: Maintenance staff will do monthly checks to ensure doors close upon activation of the fire alarm system during fire drills. Measures taken or systems altered to ensure the problem does not recur: Maintenance staff will do monthly checks to ensure doors close upon activation of the fire alarm system during fire drills. Plans to monitor performance to ensure solution is sustained: Maintenance staff will do monthly checks to ensure doors close upon activation of the fire alarm system during fire drills. Date corrective action completed: March 21, 2014 Title of person responsible for correction: Administrator and Maintenance Director	
K 051 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in	K 051		

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K 051	<p>Continued From page 2</p> <p>patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This Standard is not met as evidenced by: Surveyor: 29197 Based upon record review and staff interviews on 02/18/14 between approximately 1330 and 1700 hours the facility has failed to have appropriate testing of the fire alarm system which result in the failure of notification to staff of a water supply problem to the fire sprinkler system and endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to: There is no documentation of the last sensitivity test for the smoke detection,</p> <p>The above was discussed and acknowledged by the Director of Maintenance.</p>	K 051	<p>K051</p> <p>Correction as it relates to the resident: Sensitivity test with Ace Fire has been scheduled for March 5, 2014 at 1300.</p> <p>Action taken to protect residents in similar situations: Sensitivity test will be completed on an annual basis. This has been coordinated with Ace Fire.</p> <p>Measures taken or systems altered to ensure the problem does not recur: Ace Fire will complete an annual sensitivity test and will coordinate with Maintenance Director.</p> <p>Plans to monitor performance to ensure solution is sustained: Ace Fire will complete an annual sensitivity test and will coordinate with Maintenance Director.</p> <p>Date corrective action completed: March 21, 2014 Title of person responsible for correction: Administrator and Maintenance Director</p>
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062	

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K 062	Continued From page 3 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 This Standard is not met as evidenced by: Surveyor: 29197 Based upon observations and staff interviews on 02/18/14 between approximately 1330 and 1700 hours the facility has 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 and allow the fire to increase in size and intensity which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: The facility has 4 quarterly test for the last year but does not have a copy of the annual testing of the sprinkler system. The sprinkler head at the exterior canopy at the entry was observed to have paper taped to the head. The riser room exterior door was observed to not have a "riser room" sign. The above was discussed and acknowledged by the Maintenance Director.	K 062	K062 Correction as it relates to the resident: Semi annual inspection report faxed to Dan Young - annual inspection meets criteria for annual inspection. Tape removed from sprinkler head on exterior canopy at entry. Signage on exterior door now has Riser Room sign attached to exterior part of the door. Action taken to protect residents in similar situations: Annual inspections will be clearly delineated on report from Ace Fire to ensure that annual inspections are accurately documented. Any painting that requires taping of any surfaces will be inspected by Maintenance Director to ensure tape is completely removed and not blocking any sprinkler heads. Riser Room sign was ordered and is permanently attached to exterior door as of February 24, 2014. Measures taken or systems altered to ensure the problem does not recur: Annual inspections will be completed annually and Ace Fire will clearly delineate that it is an annual inspection. Any painting that requires taping of any surfaces will be inspected by Maintenance Director to ensure tape is completely removed and not blocking any sprinkler heads. Riser Room sign is permanently attached to exterior door. Date corrective action completed: March 21, 2014 Title of person responsible for correction: Administrator and Maintenance Director	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		

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K 072	Continued From page 4 This Standard is not met as evidenced by: Surveyor: 29197 Based upon observations and staff interviews on 02/18/14 between approximately 1330 and 1700 hours the facility has failed to maintain the exit access corridors free of obstructions and impediments to full and instant use in the event of an emergency. This could result in the delays in smoke compartment evacuations or full evacuation of the building due to a fire or other emergency which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: Medical carts were observed to be by the dining room and were not moved during the inspection. Lifts were observed to be in all hallways and plugged into electrical receptacles. DNS office exit door was observed to be blocked by file cabinets. The above was discussed and acknowledged by the Maintenance Director.	K 072	K072 Correction as it relates to the resident: Medical carts were removed from dining room door areas and staff has been instructed to not block doorway and to store medical carts in appropriate areas. Lifts were observed in hallways – waivers to have lifts in hallways on file and attached to this report. The waiver remains in effect until June 29, 2015. File cabinets in DNS office removed from area close to doorway to ensure free access to exit door. Action taken to protect residents in similar situations: Staff has been instructed to not store medical carts near dining room door area and to store medical carts in appropriate area. Lifts in hallways – waiver remains in effect and effective until June 29, 2015. DNS office has been rearranged and application is currently being completed to assess need for emergency exit in DNS office with Construction Review. Measures taken or systems altered to ensure the problem does not recur: DNS, Administrator, Charge Nurses, and Maintenance Director will monitor for compliance of medical carts not being placed near dining room doors. Lifts in hallways – waiver remains in place and effective until June 29, 2015. DNS office emergency door will continue to have free access and DNS will not rearrange her office. Sign posted to not block doorway. Will await Construction Review decision. Date corrective action completed: March 21, 2014 Title of person responsible for correction: Administrator, DNS and Maintenance	
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.	K 144		

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K 144	Continued From page 5 This Standard is not met as evidenced by: Surveyor: 29197 Based upon record review and staff interviews on 02/18/14 between approximately 1330 and 1700 hours the facility has failed to have weekly testing and maintenance conducted on the 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 has not been documenting the weekly test of the generator. The above was discussed and acknowledged by the Maintenance Director.	K 144	K144 Correction as it relates to the resident: Weekly documentation of test of generator started on February 24, 2014. Action taken to protect residents in similar situations: Weekly documentation of test of generator started on February 24, 2014. Measures taken or systems altered to ensure the problem does not recur: Maintenance Director will document weekly the test of the generator and coordinated with Maintenance worker. Date corrective action completed: March 21, 2014 Title of person responsible for corrections: Administrator and Maintenance Director	
K 147 SS=C	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: 29197 Based upon observations and staff interviews on 02/18/14 between approximately 1330 and 1700 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: Power strips were observed to be in use in	K 147	K147 Correction as it relates to the resident: A wall switch cover was added in the Oxygen storage closet. Action taken to protect residents in similar situations: Housekeeping and Maintenance to observe on Environmental rounds the wall switch covers. Staff notified that any maintenance issues are to be reported in Maintenance log on Maintenance door.	

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K 147	Continued From page 6 resident rooms 10, 20, 23. A wall switch in the Oxygen storage closet was observed to be missing the cover plate. The above was discussed and acknowledged by the Maintenance Director.	K 147	Measures taken or systems altered to ensure the problem does not recur: Staff notified that any maintenance issues are to be reported in Maintenance log on Maintenance door. Housekeeping and Maintenance to observe on Environmental rounds the wall switch covers.	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service, 9.6.1.6 This Standard is not met as evidenced by: Surveyor: 29197 Based upon record review and staff interviews on 02/18/14 between approximately 1330 and 1700 hours the facility has failed to have a written procedure for instituting as approved fire watch in the event of a failure of the fire alarm system. This could result in an inadequate fire watch which may result in a delay of fire detection and suppression, potentially endangering residents, staff and/or visitors within the facility. The findings include, but are not limited to: The facilities policy manual did not include the fire alarm, only the fire sprinkler, for fire watch. The above was discussed and acknowledged by the Maintenance Director.	K 155	Date corrective action completed: March 21, 2014 Title of person responsible for correction: Administrator and Maintenance Director K155 Correction as it relates to the resident: The facility policy was updated to include fire alarm to establish a fire watch in case of system failure and placed in Disaster Book. Maintenance department notified of requirements and updated policy in case service is out for more than four hours in a 24 hour period. Action taken to protect residents in similar situations: The facility policy was updated to include fire alarm to establish a fire watch in case of system failure and placed in Disaster Book. Maintenance department notified of requirements and updated policy in case service is out for more than four hours in a 24 hour period. Measures taken or systems altered to ensure the problem does not recur: Maintenance department notified of requirements and updated policy in case service is out for more than four hours in a 24 hour period. Date corrective action completed: March 21, 2014 Title of person responsible for correction: Administrator and Maintenance department	