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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505455</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/16/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>JUDSON PARK HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 19192 On April 16, 2013 an unannounced fire and life safety code recertification survey was conducted at Judson Park Health Center located at 23620 Marine View Drive Des Moines WA, 98198 by a representative of the Washington State Patrol, State Fire Marshal's Office, 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 located on the second and third floors of a type II-A structure, the exiting is through rated stair enclosures and direct to grade from the main floor, the first floor is dedicated to office and administrative business along with facilities functions and laundry, there is also a room used for physical therapy. The building is protected throughout by a full NFPA 13 fire sprinkler system and automatic smoke detection in the corridors and common areas with single station detectors in the resident rooms.</p> <p>The facility has a licensed capacity of 96 residents with a census today of 72.</p> <p>The facility is not in substantial compliance with the Life Safety Code 2000 Edition as adopted by CMS.</p> <p>Following are the deficiencies cited during this survey:</p> <p> Deputy State Fire Marshal</p>	K 000	<p>The following Plan of Correction constitutes Judson Park's written Credible Allegation of Compliance for the deficiencies noted. Judson Park makes its best efforts to operate in substantial compliance with both Federal and State laws. Nothing in this Plan of Correction is an admission otherwise. Judson Park has submitted this Plan of Correction in order to comply with its obligations and does not waive any objections to the merits or form of any allegations contained herein.</p> <p style="text-align: right;"><b>RECEIVED</b> MAY 09 2013 FIRE PROTECTION BUREAU</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4-25-13
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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

Printed: 04/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER <b>JUDSON PARK HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198</b>		
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K 012 K 012 SS=D	Continued From page 1 NFPA 101 LIFE SAFETY CODE STANDARD 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 Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on April 16, 2013 from 1045 to 1345 it was observed that the facility failed to maintain the fire resistive construction of the building, this has the potential for the passage of smoke and fire throughout the building in the event of a fire, this finding was acknowledged at the time of the survey by the facility maintenance director. The finding was:  1. In the second floor nurses supply closet there is a fire wall that has been penetrated for the LAN system and the drywall was left open, the ceiling tile was also removed.	K 012 K 012	K 012  1. The firewall penetrations in the 2 <sup>nd</sup> floor nursing supply closet were repaired with 5/8" commercial drywall, taped and mudded at the seams. LAN wires were bundled and pass-through hole was filled with intumescent fire caulk/fire stop material.  2. Other areas that have computer/LAN access were checked for penetrations and repaired as necessary.  3. Facilities Management will be notified by IT when computer/LAN work is scheduled to be done in the facility so any penetrations potentially left by this work can be corrected immediately.  4. Facilities Manager will report any issues/ trends through monthly Preventative Round reports to the Administrator and these will be taken to monthly QA (quality assurance committee) for recommendations and resolution.  5. May 13, 2013  6. Facilities Manager/designee	
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 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 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.	K 018		5/13/13

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K 018	Continued From page 2  This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on April 16, 2013 from 1045 to 1345 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. The findings were:  1. The door to the SW equipment hall on the third floor failed to latch closed. 2. The door to the SW equipment hall on the second floor failed to latch closed. 3. The NE side fire separation doors by resident room #2020 failed to latch closed.	K 018	K 018  1. The door to the SW equipment hall on 3 <sup>rd</sup> floor, the door to the SW equipment hall on 2 <sup>nd</sup> floor and the NE side fire separation door by resident room 2020 were repaired so they close and latch appropriately. 2. All fire doors will be checked for proper closure. 3. Fire doors will be monitored monthly through monthly PM (preventative maintenance) rounds. 4. Facilities Manager will report any issues/trends through monthly PM round reports and these will be taken to monthly QA for any recommendations and resolution. 5. May 13, 2013 6. Facilities Manager/designee	5/13/13
K 147 SS=E	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 April 16, 2013 from 1045 to 1345 it was observed that the facility failed to maintain the electrical requirements of the building, this has the potential for the over	K 147	K 147  1. a. Extension cords in rooms 3001, 2031, 2016 and 2004 were removed. b. See attached waiver request for power strips.  2. a. An audit of all rooms was completed and any	

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K 147	Continued From page 3 loading of the electrical circuits in the building, these findings were acknowledged at the time of the survey by the facility maintenance director. The findings were:  1. The following resident rooms had unapproved extension cords in use.  #3001, 2031, 2016, 2004.  2. The following resident rooms have power strip devices.  3022,3000,3030,3032,3034,3027,3025,3003,2001,2005,2027,2029,2031,2032,2030,2028,2026,2024,2022,2020, 2016,2014,2012,2010,2008,2006,2004.	K 147	unapproved extension cords were removed. b. See attached waiver request for power strips.  3. a. Housekeeping will audit rooms daily during daily cleaning rounds and remove any unapproved extension cords that might be found. They will also notify the Neighborhood Coordinators of this issue. Housekeeping has been in-serviced on approved and unapproved extension cords. b. See attached waiver request for power strips.  4. a. Any trends/issues will be brought to monthly QA by Housekeeping for recommendation and resolution. b. See attached waiver request for power strips.  5. May 13, 2013 6. Housekeeping Manager/designee	5/13/13

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