

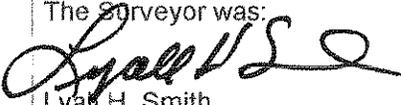
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 11/29/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505516</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/29/2012</b>
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NAME OF PROVIDER OR SUPPLIER <b>WASHINGTON SOLDIERS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1305 ORTING - KAPOWSIN HIGHWAY ORTING, WA 98360</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is a result of an unannounced Fire and Life Safety re-certification survey conducted at the Washington Soldiers Home - Orting on November 29, 2012, by a representative of the Washington State Fire Marshal. This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health and Services (DSHS).</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. This facility is a one story structure of Type I, Fire-resistive. Construction with exits to grade and is protected by a Type 13 Fire Sprinkler system and an automatic fire alarm system with corridor smoke detection. The facility has 97 licensed beds and a current census of 95.</p> <p>The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The noted deficiencies are listed below.</p> <p>The Surveyor was:</p>  <p>Lynn H. Smith Deputy State Fire Marshal Nursing Home Surveyor 08158</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau PO Box 42600 Olympia, WA 98504-2600 Telephone: (360) 596-3908 FAX: (360) 596-3934</p>	K 000	<p style="text-align: center;">RECEIVED DEC 20 2012 FIRE PROTECTION BUREAU</p> <p style="text-align: center;">RECEIVED DEC 10 2012 FIRE PROTECTION BUREAU</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>NHA</b>	(X6) DATE <b>12-5-12</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.

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K 018 SS=D	<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 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: Based upon observation and staff interviews during a tour of the facility from 0800 to 1400 on 11/29/12, the facility has failed to maintain proper operation of doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas. Doors are not maintained to resist the passage of smoke and are not maintained to properly close and/or latch. This could result in smoke passing into the corridor or into rooms in the event of a fire. These findings were acknowledged by Dennis Suarez, Facilities Manager.</p> <p>The findings include, but are not limited to:</p>	K 018	<p><b>K018</b></p> <ol style="list-style-type: none"> <li>1. Closer replaced at Nursing Station 1 Chart Room and Barber/Beauty Shop.</li> <li>2. Facilities department to check all doors to ensure appropriate closers are in place.</li> <li>3. Facilities department to inspect all doors in nursing facility every 30 days for 6 months to ensure appropriate closers are in place and functioning properly.</li> <li>4. All findings submitted to the Safety Committee then forwarded to the QA Committee quarterly for 6 months for review.</li> <li>5. Facilities Manager to validate compliance.</li> <li>6. Compliance date 12-5-12.</li> </ol>	12/5/2012

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K 064	Continued From page 3	K 064	
	<p>This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 0800 to 1400 on 11/29/12, the facility has failed to maintain portable fire extinguishers in accordance with 9.7.4.1. 19.3.5.6, NFPA 10. This could result in failure of the fire extinguisher to operate effectively in the event of a fire. These findings were acknowledged Dennis Suarez, Facilities Manager.</p> <p>The findings include, but are not limited to:</p> <p>1. Rainier Dietary Office - fire extinguisher overdue for annual inspection and certification.</p>		<h1>Refer to Pages # 3 &amp; 5</h1>
K 075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 075	
	<p>Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 0800 to 1400 on 11/29/12, the facility has failed to provide proper</p>		

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K 075	Continued From page 4 collection receptacles. This could result in excessive flame and toxic smoke production in the event of a fire. These findings were acknowledged Dennis Suarez, Facilities Manager.  The findings include, but are not limited to:  1. Recycle and shredder receptacles exceed 32 gallon capacity Printer Room Outside Physical Therapy	K 075	<b>K075</b>  1. Recycle and shredder receptacles in Printer Room and outside Physical Therapy Department that exceed 32 gallons capacity have been removed from facility. 2. No other noted locations in facility- facilities department completed audit Fire Marshal on 11-29-12. 3. Facilities department to replace receptacles with less than 32 gallon recycle and shredder receptacles in nursing facility. 4. Facilities department to audit monthly for 6 months. All findings will be submitted to Safety Committee then forwarded to the QA Committee quarterly for 6 months for review. 5. Facilities Manager to validate compliance. 6. Compliance date 12-27-12.	<b>K075</b> <b>12-27-12</b>
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: Based upon observation and staff interviews during a tour of the facility from 0800 to 1400 on 11/29/12, the facility has failed to maintain electrical wiring and equipment in accordance with NFPA 70, National Electrical Code. 9.1.2. This could result in electrical shock hazards to residents and staff. These findings were acknowledged Dennis Suarez, Facilities Manager.  The findings include, but are not limited to:  1. Electrical outlets within 6 feet of sinks are not GFCI protected Wing 2 Soiled Utility Wing 2 Treatment Room Wing 1 Treatment Room Rainier Kitchen Activities Room at Coffee Bar Room A-3	K 147	<b>K147</b>  1. Electrical outlets at Wing #2 Soiled Utility Room, Wing #2 Treatment Room, Wing #1 Treatment Room, Rainier Kitchen, Activities Room at Coffee Bar, and Room A-3 to be replaced immediately with GFCI protected outlets. 2. No other noted locations in facility- facilities department completed audit with Fire Marshal on 11-29-12. 3. Facilities department to maintain GFCI protected outlets for all electrical wiring and equipment in accordance with NFPA70 and National Electrical Code 9.1.2. 4. All findings will be submitted to the Safety Committee then forwarded to the QA Committee x 6 months	<b>K147</b> <b>11-30-12</b>

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K 147	Continued From page 5  2. Non-approved power strips in use in resident rooms Room 1217 Room 2303	K 147	K147 1. Waiver to be requested for non-approved power strips in use in resident rooms at the Washington Soldiers Home.
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623  This Standard is not met as evidenced by: Based upon observation and staff interviews during a tour of the facility from 0800 to 1400 on 11/29/12, the facility has failed to maintain Alcohol Based Hand Rubs (ABHR) in a safe manner This could result in increased fire hazard in the facility. These findings were acknowledged Dennis Suarez, Facilities Manager.  The findings include, but are not limited to:  1. Nurse Station 1, Treatment Room - ABHR dispenser installed over or adjacent to an ignition	K 211	K211 1. Alcohol Based Hand Rub (ABHR) dispenser at Nursing Station #1 (Treatment Room) removed immediately. 2. Facilities department to audit for other ABHR dispenser's installed over or adjacent to an ignition source and to remove immediately if noted in the facility. 3. Facilities department to audit for 30 days for a quarter (90 days) to ensure no new ABHR dispenser has been installed over or adjacent to an ignition source. 4. All findings will be submitted to the Safety Committee then forwarded to the QA Committee x 90 days for review. 5. Facilities Manager to validate compliance. 6. Compliance date 11-30-12.

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K 211	Continued From page 6 source.	K 211	<h1>Refer to Page # 6</h1>

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