

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

Printed: 06/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>504003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - WESTERN STATE HOSPITAL</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/01/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>WESTERN STATE HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9601 STEILACOOM BLVD SW TACOMA, WA 98498</b>		
(X4) ID PREFIX TAG <b>K 000</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG <b>K 000</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Western State Hospital on May 8th through June 1, 2017 by a representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health survey teams. The surveyors were: Donald West, Kenneth Dellsite, Brendan Magee, and Kimberly Bloor.</p> <p>The facility has a total of 842 beds and at the time of this survey the census was over 800. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 483.70. The facility consists of multiple buildings ranging from Type 1 to Type V construction with exits to grade, protected stairwells, smoke compartments, protected vertical shafts, and emergency exits. Resident care areas protected by a Type 13 fire sprinkler system with an automatic fire alarm and smoke detection systems. Other buildings are equipped with heat and or smoke detection systems reporting to the fire alarm system. All exits are to grade with paved exit discharges to the public way. The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare &amp; Medicaid Services.</p> <p>The following immediate jeopardies were called with the approval of the Centers for Medicare and Medicaid:</p> <p>On May 8, 2017 at 1800 the fire and life safety code surveyors identified the following deficiencies: All fire extinguisher cabinets facility wide were locked and the staff did not have access with keys.</p>			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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 000	Continued From page 1 The facility failed to follow NFPA 101-2012 guidelines by pre-announcing fire drills. The fire drills were also taking an excessively long amount of time, from 30 minutes to 5.5 hours. The exits from stairwells 6 and 9 in building 28 required 3 different keys to exit the fire-rated stairwell and onto the public way.  On May 9, 2017 at 1653 the fire and life code surveyors identified the following deficiencies:  The fire alarm and sprinkler systems have not been inspected by competent and qualified inspectors. This included not performing all tests as required by NFPA 25 and 72. Plans of removal were provided by the facility on the same day each Immediate Jeopardy was cited. The facility removed all Immediate Jeopardies on June 1, 2017.  The surveyor was: Donald West Deputy State Fire Marshal	K 000		
K 161	NFPA 101 Building Construction Type and Height  Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5  Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered  2 II (111) One story non-sprinklered	K 161		

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K 161	<p>Continued From page 2</p> <p>Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 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.</p> <p>The findings include, but are not limited to:</p> <p>S3-MedRoom - 5 inch round hole in the ceiling</p>	K 161		

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K 161	Continued From page 3  In building 28 across from the activity center next to stairwell nine, there is a 36" x 36" hole in sheet rock.  The above was discussed and acknowledged by the facility staff.	K 161		
K 271	NFPA 101 Discharge from Exits  Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to maintain the exit discharge free of obstructions. This could cause an inability or delay in the evacuation of residents in the event of an emergency which would endanger residents, staff and/or visitors.  The findings include, but are not limited to:  Stairwell six and 9 have three locks all keyed differently to get out of the building. At the time of the survey, staff were unable to access all three keys to unlock the doors. This deficiency was corrected at time of survey.  Ground floor building 28 Corridor exit stairwell discharged to a courtyard with a locked gate, at the time of survey no staff had the key to unlock	K 271		

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K 271	Continued From page 4 this gate.  The egress exit out of wings E2 and E1 goes into a gate area. Staff from both wings did not have required keys to open the gate.  THE ABOVE CITATIONS RESULTED IN AN IMMEDIATE JEOPARDY.  The above was discussed and acknowledged by the facility staff.	K 271		
K 293	NFPA 101 Exit Signage  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to maintain proper exit signage. This could potentially misdirect residents, staff and/or visitors during an emergency.  The findings include, but are not limited to:  C2, above the fire separation doors by med room, exit sign has no illumination.  The above was discussed and acknowledged by the facility staff.	K 293		
K 311	NFPA 101 Vertical Openings - Enclosure	K 311		

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K 311	Continued From page 5 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15 between approximately 0800 and 1700 hours the facility has failed to maintain vertical openings between floors with a construction having a fire resistive rating of at least one hour. This could result in the passage of toxic products of combustion from one floor to another which would endanger the residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  The elevator lobby door in building C-9 failed to close and latch.  The above was discussed and acknowledged by the facility maintenance staff.	K 311			
K 321	NFPA 101 Hazardous Areas - Enclosure  Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the	K 321			

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K 321	<p>Continued From page 6</p> <p>approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1</p> <p>Area                                      Automatic Sprinkler Separation    N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8, 15, 2017 between approximately 0800 and 1700 hours the facility has failed to maintain doors to hazardous areas as self or automatic closing. This could result in the spreading of the toxic products of combustion into the corridor in the event of a fire which would endanger residents, staff and/or visitors.</p> <p>The findings include, but are not limited to:</p> <p>The Laundry chute in room A019 had laundry bags holding the fire door open</p>	K 321		

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K 321	Continued From page 7 The 1.5 hour fire door to the generator room is missing the key cylinder.  The above was discussed and acknowledged by the facility staff.	K 321		
K 324	NFPA 101 Cooking Facilities  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to conduct testing of the hood and duct fire suppression equipment protecting the commercial cooking equipment in the kitchen. This could result in the	K 324		



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K 324	Continued From page 8 failure of the system to operate properly which would endanger the residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  ANSUL The ANSUL system in Central Forensic treatment mall was last serviced in 2002.  There is no documentation of the range hood suppression system inspections.  The above was discussed and acknowledged by the facility staff.	K 324		
K 325	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)  Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)	K 325		

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K 325	Continued From page 9 * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to properly install alcohol based hand rub dispensers. Dispensers installed improperly could result in hand rub coming in contact with an electrical source resulting in a fire causing potential endanger to residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  S5-512 - Hand sanitizer over the light switch  E7 medication room hand sanitizer mounted over light switch  Exam room in E5 ABHR is directly above a power outlet.  C5-med room over light switch  The above was discussed and acknowledged by the facility staff.	K 325		
K 345	NFPA 101 Fire Alarm System - Testing and Maintenance  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 345		

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K 345	Continued From page 10  This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 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 problem to the fire sprinkler system or fire alarm system and could endanger the residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  The facility is unable to provide sensitivity testing showing pass/fail for building 21, 29  The fire alarm in building 27/28 was showing that it was in trouble since 4/29/17 on 5/15/2017  Building 9 third floor S wing showing in trouble.  The person's responsible for conducting the tests were unable to articulate the standards from NFPA 72 and NFPA 25 for which to test the systems.  THE ABOVE CITATION RESULTED IN AN IMMEDIATE JEOPARDY.  The above was discussed and acknowledged by the facility staff.	K 345		
K 346	NFPA 101 Fire Alarm System - Out of Service  Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour	K 346		

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K 346	Continued From page 11 period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be 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: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to provide an approved written policy for instituting a 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 facility is not following their fire watch policies. Per interview with the lead project manager they agreed that one of the steps (3B) is to notify the Office of the State Fire Marshal. They agreed that they have not been doing this.  Per interview, the facility is taking the fire alarm system off line for 8+ hours and not doing a fire watch.  The above was discussed and acknowledged by the facility staff.	K 346		
K 351	NFPA 101 Sprinkler System - Installation  Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for	K 351		

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K 351	<p>Continued From page 12</p> <p>sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This Standard is not met as evidenced by:</p> <p>Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to install 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.</p> <p>The findings include, but are not limited to:</p> <p>There was no sprinkler coverage in the daylight basement loading dock.</p> <p>In building E-5 the sprinkler heads in the dining room are within two feet of each other causing a possible cold solder situation.</p> <p>Central Forensic Services Dining services pantry room has no sprinkler heads</p> <p>The above was discussed and acknowledged by the facility staff.</p>	K 351		
K 353	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are</p>	K 353		

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K 353	<p>Continued From page 13</p> <p>inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility 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.</p> <p>The findings include, but are not limited to:</p> <p>SPRINKLER HEAD DAMAGE/PAINTED E5 room 151 sprinkler head needs replaced pushed up in the ceiling</p> <p>E2 Sally-Port head painted E2 A233, A234 heads damaged E2 A232, A230 heads painted E4 233 head missing fins E4 240 fins bent E4 250 head bent and pushed into wall</p>	K 353		

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K 353	<p>Continued From page 14</p> <p>E4 shower room (possible recalled heads, the facility shall verify.)</p> <p>E4 by room 224 sprinkler head painted</p> <p>E4 by room 258 head pushed into ceiling</p> <p>Sprinkler head in staff cleaning supply room</p> <p>C3-338 missing fins.</p> <p><b>SPARE SPRINKLER HEADS MISSING</b></p> <p>Building 28 sprinkler head box missing heads</p> <p>Building 29 sprinkler head box missing heads</p> <p>E4 263 sprinkler valve room, no spare heads</p> <p>The facility was only able to show 4 sprinkler heads in boxes for buildings 27 and 28.</p> <p><b>OBSTRUCTIONS</b></p> <p>Sprinkler obstructed by wardrobe in room C-3 329.</p> <p>Sprinkler head obstructed by wardrobe in room C-2 227.</p> <p><b>ESCUTCHEON RINGS</b></p> <p>E5 116 falling down</p> <p>E7 111 falling down</p> <p>E7 146 missing</p> <p>E4 nurses station missing escutcheon rings</p> <p>E4 by room 258 missing escutcheon ring</p> <p>E4 by room 248 has hole around escutcheon ring</p> <p><b>INTERNAL PIPE INSPECTIONS</b></p> <p>The facility was unable to provide documentation for the following buildings: 15, 10, 16, 17, 18, 19, 20, 28, 29, 9, 26, 21</p> <p>Building 28 dry system into E6 and E8 has a lot of corrosion per the report</p>	K 353		

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K 353	Continued From page 15 ANNUAL INSPECTIONS  The facility was unable to provide any annual sprinkler inspection for any buildings.  THE ABOVE CITATION RESULTED IN AN IMMEDIATE JEOPARDY  BACKFLOW INSPECTIONS  The facility was unable to provide any backflow reports for any buildings.  The above was discussed and acknowledged by the facility staff.	K 353		
K 354	NFPA 101 Sprinkler System - Out of Service  Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to have an approved written policy for instituting as approved fire watch in the event of a failure of the sprinkler system. This could result in an inadequate fire watch which may result in a delay of fire detection	K 354		



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K 354	Continued From page 16 and suppression, potentially endangering residents, staff and/or visitors within the facility.  The facility is not following their fire watch policies. Per interviews with the lead project manager they agreed that one of the steps (3B) is to notify the Office of the State Fire Marshal. They agreed that they have not been doing this.  The above was discussed and acknowledged by the facility staff.	K 354		
K 355	NFPA 101 Portable Fire Extinguishers  Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This Standard is not met as evidenced by: Based upon record review and observation on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to assure proper maintenance of the facilities portable fire extinguishers. This potentially delays a quick response to contain a fire from spreading which could expose and endanger residents, staff and/or visitors within the facility.  The findings include, but are not limited to:  In building F, the fire extinguishers have over 75 feet in travel distance between each extinguisher located in the corridor.  At nurses station in F4, the extinguisher box won't open.  Staff members were asked to unlock the fire	K 355		

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K 355	<p>Continued From page 17</p> <p>extinguisher cabinets at the time of the survey and were unable to unlock any of the cabinets due to not having the appropriate key.</p> <p>In building E-7 the fire extinguisher #2951 located in room 105 has not been inspected, initialed, and dated on a monthly basis.</p> <p>The smoking area in the courtyard of building 28/29, the fire extinguisher has an expired inspection tag dated 8/2015.</p> <p>In Central Forensic Services the fire extinguisher located by dietary services has an expired inspection tag dated 8/2015.</p> <p>The Fire Extinguisher in Central Forensic Services treatment mall by the motor control room is mounted approximately 6.5 feet above the floor.</p> <p>The fire extinguishers in building 28/29 have no initials and dates for the required monthly inspections.</p> <p>The fire extinguisher in building F-5 Room M -198 is missing the initials and dates for the monthly inspection.</p> <p>In building C-5 staff were unable to open the fire extinguisher cabinet in room C5-220.</p> <p>THE ABOVE CITATION RESULTED IN AN IMMEDIATE JEOPARDY.</p> <p>The above was discussed and acknowledged by the facility staff.</p>	K 355		
K 363	NFPA 101 Corridor - Doors	K 363		

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K 363	<p>Continued From page 18</p> <p>Corridor - Doors 2012 EXISTING</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.</p> <p>Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15 between approximately 0800 and 1700 hours the facility has failed to maintain doors on the corridor capable of resisting the passage of smoke. This could result in toxic products of</p>	K 363		

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K 363	<p>Continued From page 19</p> <p>combustion getting into the room and into the exit corridor which would endanger the residents, staff and/or visitors within the smoke compartment.</p> <p>The findings include, but are not limited to:</p> <p>The shower room door that opens to the corridor in F-1 has through penetrations in the door.</p> <p>The above was discussed and acknowledged by the facility maintenance staff.</p> <p>Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 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.</p> <p>The findings include, but are not limited to:</p> <p>S8-dayroom - door to the corridor not closing and latching S8-365 - door to the corridor not closing and latching S9-dayroom - door to the corridor not closing and latching</p> <p>Corridor door B139b not latching</p> <p>Building 28 sprinkler riser room fire door not closing</p> <p>The fire door to the dishwasher room in Central Forensic Treatment Mall was wedged open.</p>	K 363		

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K 363	Continued From page 20  The fire doors between F-3 and F-7 do not close when released from the open position due to dragging on the carpet.  ROLLDOWN FIRE CURTAINS Buildings 13, 16, 17, 18, 20, 21, 27, 28, 29 have only had visual inspections of fusible links and have not been replaced per NFPA 80.  The following doors are not closing and latching:  Door to C9-364 Door to laundry C9-346 Door to dirty utility C9-341  The above was discussed and acknowledged by the facility staff.	K 363		
K 372	NFPA 101 Subdivision of Building Spaces - Smoke Barrie  Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to maintain	K 372		

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K 372	Continued From page 21 smoke barrier walls to the required one hour fire resistive rating. 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:  In S7-230 there is a penetration to the smoke barrier wall above the cross corridor smoke doors.  The above was discussed and acknowledged by the facility maintenance staff.	K 372		
K 374	NFPA 101 Subdivision of Building Spaces - Smoke Barrie  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to maintain the fire separation doors in the building. This could result in the passage of smoke from one	K 374		

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K 374	Continued From page 22 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:  The cross corridor fire doors between building 28-29 have holes in doors, are missing hinge plates, and have holes in frame.  The 1.5 hour fire door to the generator room is missing the locking hardware causing a through penetration in the door.  In building 27 Ward E7 cross corridor fire separation doors next to Clinic had one half of the assembly removed and replaced with a wood frame wall with sheetrock.  The above was discussed and acknowledged by the facility staff.	K 374			
K 531	NFPA 101 Elevators  Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service	K 531			

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

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K 531	Continued From page 23 Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to properly maintain their elevators.  The findings include, but are not limited to:  The elevators are not checked for their monthly fire recalls  The above was discussed and acknowledged by the facility staff.	K 531		
K 712	NFPA 101 Fire Drills  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to provide fire drill records reflecting drills being conducted on	K 712		



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K 712	Continued From page 24 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. The findings include, but are not limited to: FIRE DRILLS The facility is pre-announcing fire drills per documentation. The fire drills took anywhere from 20 minutes to 5.5 hours which is not prompt and effective, placing the staff and residents in possible harm. The inspectors walked into building 28/29 and the fire alarm activated due to construction taking place in the building, the inspectors observed that staff failed to respond to the alarm, and no doors were closed.  THE ABOVE CITATION RESULTED IN AN IMMEDIATE JEOPARDY.  The above was discussed and acknowledged by the facility staff.	K 712		
K 741	NFPA 101 Smoking Regulations  Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not	K 741		

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K 741	<p>Continued From page 25</p> <p>responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to provide the required equipment at the designated smoking area(s). This could result in the ignition of the combustible materials adjacent to the staff smoking area which would endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to:</p> <p>The patients are not being security wanded as per facility policy and implemented into their smoking policies and procedures after returning from smoking in building 27/28. This was observed on 5/15/2017. The facility stated in a previous POC that they would do this after a patient started a room on fire with a lighter that they smuggled into the facility.</p> <p>The above was discussed and acknowledged by the facility staff.</p>	K 741		
K 781	<p>NFPA 101 Portable Space Heaters</p> <p>Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except,</p>	K 781		

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K 781	Continued From page 26 unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to prohibit the use of portable electric heaters within the facility. This could result in a fire due to the ignition of combustible materials that would place residents, staff and/or visitors in danger.  The findings include, but are not limited to:  Room F270 heater plugged into extension cord (fixed the time inspection.)  The above was discussed and acknowledged by the facility staff.	K 781		
K 901	NFPA 101 Fundamentals - Building System Categories  Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)  This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to have a written risk assessment.	K 901		

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K 901	Continued From page 27  The findings include, but are not limited to:  The facility was unable to provide a risk assessment.  The above was discussed and acknowledged by the facility staff.	K 901		
K 918	NFPA 101 Electrical Systems - Essential Electric System  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the	K 918		

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K 918	<p>Continued From page 28</p> <p>emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This Standard is not met as evidenced by: Based upon record review and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to have annual 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.</p> <p>The findings include, but are not limited to:</p> <p><b>GENERATOR</b> Per the generator inspections the following have not been fixed: Gen 1 3/9/17 block heater lacking coolant. Missing weekly inspections for September 2016. Gen 2 4/4/17 radiator needs coolant. Missing weekly May-September. Gen4 4/4/17 Engine has an oil leak on the right side, coolant leak on the left side. Missing weekly inspections May, July-September. Gen5 Oil leak right side, coolant leak right side. Manifold lead left side missing weekly inspections for May 2016.</p> <p>The above was discussed and acknowledged by the facility staff.</p>	K 918		
K 920	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Electrical Equipment - Power Cords and Extension Cords</p>	K 920		

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K 920	<p>Continued From page 29</p> <p>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This Standard is not met as evidenced by: Based upon observations and staff interviews on May 8-15, 2017 between approximately 0800 and 1700 hours the facility has failed to restrict the use of multi-plug outlets (power strips) and extension cords 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.</p> <p>The findings include, but are not limited to:</p> <p><b>EXTENSION CORDS</b></p> <p>Extension cord and use building F6 room E-272. Extension cord and use building F 2 room F211 (fixed at the time of inspection.)</p>	K 920		

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K 920	<p>Continued From page 30</p> <p>Extension cord plugged in to power strip with fridge raider plugged into power strip room F260 (fixed at the time of inspection.)</p> <p>Room F270 heater plugged into extension cord fixed at time of inspection nurses station building at five power strips daisy chained (fixed at the time of inspection.)</p> <p>Room E101 extension cord and use IT room. E6 staff area has an extension cord plugging a microwave.</p> <p>Room C167 extension cord plugged in the power strip with coffee maker plug-in it (fixed at the time of inspection.)</p> <p>Extension cord in use C9-306 (fixed at time of inspection.)</p> <p><b>POWERSTRIPS</b></p> <p>S3-throughout - power strips in multiple patient rooms. S-060 coffee pot plugged into the power strip.</p> <p>Room F256 coffee maker plugged into power strip (fixed at the time of inspection.)</p> <p>Room E168 microwave fridge raider coffee maker plugged in the power strip E2 exam room has medical equipment plugged into a powerstrip that is not 1363A. Building E7 power strip in exam room needs to be hospital grade.</p> <p>D001 power strips daisy chained times three (fixed at the time of inspection.) Room D067 power strip daisy chained (fixed at the time of inspection.)</p>	K 920		

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K 920	Continued From page 31 D011 fridge raider plugged into power strip.	K 920		
K 921	The above was discussed and acknowledged by the facility staff.  NFPA 101 Electrical Equipment - Testing and Maintenance  Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This Standard is not met as evidenced by:	K 921		



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K 921	<p>Continued From page 32</p> <p>Based upon observations and staff interviews on May 8-15 between approximately 0800 and 1700 hours the facility has failed to safely fix electrical issues. This could lead to staff, visitors, and patients being exposed to electrical fires and shocks.</p> <p>The findings include, but are not limited to:</p> <p>OPEN JUNCTION BOXES:</p> <p>Building 27 Room 009 was missing a junction box.</p> <p>The generator room in building 27/28 had an open junction box.</p> <p>C2-234 open junction box. in interstitial space above ceiling</p> <p>C5 has an open junction box. interstitial space by room 215 at smoke separation doors.</p> <p>The above was discussed and acknowledged by the facility staff.</p>	K 921		