STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING 01 - WESTERN STATE HOSPITAL B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

(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 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. 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 & Medicaid Services. The following immediate jeopardies were called with the approval of the Centers for Medicare and Medicaid: 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Executive Officer — (X6) DATE: 7/1/17

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	**Plan of Correction for each specific deficiency cited:** (K 161) The hospital failed to maintain fire resistive construction of the building capable of resisting the passage of smoke and fire into the other compartments. To ensure the hospital meets the 2012 Life Safety Code the following corrections will be made: • A work order was created to assess the 5 inch round hole in the ceiling in the S3 ward medication room and the "36x36" hole in the sheet rock in building 28 next to stairwell nine. • The 5 inch hole in the S3 Medication room and the "36x36" hole in the sheetrock of building 28 will be repaired to ensure the capability of resisting the passage of smoke and fire into the other compartments.	

Procedure/process for implementing the plan of correction:

- Work orders have been generated to repair the 5 inch hole in the ceiling of the S3 medication room and the "36x36" hole in the sheetrock in building 28.
- Consolidated Maintenance and Operations (Maintenance) work order priority for the 5 inch hole in the ceiling of the S3 medication room and the "36x36" hole in the sheetrock in building 28 will be set as a priority for trades to respond and assess the level of damage.
- Maintenance teams will make repairs and resurface the damaged areas in a timely manner.

Monitoring and tracking procedures to ensure the plan of correction is effective:

- Maintenance Supervisor 3 to monitor the completion of work.
- A monthly maintenance dashboard is used to monitor and track the overall number of work orders presently in open status and the number of work orders completed.

Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:

- The Maintenance Facilities Manager will add to the maintenance dashboard K 161 status and report actions taken on the dashboard to the Chief Operating Officer monthly until compliance has been met for two consecutive months.
- The Maintenance Facilities Manager will present the maintenance dashboard results and actions taken quarterly to the Patient Care Quality Council and the Governing Body.

Individual Responsible:

- The Chief Operating Officer

Date completed:

- August 15, 2017

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K 161	Continued From page 2 Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) 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. 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. The findings include, but are not limited to: S3-MedRoom - 5 inch round hole in the ceiling	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	**Plan of Correction for each specific deficiency cited:** (K 271) The hospital failed to maintain the exit discharge doors free of obstructions. To ensure the NFPA 101 Discharge from Exits standard is met the following corrections were made: • All exit door key cores in stairwell 6 and 9 have been re-keyed to only require two keys to unlock the exit doors. *(corrected at time of survey)* • The key core on the ground floor of building 28 corridor exit stairwell that discharges to the courtyard and egress from Ward E2 and E1 into a gate area have been re-keyed to a CT2 key; a key is issued to all staff. • Policy 13.04 “Key Control” will be updated to require an elevated level of review including safety and security to approve key core changes to building exit doors and gates. **Procedures/process for implementing the plan of correction:** • The updated policy 13.04 “Key Control” will be approved by the Patient Care Quality Council and the Governing Body Designee (CEO). • The updated policy 13.04 “Key Control” will be posted to the hospital’s electronic policy manual for all staff to access and changes communicated to all staff. • All door cores for fire exits were assessed and re-keyed to ensure two or less keys were required for egress hospital wide.	

- Key core changed to a CT-2 key core for ground floor of building 28 corridor exit stairwell and egress from Ward E2 and E1 in building 29 into a gate area.
- All of building 29 external (leading to an outside area) key cores were changed to a CT-2 key core.

Monitoring and tracking procedures to ensure the plan of correction is effective:

- Security will conduct a walk through twice yearly of the egress points to monitor that lock schemes have not changed and are functioning as designed.
- An annual inventory will be conducted to monitor and track that the CT2 key is on key rings assigned to staff in building 28 and 29.
- The inventory and completion rate will be submitted to the Chief of Safety and Security for review.

Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:

- The Chief of Safety and Security will provide a report of any patterns of deficiencies if found during the twice yearly security walk-through of the egress points to the Patient Care Quality Council and Governing Body.

Individual Responsible:

- The Chief of Safety and Security

Date completed:

- August 1, 2017

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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	**Plan of Correction for each specific deficiency cited:** (K 293) The hospital failed to maintain proper exit signage. To ensure the NFPA 101 Exit Signage standard is met the following correction was made: • The exit sign on Ward C2, above the fire separation doors by med room, will be repaired to provide illumination. **Procedure/process for implementing the plan of correction:** • A work order has been generated to assess and repair the exit sign on Ward C2, above the fire separation doors by med room, to correct improper exit signage illumination. • Maintenance will inspect and replace exit signage as needed. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3 will monitor the completion of the work order. • Exit signage inspections are part of ongoing monthly preventative maintenance cycles. • To track this process, the maintenance system automatically generates a work order for trades to inspect exit signage on a monthly basis to ensure proper functioning.	

			Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program: • The Maintenance Facilities Manager will add to the maintenance dashboard K 293 status and report actions taken on the dashboard to the Chief Operating Officer monthly until compliance has been met for two consecutive months. • The Maintenance Manager will report the completion of the repair of the exit sign to the Patient Care Quality Council and Governing Body. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • August 31, 2017	
K 311	NFPA 101 Vertical Openings - Enclosure	K311	**Plan of Correction for each specific deficiency cited:** (K 311) The hospital failed to maintain vertical openings between floors with a construction having a fire resistive rating of at least one hour. To ensure the NFPA 101 Vertical Openings-Enclosure standard is met the following correction was made: • The elevator lobby door in building C-9 will be repaired to close and positively latch. **Procedure/process for implementing the plan of correction:** • A work order has been generated to assess and repair elevator lobby door in building C-9, to close and positively latch. • Maintenance will inspect and repair the elevator lobby door. • Maintenance teams will make repairs and ensure positive latching in a timely manner. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3 will monitor the completion of the work order. • Yearly fire alarm system device testing for hold open devices is now an established Preventative Maintenance cycle being performed by a 3rd party contract vendor as of April 2017. • Preventative maintenance cycles will be created for fire door inspections in accordance with NFPA 80, 2012 edition. Fire door inspections will be tracked via the automated maintenance system; the system will generate a work order automatically when the yearly inspection cycle is due.	

			• Fire door locations with hold open devices tied into the fire alarm system will now be inspected and tested twice a year; once by onsite maintenance staff and once by a contracted vendor. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 311 status and report actions taken on the dashboard to the Chief Operating Officer monthly until this deficiency is corrected. • The Maintenance Facilities Manager will report on the compliance of any improperly functioning fire doors from the testing and actions taken for correction to the Patient Care Quality Council and the Governing Body on a yearly basis. **Individual Responsible:** • The Chief Operation Officer **Date completed:** • August 31, 2017	

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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	**Plan of Correction for each specific deficiency cited**: (K 321) The hospital failed to maintain doors to hazardous areas as self or automatic closing. To ensure the NFPA 101 Hazardous Areas-Enclosure standard is met the following corrections were made: • Laundry bags holding the fire door open to the laundry chute in room A019 were removed. • The key cylinder was replaced in the 1.5 hour fire door to the generator	

			room. **Procedure/process for implementing the plan of correction:** • A work order was generated to validate completion of trade work. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3 will monitor the completion of the work order. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 321 status and report actions taken on the dashboard to the Chief Operating Officer monthly until compliance has been met for two consecutive months. • Maintenance Facility Manager will report to the Patient Care Quality Council and the Governing Body the completion of the repair of the missing key cylinder to the 1.5 hour fire door to the generator room. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • July 31, 2017	

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K 321	Continued From page 6 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A 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) 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. The findings include, but are not limited to: The Laundry chute in room A019 had laundry bags holding the fire door open	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	**Plan of Correction for each specific deficiency cited:** (K 324) The hospital failed to conduct testing of the hood and duct fire suppression equipment protecting the commercial cooking equipment in the kitchen. To ensure the NFPA 101 Cooking Facilities standard is met the following corrections will be completed: *Note: WSH does not have an ANSUL hood system inside the building 28, Center for Forensic Treatment Mall. There is an ANSUL hood system in building 29, East Campus that is stamped as last serviced in 2002. The below plan of correction address's the building 29, East Campus ANSUL System.* • The building 29 ANSUL system that was last serviced in 2002 has not been used since that time; the cooking service in this location is no longer used. This system will be decommissioned by a 3rd party vendor and tagged "out of service". **Procedure/process for implementing the plan of correction:** • A state contracted vendor will be contacted to schedule the decommissioning and tag-out of the unused ANSUL system. • The ANSUL system will be decommissioned and appropriately tagged out by the contract vendor. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • To monitor and track the decommission process, maintenance will inspect all ANSUL systems on campus (in-use and	

			decommissioned) to ensure all units are properly tagged out. Maintenance Supervisor 3 to conduct a second inspection to ensure all ANSUL systems have been assessed. • Maintenance Supervisor 3 to communicate and coordinate with contract vendor to expedite decommissioning and perform oversight. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 324 status and report actions taken on the dashboard to the Chief Operating Officer. • Maintenance Facility Manager will report to the Patient Care Quality Council and the Governing Body the decommissioning and appropriate tag-out of the ANSUL system on East Campus and report any findings and action taken to correct deficiencies found on the hospital wide assessment of existing hospital ANSUL systems. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • August 31, 2017	

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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	**Plan of Correction for each specific deficiency cited:** (K 325) The hospital failed to properly install alcohol based hand rub dispensers. To ensure the NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) standard is met the following corrections were made: • The Alcohol Based Hand Rub Dispensers (ABHR) listed below were moved to locations which met all code requirements: -S5- 512 hand sanitizer over the light switch -E7 medication room hand sanitizer mounted over the light switch -E5 exam room ABHR directly above the power outlet -C5 medication room over the light switch • Staff was informed via Electronic Bulletin Board (EBB) and an all staff email was sent to all staff directing the reasons Alcohol Based Hand Rub Dispensers (ABHR) were relocated. **Procedure/process for implementing the plan of correction:** • Work orders were generated and completed to relocate the hand sanitizer dispensers to an appropriate location.	

			• The relocation of the hand sanitizer dispensers will be physically inspected to ensure work was completed. • Installation staff will be trained on the code requirements for future requests to install or relocate of the ABHR dispensers. • Custodial staff will be trained to recognize and report improperly installed AHBR dispensers. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Monitoring and tracking of future ABHR installations will be performed by physical inspection to ensure code requirements are followed. • Any improperly installed ABHR dispensers will be reported upon discovery and work orders will be completed to move dispenser(s) to a proper location. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The monitoring of proper installations of the ABHR dispensers and actions taken will be reported Patient Care Quality Council and Governing Body. **Individual responsible:** • The Chief of Safety and Security **Date Completed:** • August 1, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING **01 - WESTERN STATE HOSPITAL** B. WING _____	**06/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	**9601 STEILACOOM BLVD SW TACOMA, WA 98498**

(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 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	**Plan of Correction for each specific deficiency cited**: (K 345) The hospital failed to have appropriate testing of the fire alarm system. To ensure NFPA 101 Fire Alarm system- Testing and Maintenance is met the following corrections will be made: *Note: The buildings depicted in the Statement of Deficiencies report were buildings 27, 28. Corrections needed were made to buildings 28 & 29.* *Note: Building 09 is not a health care occupancy; this is a staff only building in its entirety. Building 09 does not have*	

			an "S" wing; additional clarification is needed from the surveyors to accurately respond to this deficiency. No Plan of Correction has been submitted for Building 09. • Maintenance Supervisor 3 will coordinate with 3rd party contractors to perform sensitivity testing showing pass/fail for buildings 28, 29. • A 3rd party vendor to perform system wide inspections and make repairs throughout buildings 28 and 29. Fire alarm devices to be inspected, tested and / or replaced as needed. • A state project is underway to replace the existing fire alarm system in building 09. Construction and installation of the new fire alarm system was 90% complete at the time of survey. There are no troubles on the existing system to date. • Maintenance had a team member challenge the NICET Level 2 test and passed to ensure understanding and articulation of the standards from NFPA 72 and NFPA 25 for which to test systems. • Policy 12.06 "Interim Life Safety Measures" was updated to reflect the process for conducting fire watches that meet the Life Safety Code requirements. • An Immediate Clinical Safety Measures Management bulletin was issued regarding fire safety through the use of increased frequency in fire watch. **Procedure/process for implementing the plan of correction:** • The updated policy 12.06 "Interim Life Safety Measures" was approved through Executive Leadership and the Governing Body Designee (CEO). • The hospital to establish a contract with a licensed and bonded 3rd party vendor to perform the fire alarm testing. • A 3rd party contractor to a set timeline for sensitivity testing in health care occupancies and perform the sensitivity testing. • Sensitivity testing to be added to the Life Safety Binders for future surveyors. ▪ Maintenance to maintain NICET certified personnel. ▪ Maintenance hired a qualified NICET Level 2 Supervisor and now has two, NICET Level 2 certified personnel. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Maintenance Supervisor 3 to review and ensure testing documentation is accurate and has	

			been provided to the hospital's Facility Coordination Office. • Facility Coordinator Office will maintain the Sensitivity and fire alarm system testing documentation. • WSH Facility Coordination Office to assure documentation is available for future survey review. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 345 status and report actions taken on the dashboard to the Chief Operating Officer monthly until compliance has been met for two consecutive months. • Maintenance Facility Manager will report to the Patient Care Quality Council and the Governing Body the status of sensitivity and fire alarm system testing on a yearly basis. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • August 31, 2017	

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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	**Plan of Correction for each specific deficiency cited**: (K 346) The hospital failed to provide an approved written policy for instituting a fire watch in the event of a failure of the fire alarm system, notify the Office of the State Fire Marshal and taking the fire alarm system off line for 8+ hours and not doing a fire watch. To ensure NFPA 101 Fire Alarm System- Out of Service is met the	

			following corrections will be made: • Policy 12.06 “Interim Life Safety Measures” was updated to reflect the process for conducting fire watches that meet the Life Safety Code requirements: -When a fire alarm system, smoke alarm or sprinkler system is or will be out of service for more than 4 hours in a 24 hour period, evacuation of the area or an approved fire watch must be implemented. - Notifying the Office of State Fire Marshal within twenty-four hours of the Life Safety Code deficiency/impairment and the approved fire watch for all parties left unprotected by the shutdown until the fire alarm, smoke alarm, or sprinkler system has been returned to service. • An Immediate Clinical Safety Measures Management bulletin was issued regarding fire safety through the use of increased frequency in fire watch and the immediate changes to the Fire Watch and Patient Census while fire alarms and sprinkler system testing was in place. • A “Just in Time Training” and competency test was developed on the new procedure for implementing and conducting a fire watch. **Procedure/process for implementing the plan of correction:** • The updated policy 12.06 “Interim Life Safety Measures” was approved through Executive Leadership and the Governing Body Designee (CEO). • The Immediate Clinical Safety Measures Management bulletin was sent to all staff via email, Electronic Bulletin Board (EBB) and posted to the electronic policy manual site. • Staff completing the fire watch received the “Just in Time Training” and competency on the new process. • The fire watch training and competency test will be given on a quarterly basis to staff that are responsible for conducting the fire watch. • A Fire watch initiation checklist has been developed for implementation to ensure that all pertinent staff follows the WSH fire watch procedure to include contacting appropriate outside agencies. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Safety Manager will monitor and track the need for implementing a fire watch at the hospital and ensure a fire watch is implemented if necessary. • The Safety Manager will monitor and	

			track that the Office of the State Fire Marshal has been notified when the hospital implements a fire watch per policy 12.06 “Interim Life Safety Measures”. • The Safety Manager will monitor and track that staff conducting the fire watch have received the appropriate training and competency testing regarding conducting fire watches. • The Fire Watch initiation checklist will be completed for all Fire Alarm and Suppression deficiencies and forwarded to the Safety Office for tracking and monitoring quality control. • All Fire Watch Report forms will be forwarded to the Safety Office for tracking and monitoring quality control. The Safety Office will track all Fire Watches to include Fire Watch paperwork and address any deficiencies. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Safety Manager will report compliance implementing a fire watch when needed including notification of the Office of the State Fire Marshal to the Patient Care Quality Council & the Governing Body on a quarterly basis until 100% compliance has been met for two consecutive quarters. • The Safety Manager will report to the Fire Watch data and deficiencies quarterly in the Life Safety report to the Patient Care Quality Council and Governing Body. **Individual Responsible:** • The Chief of Safety and Security **Date completed:** • August 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING **01 - WESTERN STATE HOSPITAL** B. WING _____	**06/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 Sprinkler 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	**Plan of Correction for each specific deficiency cited:** (K 351) The hospital failed to install the fire sprinkler system as required. To ensure the NFPA 101 Sprinkler System- Installation standard is met the following corrections will be made: • The hospital will request for 3rd party engineer(s) to review and provide an official report of the building 29, East Campus loading dock sprinkler coverage. Any deficiencies identified by the 3rd party engineering report will be corrected or coverage expanded. • Maintenance Supervisor will contact 3rd party sprinkler vendor to review the ward E5 sprinkler heads and correct the cold soldering effect situation of being within two feet of each other. **Line Item:** Central Forensic Services Dining services pantry room has no sprinkler heads ***Note**: Clarification requested by Clinical Services Management from CMS on 7/05/17. All sprinkler heads were assessed by state contract vendor and repaired as needed. Plan of Correction has not been submitted for the pantry room.* **Procedure/process for implementing the plan of correction:** • The 3rd party engineer consultant(s) to	

review and provide report of coverage and any necessary modifications needed to ensure adequate coverage.
- WSH and Maintenance to review engineer consultant(s) report.
- Establish 3rd party contractor to make repairs, modifications or alterations as necessary to deficiencies listed below:
  - The installation of the sprinkler system in the daylight basement loading dock
  - Correction of the spacing of the sprinkler heads in the E5 dining room

Monitoring and tracking procedures to ensure the plan of correction is effective:

- Maintenance Supervisor 3's will monitor and track the completion of engineering consult report.
- Areas resulting in the need for contract vendor modifications or expansion will be monitored and work verified as completed on site by Maintenance Supervisor 3's.

Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:

- The Maintenance Facilities Manager will add to the maintenance dashboard K 351 status and report actions taken on the dashboard to the Chief Operating Officer monthly until compliance has been met for two consecutive months.
- The Maintenance Facilities Manager will report findings on the engineering compliance report to the Patient Care Quality Council when received.
- The Maintenance Facilities Manager will report corrective actions taken as a result of the 3rd party engineering report and completion of those actions to the Patient Care Quality Council and the Governing Body.

Individual Responsible:

- The Chief Operating Officer

Date completed:

- September 30, 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 12 sprinkler protection in specific areas where state or local regulations prohibit sprinklers. 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. 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) 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 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. The findings include, but are not limited to: There was no sprinkler coverage in the daylight basement loading dock. In building E-5 the sprinkler heads in the dining room are within two feet of each other causing a possible cold solder situation. Central Forensic Services Dining services pantry room has no sprinkler heads The above was discussed and acknowledged by the facility staff.	K 351		
K 353	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353	**Plan of Correction for each specific deficiency cited:** (K 353) The hospital failed to maintain the fire sprinkler system as required. To ensure that NFPA 101 Sprinkler System - Maintenance and Testing is met the following corrections will be made:	

SPRINKLER HEAD DAMAGED/PAINTED

- Maintenance Supervisor 3 will contact a 3rd party sprinkler system vendor to establish a date the vendor can be on site to review noted deficiencies and begin making repairs/replacements to the following:
  -E5 room 151 sprinkler head needs replaced pushed up in the ceiling
  -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
  -E4 shower room (possible recalled heads, the facility shall verify.)
  -E4 by room 224 sprinkler head painted
  -E4 by room 258 head pushed into ceiling
  -Sprinkler head in staff cleaning supply room C3-338 missing fins.

SPARE SPRINKLER HEADS MISSING

- Maintenance Supervisor 3 will contact a 3rd party sprinkler system vendor to order materials and replace missing sprinkler heads in the following locations:
  -Building 28 sprinkler head box missing heads
  -Building 29 sprinkler head box missing heads
  -E4 263 sprinkler valve room, no spare heads
  -Sprinkler heads missing from boxes in buildings 27, 28.

OBSTRUCTIONS

- Maintenance Supervisor 3 will contact a 3rd party sprinkler system vendor to review noted deficiencies and begin making repairs as needed to the following:
  -Sprinkler obstructed by wardrobe in room C-3 329.
  -Sprinkler head obstructed by wardrobe in room C-2 227.

ESCUTCHEON RINGS

- Maintenance Supervisor 3 will generate a work order to assess and make repairs as listed below:
  -E5 116 falling down
  -E7 111 falling down
  -E7 146 missing
  -E4 nurses station missing escutcheon rings
  -E4 by room 258 missing escutcheon ring
  -E4 by room 248 has hole around escutcheon ring

INTERNAL PIPE INSPECTIONS

- Stand pipe inspection reports

(documentation) for buildings requiring standpipe inspection has been located and placed in the Environment of Care binders for the following buildings: 15, 10, 16, 17, 18, 19, 20, 28, 29, 9, 26, 21 for future survey inspection.
- Maintenance Supervisor 3 will contact a 3rd party sprinkler system vendor to review noted deficiencies and begin making repairs as needed to the following:
  - Building 28 dry system into E6 and E8 has a lot of corrosion per the report.

Note: Wards E6 and E8 are in building 29.

ANNUAL INSPECTIONS
- Sprinkler inspection and reports were completed in healthcare occupancy buildings 16-20, 21, 27-29.
- A schedule for the remaining building inspection of the sprinkler systems of the hospital is in place with the 3rd party vendor now conducting inspection, testing and replacement or repair as necessary.

BACKFLOW INSPECTIONS.
- The backflow inspection reports have been located and will be placed in the Environment of Care binders.

Procedure/process for implementing the plan of correction:
- Work orders were created to assess and repair the deficiencies noted above to the damaged or painted sprinkler heads.
- Spare sprinkler heads that are missing will be ordered and replaced when received.
- Obstructed sprinkler heads and escutcheon rings deficiencies will be corrected.
- Internal standpipe inspections added to the Environment of Care documentation binders.
- The 3rd party contract vendor will make sprinkler system repairs for the deficiencies noted above.

Monitoring and tracking procedures to ensure the plan of correction is effective:
- Completion of the repairs made to the damaged or painted sprinkler heads, spare sprinkler heads missing, obstructions and escutcheon rings by the 3rd party contract vendor will be monitored by the Maintenance Supervisor 3's and verified in field for completion.
- The Maintenance Facility Manager will monitor and track completion of the required annual backflow and sprinkler

			systems inspections and ensure the documentation of the inspections is placed in the Environment of Care binders. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 353 status and report actions taken on the dashboard to the Chief Operating Officer monthly. • The Maintenance Facility Manager will report completion of repair or replacement of the deficiencies noted above to the Patient Care Quality Council. • The Maintenance Facility Manager will report completion of the annual backflow and sprinkler system testing on a rolling basis as completed to Patient Care Quality Council and the Governing Body. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • August 31, 2017	

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K 353	Continued From page 13 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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. The findings include, but are not limited to: SPRINKLER HEAD DAMAGE/PAINTED E5 room 151 sprinkler head needs replaced pushed up in the ceiling 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	K 353		

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K 353	Continued From page 14 E4 shower room (possible recalled heads, the facility shall verify.) E4 by room 224 sprinkler head painted E4 by room 258 head pushed into ceiling Sprinkler head in staff cleaning supply room C3-338 missing fins. SPARE SPRINKLER HEADS MISSING Building 28 sprinkler head box missing heads Building 29 sprinkler head box missing heads E4 263 sprinkler valve room, no spare heads The facility was only able to show 4 sprinkler heads in boxes for buildings 27 and 28. OBSTRUCTIONS Sprinkler obstructed by wardrobe in room C-3 329. Sprinkler head obstructed by wardrobe in room C-2 227. ESCUTCHEON RINGS E5 116 falling down E7 111 falling down E7 146 missing E4 nurses station missing escutcheon rings E4 by room 258 missing escutcheon ring E4 by room 248 has hole around escutcheon ring INTERNAL PIPE INSPECTIONS The facility was unable to provide documentation for the following buildings: 15, 10, 16, 17, 18, 19, 20, 28, 29, 9, 26, 21 Building 28 dry system into E6 and E8 has a lot of corrosion per the report	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	**See Plan of Correction for K 346 for K 354 (cross reference K 346 NFPA101 Sprinkler System - Out of Service)**	

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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
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	**Plan of Correction for each specific deficiency cited:** (K 355) The hospital failed to ensure proper maintenance of the facilities portable fire extinguishers. To ensure the NFPA 101 Portable Fire Extinguishers standard is met the following corrections will be made: *Note: Clarification requested by Clinical Services Management from CMS on 7/07/17 related to travel distance. No Plan of Correction has been submitted related to travel distance.* • The fire extinguisher box at the nurse's station on F4 has been repaired. • All staff was issued a fire extinguisher box key and has been trained on the appropriate use of the key. • Staff in building C5 were trained on how to open the fire extinguisher cabinet in room C5-220. • Staff will be issued key identifiers for the fire box key so they can readily recognize the key on their ring. • All Fire Inspection tags will be properly initialed, dated and completed in the following areas: -the fire extinguisher #2951 located in room 105 in building E7 -the fire extinguisher in the smoking area in the courtyard of building 28/29 dated 8/2015 -the fire extinguisher located by dietary services in Central Forensic Services dated 8/2015	

-the fire extinguishers in building 28/29
-the fire extinguisher in room M-198 in building F5

- The fire extinguisher box placed at 6.5 feet in Central Forensic Services treatment mall by the motor control room will be moved and mounted to an appropriate level.

Procedure/process for implementing the plan of correction:

- Maintenance has measured the area and ordered additional fire boxes to be installed.
- Once the work order is closed, safety staff will validate completion.
- All fire keys will be marked with a red key sleeve for quick identification of the accurate fire extinguisher box key.
- A "Just in Time" training has been given to all staff in patient care areas on how to use the fire keys and fire extinguishers. If the key does not work, the staff will request a new key. If the lock does not work, a lock replacement will be ordered. If keys need to be replaced the trainer will replace their key for them.
- The Safety Manager will ensure all hospital Fire Marshals and Fire Marshal Supervisors are re-trained regarding how to properly complete the fire extinguisher tags.
- Organizational Development and Safety Staff will provide the training to all Fire Marshals
- Hospital personnel will ensure that month and year on the annual check are accurate for the fire extinguisher inspection tags. If a deficient lock is found it will be reported and repaired or replaced.
- The Safety Officers and Maintenance will review all fire extinguishers inspection cards throughout the hospital to ensure they are all correct.
- A Work Order will be generated to remove and lower fire extinguisher box to the CFS Main Corridor to ensure compliance to NFPA 101 appropriate height.

Monitoring and tracking procedures to ensure the plan of correction is effective:

- The Safety Office staff will visually confirm that boxes have been installed that meets NFPA 101/10 requirements for portable fire extinguisher.
- Hospital Fire Marshal Supervisors will verify on a monthly basis that fire extinguisher inspection tags are being properly completed.
- Once the work order is completed for removing the fire extinguisher box that

			is 6.5 feet from the floor to an appropriate height, the Safety Manager will visually confirm that boxes have been installed that meets NFPA 101. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The proper completion of the fire extinguisher inspection tags, and completion of the removal and installation of the fire boxes to the appropriate height will be reported to the Patient Care Quality Council and Governing Body in the Life Safety report as the item is completed. **Individual Responsible:** • The Chief Safety and Security Officer **Date completed:** • August 16, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING **01 - WESTERN STATE HOSPITAL** B. WING _____	**06/01/2017**

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WESTERN STATE HOSPITAL	**9601 STEILACOOM BLVD SW TACOMA, WA 98498**

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

			without impediments to their closing and latching. To ensure that NFPA 101 Corridor-Doors standard is met the following corrections will be made: Door Penetrations • The penetrations in the door of the shower room door that opens to the corridor in F-1 will be repaired or replaced to maintain the capability of resisting the passage of smoke. • Work order created to assess and either replace the door or repair as required. Positive Door Latching / Impediments • Work orders created to assess and either replace door hardware or repair as necessary to ensure positive latching and free movement without impediments: -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 -Corridor door B139b not latching -Building 28 sprinkler riser room fire door not closing -The fire door to the dishwasher room in Central Forensic Treatment Mall was wedged open. -The fire doors between F-3 and F-7 do not close when released from the open position due to dragging on the carpet. • Central Forensic Treatment Mall Supervisors will round weekly to ensure no doors are wedged open in the Treatment Mall and make on spot corrections until 100% compliance is achieved for two consecutive months. ROLLDOWN FIRE CURTAINS • Fusible links will be ordered and replaced: -Buildings 13, 16, 17, 18, 20, 21, 27, 28, 29 will have material ordered and the fusible links replaced per NFPA 80. • The doors listed below will be corrected, replaced or repaired to close and positively latch to ensure proper operation: -Door to C9-364 -Door to laundry C9-346 -Door to dirty utility C9-341 **Procedure/process for implementing the plan of correction:** • Work orders were generated for assessment, replacement and/or repair of penetrations of the shower room door on F1, doors to the corridor on South, Central, and Forensic Centers to ensure closing and positive latching doors, and replacement of fusible links.	

			• Maintenance to complete repair work for penetrations, door closing and latching deficiencies and replacement of the fusible links. • Maintenance teams will expedite materials orders where permissible by vendors, make repairs, and ensure positive latching, fusible link replacement and removal of impediments in a timely manner. • Fire door inspections will be tracked via the automated maintenance system; the system will generate a work order automatically when the yearly inspection cycle is due. • Fire door locations with hold open devices tied into the fire alarm system will now be inspected and tested twice a year; once by onsite maintenance staff and once by a contracted vendor. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3s to verify completion of work on site. • Monitor and tracking of actions related to door deficiencies will be captured through automated preventive maintenance cycles. Reports will be placed in Environment of Care binders as completed. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 363 status and report actions taken on the dashboard to the Chief Operating Officer monthly until all deficient items are corrected. • The Maintenance Facility Manager will report to the Patient Care Quality Council and the Governing Body the completion of the repair and or replacements of the doors with penetrations, closing and latching deficiencies and fusible link replacements. (*See K 311; cross references*) **Individual Responsible:** • The Chief Operating Officer **Date completed:** • November 30, 2017	

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	504003	A. BUILDING **01 - WESTERN STATE HOSPITAL** B. WING _____	**06/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	**9601 STEILACOOM BLVD SW TACOMA, WA 98498**

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K 363	Continued From page 18 Corridor - Doors 2012 EXISTING 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. 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 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 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	K 363		

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K 363	Continued From page 19 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: The shower room door that opens to the corridor in F-1 has through penetrations in the door. The above was discussed and acknowledged by the facility maintenance staff. 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. The findings include, but are not limited to: 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 Corridor door B139b not latching Building 28 sprinkler riser room fire door not closing The fire door to the dishwasher room in Central Forensic Treatment Mall was wedged open.	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	**372 Plan of Correction for each specific deficiency cited:** (K 372) The hospital failed to maintain smoke barrier walls to the required one hour fire resistive rating. To ensure that NFPA 101 Subdivision of Building Spaces -Smoke Barrier is met the following correction will be made: • Work order was generated to seal the smoke barrier wall penetration in the below location: -In S7-230 there is a penetration to the smoke barrier wall above the cross corridor smoke doors. **Procedure/process for implementing the plan of correction:** • A work order was generated for the assessment and repair of the S7-230 smoke barrier penetration. • Maintenance to seal the smoke barrier penetration. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3 to verify completion of work on site.	

			Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program: • The Maintenance Facilities Manager will add to the maintenance dashboard K 372 status and report actions taken on the dashboard to the Chief Operating Officer monthly until this deficient penetration is corrected. • The Maintenance Facility Manager will report to the Patient Care Quality Council and Governing Body completion of sealing the smoke barrier penetration. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • July 15, 2017	

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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	**Plan of Correction for each specific deficiency cited:** (K 374) The hospital failed to maintain the fire separation doors in the building. To ensure that NFPA 101 Subdivision of Building Spaces - Smoke Barrier standard is met the following corrections have been made: *Note: There are three cross corridor separation doors separating buildings 28 & 29. Below is a bulleted list of these locations with explanatory material to better identify cross corridor door locations as depicted on the WSH Life Safety Drawings separating building 28 & 29.* ▪ Bld. 29, Ground Floor – Level 0, Corridor # 0A00 - Separating - Bld. 28, Ground Floor – Level 0, Corridor # 0A00 ▪ WSH Life Safety Sheet Set No. LS 4 -2 ▪ Bld. 29, 1st Floor – Level 1, Corridor # 1A00 - Separating - Bld. 28, 1st Floor – Level 1, Corridor #1A09 ▪ WSH Life Safety Sheet Set No. LS 4 -4 ▪ Bld. 29, 2nd Floor – Level 2, Corridor # A200 - Separating - Bld. 28, 2nd Floor – Level 2,	

Corridor # 2A00
-WSH Life Safety Sheet Set No. LS 4 -6

- Maintenance Carpenter Shop will perform 13 point inspection of identified doors.
- The cross corridor fire doors between building 28-29 that have holes in doors, are missing hinge plates, and have holes in frame will be repaired and/or replaced to be maintained as fire separation doors via state project 2017-404.
- The 1.5 hour fire door to the generator room that was missing the locking hardware causing a through penetration in the door has been replaced. (see K 321; cross reference)

Note: Correction made for building location noted on statement of deficiency report for building 29, Ward E7. Explanatory material to assist in depicting the location is noted below:

- Bld. 29, 1st Floor, Ward E7 Corridor No. D135 - Separating - Bld. 29, 1st Floor, Clinic Corridor No. E110
  -WSH Life Safety Sheet Set No. LS 5 – 1

- Under state project 2017- 418, the cross corridor fire separation doors next to Clinic (in building 29 Ward E7) which had one half of the assembly removed and replaced with a wood frame wall with sheetrock, will be replaced.

Procedure/process for implementing the plan of correction:

- Maintenance teams will perform 13 point door inspections on the three bulleted buildings 28 / 29 locations above in accordance with NFPA 80, 2012 edition. (See K 311; cross reference).
- Doors separating building 28 and 29 failing inspection and requiring replacement will be added to state project number 2017-404 and work to be completed.
- Doors identified in this deficiency will be prioritized over all other doors under state projects numbers 2017-404 and 2016-418.
- Building 27 Ward E7 cross corridor fire separation doors will have the assembly replaced and/or repaired via state project 2017-418.

Monitoring and tracking procedures to ensure the plan of correction is effective:

- Facilities Planner 2 will coordinate with The Office of Capital Projects

			Managers to ensure door replacement for Deficiencies 1-3 are completed under state project numbers 2017-404 and 2016-418. • Yearly fire door inspections in all Western State Hospital healthcare occupancies will be added to the automated maintenance system as an annual preventative maintenance cycle for inspection and repair. *(See K 311; cross reference)* • Maintenance Supervisor 3 will ensure annual fire door preventative maintenance inspections are completed and documentation placed in the Environment of Care binders. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 374 status and report actions taken on the dashboard to the Chief Operating Officer. • The Maintenance Facilities Manager will report the completion of the state projects 2017-404 and 2017-418 to the Patient Care Quality Council and Governing Body. • The Maintenance Facilities Manager will report on the compliance of any improperly functioning fire doors from the testing and actions taken for correction to the Patient Care Quality Council and the Governing Body on a yearly basis. *(See K 311; cross reference).* **Individual Responsible:** • The Chief Operating Officer **Date completed:** • October 31, 2017	

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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	**Plan of Correction for each specific deficiency cited:** (K 531) The hospital failed to properly maintain their elevators. To ensure that NFPA 101 Elevators is met the following corrections will be made: • The elevators will be checked for fire recalls. • The elevator fire recall checks will be completed by a state contracted vendor. **Procedure/process for implementing the plan of correction:** • Maintenance to perform code analysis/ research and discuss options with the state contracted elevator vendor. • State contract addendum creation and contract vendor sign offs for monthly elevator fire recall testing (as applicable) for elevators. • Monthly log of elevator testing and or	

			maintenance book to be maintained. • State contracted elevator vendor to complete elevator fire recall testing. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3 to provide oversight of the elevator contract, coordinate repairs and monitor monthly elevator fire recall testing. • Maintenance Supervisor 3 to review and ensure documentation is accurate for the fire recall testing. • Maintenance to inspect state contract elevator company's log book monthly and record findings on preventative maintenance work order. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 531 status and report actions taken on the dashboard to the Chief Operating Officer monthly until compliance has been met for two consecutive months. • The Maintenance Facilities Manager will report the compliance with completion of the elevator fire recall testing to the Patient Care Quality Council and the Governing Body. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • September 30, 2017.	

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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	**Plan of Correction for each specific deficiency cited:** (K 712) The hospital failed to provide fire drill records reflecting drills being conducted on all shifts for the past 12 months. To ensure that NFPA 101 Fire Drills standard is met the following corrections will be made: • Policy 12.03 Fire Safety and Evaluation Drills will be updated to specify training will be provided to staff delegated to be the Hospital Fire Marshall and back up Hospital Fire Marshall. • The facility will not pre-announce fire drills. • The fire drill form will be updated to no longer have an option to announce the fire drill. • The fire drill form will be updated to ensure it is accurate and timeframes are documented appropriately. • Train all Hospital Fire Marshals and back-ups on the updated fire drill forms and the importance of responding to the fire alarm, closing doors and expediting the evacuation and accountability during the fire drill. **Procedure/process for Implementing the Plan**	

			of Correction : • Updated policy 12.03 Fire Safety and Evaluation Drills will be approved by Executive Leadership and the Governing Body Designee (CEO). • Update the fire drill form to provide new language that fire drills must be unannounced and conducted within appropriate timeframes. • Train Hospital Fire Marshal staff and back-ups on the updates made to the fire drill form, importance of responding to the fire alarm, closing doors and expediting the evacuation and accountability process during the fire drill. • Educate the communication department on the new process regarding announcements of testing of the hospital fire systems. • Educate all staff through the electronic bulletin board and all hospital email regarding new announcement for testing on the fire system. • Implement the updated form. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Audits will be performed quarterly to monitor and track the fire drill process to ensure fire drills are not pre-announced, drills occur within the appropriate timeframes and staff adequately respond to the fire alarms. • Maintenance staff will inform the Safety Office when fire system testing will be done. • The Safety Office will randomly audit the announcement of fire drill testing for compliance on a quarterly basis. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Safety Manager will report the audit results and actions taken for pre-announcement testing of the system and timeframes of fire drills to the Patient Care Quality Council and the Governing Body on a quarterly basis until 95% compliance has been achieved for two consecutive quarters. **Individual Responsible:** • Chief of Safety and Security **Date completed:** • August 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING **01 - WESTERN STATE HOSPITAL** B. WING _____	**06/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	**9601 STEILACOOM BLVD SW TACOMA, WA 98498**

(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 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	**Plan of Correction for each specific deficiency cited:** (K 741) The hospital failed to provide the required equipment at the designated smoking area(s). To ensure that NFPA 101 Smoking Regulations is met the following corrections will be made: • Policy 13.06 “Searches” will be updated to include that any time a patient leaves the ward and goes to a designated smoking area, a staff member must complete a Wand Search on the patient to ensure that he/she does not bring any unauthorized items to the ward upon return. • Policy 4.05 “Tobacco Use” will be updated to include that all ward staff will be trained on the use of Electronic hand held Scanners. • Develop a new policy for specialty purpose detectors that includes instructions for use, operability testing, inspection, and maintenance of hand	

			held metal scanning equipment used. • Security Standard Operating Procedure (SOP) # 32 Searches conducted by security officers will be updated to identify when Electronic Handheld Scanner Searches will be completed. • Ward staff will be trained on security wanding policies and procedures. **Procedure/process for Implementing the Plan of Correction :** • The updated policies 13.06 “Searches”, 4.05 “Tobacco Use”, and the new policy for “Specialty Purpose Detectors” will be approved by Executive Leadership and the Governing Body Designee (CEO). • All Ward Administrators will ensure that each ward has a functional hand held scanner and ensure that their staff has been properly trained on how and when they should use the scanner. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Ward Administrators and Security Management will ensure that all wards are equipped with the appropriate number of working hand held scanners. • The Director of Security will ensure that all Security SOP’s are updated accordingly. • The Director of Security will ensure that staff inspects all smoking areas monthly. • Ward Administrators and/or Security will perform monthly audits to ensure that ward staff are performing security wanding per hospital policy and track compliance with the process. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Director of Security will report compliance with security wanding on the wards to the Patient Care Quality Council and Governing Body on a quarterly basis until 95% compliance has been achieved for two consecutive quarters. **Individual Responsible:** • The Chief of Safety and Security **Date completed:** • August 31, 2017	

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K 741	Continued From page 25 responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (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. 18.7.4, 19.7.4 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. The findings include, but are not limited to: 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. The above was discussed and acknowledged by the facility staff.	K 741		
K 781	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except,	K 781	**Plan of Correction for each specific deficiency cited:** (K 781) The hospital failed to prohibit the use of portable electric heaters within the facility. To ensure that NFPA 101 Portable Space Heaters is met the following corrections will be made: • The heater that was plugged into the extension cord in room F270 has been removed. *(fixed at time of inspection)*	

			• Communicate the expectations of standards related to space heaters to all staff. • Enforce WSH policy 4.17 on prohibition of space heaters. **Procedure/process for implementing the plan of correction:** • Educate on WSH policy 4.17 on prohibition of space heaters. • Include space heater information in the Safety and Emergency section during New Employee Orientation (NEO). • Facility Coordination Office will provide an annual inspection and a random quarterly audit of staff offices to ensure compliance with policy. • All space heaters detected will be removed immediately and an eAROI will be submitted for the safety violation. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Facilities Coordination Office will round and review a sample of areas quarterly to determine compliance with the prohibition of space heaters. • Safety will randomly check the area of the space heater removal to ensure the employee has not returned the item to the workplace. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Safety Manager will report compliance with the prohibition of space heaters in the facility and actions taken to the Patient Care Quality Council and the Governing Body on a quarterly basis until 95% compliance has been achieved for two consecutive quarters. **Individual responsible:** • The Chief Safety and Security Officer **Date completed** • November 30, 2017	

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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	**Plan of Correction for each specific deficiency cited:** (K 901) The hospital failed to have a written risk assessment. To ensure that NFPA 101 Fundamentals - Building System Categories is met the following corrections will be made: • Identify building systems, categorize and identify qualified personnel in accordance with NFPA 99 Chapter 4. • Qualified personnel will conduct a building system risk assessment. **Procedure/process for implementing the plan of correction:** • Identify the systems that require risk assessments in health care occupancies. • Identify qualified personnel for each system. • Conduct a risk assessment through qualified personnel. • Establish health care occupancy systems categories in accordance with NFPA 99 Chapter 4.	

			• Conduct a risk assessment by qualified personnel a resent risk assessment to the Environment of Care Committee. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Facility Planner 2 will monitor that a building system category risk assessment is conducted by qualified personnel annually. • The Facility Planner 2 will monitor and facilitate completion of the risk assessment, documentation to be placed in the Environment of Care binder. • The Environment of Care Committee will review building system category risk assessment annually to address any changes to or addition thereof new systems. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Environment of Care Committee Chair will report completion of the risk assessment and building categorization to the Patient Care Quality Council annually. • The Chief Operating Officer will include the completion of the annual risk assessment and building categorization to the Governing Body annually. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • October 31, 2017	

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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	**Plan of Correction for each specific deficiency cited:** (K 918) The hospital failed to have annual testing and maintenance conducted on the emergency generator. To ensure that NFPA 101 NFPA 101 Electrical Systems - Essential Electrical System is met the following corrections will be made: • All missing weekly generator inspection sheets for Gen 1 (9/16), 2 (5/16-9/16), 4 (5/16 & 7/16-9/16), and 5 (5/16) have been located and placed into Environment of Care binders. • The following assessments and repairs and/or maintenance for the generators will be made: -Gen 1 block heater lacking coolant. -Gen 2 radiator needs coolant. -Gen 4 Engine has an oil leak on the right side and a coolant leak on the left side. -Gen 5 Oil leak right side, coolant leak right side and manifold lead left side **Procedure/process for implementing the plan of correction:** • Work orders will be generated for assessment, replacement/maintenance and/or repair for the above generator deficiencies. • Maintenance will make repairs to deficiencies or schedule for a 3rd party vendor to make repairs. • Maintenance Supervisor 3 to perform on site survey to validate completion of trade work. **Monitoring and tracking procedures to ensure the plan of correction is effective:**	

			• The Maintenance Supervisor 3 will monitor and track the completion of work. • Generator inspection forms will be reviewed by the Maintenance Supervisor 3 on a monthly basis to ensure weekly generator inspections occur per NFPA 101 and 110 standard, quality of documentation is accurate and follow-up work orders for repair are generated and placed in the Environment of Care binders. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard K 918 status and report actions taken on the dashboard to the Chief Operating Officer monthly until the aforementioned deficiencies are corrected. • The Maintenance Facility Manager will report completion of weekly and monthly inspections and any outstanding generator deficiencies on a yearly basis to the Patient Care Quality Council and Governing Body. **Individual Responsible:** • The Chief Operating Officer **Date completed:** • September 30, 2017	

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K 918	Continued From page 28 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) 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. The findings include, but are not limited to: GENERATOR 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. The above was discussed and acknowledged by the facility staff.	K 918		
K 920	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords	K 920	**Plan of Correction for each specific deficiency cited:** (K 920) The hospital failed to restrict the use of multi-plug outlets (power strips) and extension cords to providing power to permitted electrical equipment. To ensure that NFPA 101 Electrical Equipment - Power Cords and Extension Cords- is met the following corrections will be made:	

- Validate that the item listed below meets the policy standard and has been removed:

EXTENSION CORDS

-extension cord and its use in building F6 room E-272

-extension cord and its use in building F2 room F211 *(fixed at time of inspection)*

-extension cord and the refrigerator plugged into a power strip in room F260 *(fixed at time of inspection)*

-heater plugged into extension cord room F270; nurses station building at five power strips daisy chained *(fixed at time of inspection)*

-extension cord and its use in room E101 and IT room plugging into a microwave

-extension cord plugged into the power strip with coffee maker plugged in room C167 *(fixed at time of inspection)*

-extension cord and its use in room C9-306 *(fixed at time of inspection)*

POWERSTRIPS

-S3 throughout; multiple power strips in multiple patient rooms

-S-060 coffee pot plugged into power strip

-coffee maker plugged into a power strip in room F256 *(fixed at time of inspection)*

-microwave, refrigerator, coffee maker, and medical equipment plugged into a power strip in room E168 and E2 exam room has medical equipment plugged into a power strip that is not 1363A

-E7 power strip in the exam room needs to be hospital grade

-daisy chained power strips in D001 *(fixed at time of inspection)*

-daisy chained power strips in D067 *(fixed at time of inspection)*

-refrigerator plugged into a power strip in D011

- Update policy 4.17 “Personal Electronic Equipment” on proper use of extension cords and power strips and communicate the expectations of standards related to extension cords and power strips to all staff.

Procedure /process for implementing the plan of correction

- Educate staff on revised policy 4.17 on proper use of extension cords and power strips.
- Reoccurring violations will be corrected and reported using an electronic Administrative Incident Report (eAROI) immediately.
- Include this information in the Safety and Emergency training component during New Employee Orientation.
- The Facility Coordination Office will

			provide an annual inspection and a random quarterly audit of staff offices to ensure compliance with policy. • All improperly used extension cords and power strips will be removed immediately and an eAROI will be submitted for the safety violation. **Monitoring and tracking procedures to ensure the plan of correction is effective** • Supervisors will monitor for improper use of extension cords and power strips in employee offices, ward common areas, patient rooms or break rooms and remove them immediately. If found, then complete an eAROI. • The Facilities Coordination Office and the Safety Officer will randomly check areas hospital wide for the use of extension cords and power strips when they conduct fire drills or do rounding and immediately remove extension cords and power strips not in compliance. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program.** • The Facilities Coordination Office will report quarterly to the Patient Care Quality Council and Governing Body on the number of extension cord and power strip violation reports and actions taken for two consecutive quarters. **Individual responsible:** • Chief of Safety and Security **Date completed**: • August 31, 2017	

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K 920	Continued From page 29 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles 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. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 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. The findings include, but are not limited to: EXTENSION CORDS Extension cord and use building F6 room E-272. Extension cord and use building F 2 room F211 (fixed at the time of inspection.)	K 920		

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

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K 920	Continued From page 31 D011 fridge raider plugged into power strip. The above was discussed and acknowledged by the facility staff.	K 920		
K 921	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	**Plan of Correction for each specific deficiency cited:** (K 921) The hospital failed to safely fix electrical issues. To ensure that NFPA 101 Electrical Equipment - Testing and Maintenance is met the following corrections will be made: • The junction box covers will be replaced: -Building 27 Room 009 was missing a junction box. -The generator room in building 27/28 had an open junction box. -C2-234 open junction box, in interstitial space above ceiling -C5 has an open junction box. Interstitial space by room 215 at smoke separation doors. **Procedure/process for implementing the plan of correction:** • Work orders will be generated for assessment and repair of the above listed junction box deficiencies. • Maintenance to put a cover on junction boxes and complete the work orders. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Maintenance Supervisor 3's to monitor and track completion of work on site. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facility Manager will report completion of the repairs to the junction box covers to the Patient Care Quality Council and Governing Body. **Individual Responsible:** • The Chief Operating Officer	

			Date completed: • July 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING **01 - WESTERN STATE HOSPITAL** B. WING _____	**06/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	**9601 STEILACOOM BLVD SW TACOMA, WA 98498**

(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 921	Continued From page 32 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. The findings include, but are not limited to: OPEN JUNCTION BOXES: Building 27 Room 009 was missing a junction box. The generator room in building 27/28 had an open junction box. C2-234 open junction box. in interstitial space above ceiling C5 has an open junction box. interstitial space by room 215 at smoke separation doors. The above was discussed and acknowledged by the facility staff.	K 921		