| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505093 | A. Building<br>B. Wing | 08/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Orchard Park Health Care & Rehab Center | 4755 South 48th<br>Tacoma, WA 98409 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment when the fire alarm panel malfunctioned, and fire watch was not performed as directed. The failure to perform fire watch, in the absence of a functioning fire alarm system, would likely cause a delayed response if a fire were to occur, which placed residents at risk for smoke inhalation, burns, displacement from their homes, and death.Findings included .Review of the facility August 2018 Emergency Procedure - Fire Watch policy showed Fire Watch procedures would be initiated if the fire alarm system failed. The purpose of a Fire Watch is to serve as a plan of action should the fire alarm system fail to work properly to provide continuous facility-wide fire detection and alarm capabilities. Fire watch tours occur at one half hour intervals, 24 hours a day, and consist of a periodic walking tour of the entire facility by one or more assigned and trained staff. The fire watch staff monitors the facility through direct observation of all rooms, including resident rooms, mechanical and electrical rooms, for possible signs of fire. The fire watch staff consists of personnel solely dedicated to the fire watch with no other facility-related activities or events.According to a facility reported incident on 08/06/2025 the facility fire alarm system malfunctioned, with error codes on the screen. The Fire Alarm company determined faulty wires needed replacement. The Fire alarm system was turned offline and the facility implemented Fire Watch Protocols, every 15 minutes until the fire alarm system was repaired and back online.Review of the Fire Alarm Company workorder showed the techs were onsite from 3:15 PM to 5:00 PM on 08/06/2025 and placed the facility on modified fire watch.In an interview on 08/07/2025 at 12:47 PM, Staff C, Maintenance Director stated the fire alarm company disconnected the D Hallway on the [NAME] side of the facility, from the fire alarm panel so the trouble alarm would no longer alarm. Staff C stated the Fire Watch was only required on the D Hall.Review of the 08/07/2025 census showed 110 residents in the facility and 31 residents on the D Hall.On 08/07/2025 the investigator stood continuously at the entrance to D Hall, at the nurses' station, across from room [ROOM NUMBER] and 57 from 1:00 PM until 1:36 PM and no one was observed methodically going in and out of rooms looking for fires.On 08/07/2025 at 1:09 PM, Staff A, Administrator, came onto the unit and said the med nurse was assigned to perform fire watch. At 1:17 PM, Staff A stated that Staff C told them it was the nursing assistant that was supposed to be doing fire watch, not the nurse.During an interview on 08/07/2025 at 1:30 PM, when asked what a fire watch was Staff D, Nursing Assistant Certified (NAC), explained the actions they would take in the event of a fire drill, not a fire watch.During an interview on 08/07/2025 at 1:35 PM, Staff E, NAC, was able to describe what constituted a fire watch, in 15-minute intervals, and said they had performed fire watch in the past, but not on 08/06/2025 or 08/07/2025.On 08/07/2025 at 1:36 PM, Staff A stated that Staff F, Licensed Practical Nurse (LPN), was assigned Fire Watch, was returning from break and had the Fire Watch Log Sheet.During an interview on 08/07/2025 at 1:38 PM, Staff F stated they conducted fire watch at 1:00 PM before they went to lunch and at 1:30 PM when they returned. Review of the Fire Watch Log Sheet showed on Staff F signed off they conducted Fire Watch also at 1:15 PM. When asked about that, Staff F stated, That was in error.On 08/07/2025 at 1:39 PM Staff F (continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | was observed to conduct Fire Watch. Staff F walked down the hallway and said, I'm looking in each room, I don't see anything, I don't smell anything. Staff F opened the door of room [ROOM NUMBER] and room [ROOM NUMBER] respectively, popped their head in the room, but did not enter any of the rooms. When asked about training, Staff F said, That's all I was told to do, specifically, Maintenance told them to go down the hall and check each room for smoke and fire. If they saw or smelled smoke, they were to write it down in the comments. Staff F said at the end of their shift they passed the Fire Watch duty to the evening shift NAC. Staff F confirmed they were working administering medications on the D Hall and the NAC was assigned a run with residents to care for.Further review of the Fire Watch Log Sheet showed on 08/06/2025 evening shift Staff G, NAC was performing Fire Watch while they were assigned to care for residents on Run 4, in rooms 57-66A. On 08/06/2025 night shift, Staff H, NAC, was performing Fire Watch while they were assigned to care for residents on Run 2.During an interview on 08/07/2025 at 1:51 PM, Staff C stated dedicated staff were expected to make rounds every 15 minutes, open doors, walk into rooms and make sure there were no fires inside the room.During an interview on 08/07/2025 at 1:59 PM, Resident 1 stated they heard something about fire watch, but stated staff only went in the room once. During an interview on 08/07/2025 at 2:00 PM, Resident 2 stated, Not today. During an interview on 08/07/2025 at 2:02 PM, Resident 4 stated they knock on the door, the residents say to come in, the staff open the door, look inside and leave. They don't talk to us, don't say what they're doing. When asked about fire watch, Resident 4 stated, They didn't say anything about that. During an interview on 08/07/2025 at 2:03 PM, Resident 5 stated staff were not entering their room and making frequent rounds, no, nothing like that. During an interview on 08/07/2025 at 2:06 PM, Resident 6 stated staff were not checking their room for fires, and added, That's fine with me if they do. They have to do what they have to do. Similar findings were noted during interviews with Residents 7, 8, 9 and 10.On 08/07/2025 at 2:10 PM, Staff C stated the facility assigned Staff I, Maintenance Assistant, Fire Watch to a dedicated staff member, who had no additional duties and provided them training on how to conduct fire watch.REFERENCE: WAC 388-97-2080(1), -1660(1)(a). |