

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

Printed: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505188	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FEDERAL WAY		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003		
(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	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced a Fire and Life Safety re-certification survey conducted at the Life Care Center of Federal Way located at 1045 South 308th Street, Federal Way, WA on August 22, 2014 by a representative of the Office of the State Fire Marshal.</p> <p>This unannounced survey was conducted in cooperation with the Health Survey conducted by Washington State Department of Social and Health Services. The facility is two story of Type V (111) Construction with direct exiting to grade. The facility is protected by a Type 13 Automatic Fire Sprinkler System and an Automatic Fire Alarm System with corridor detection and manual pull stations. The census today is 105 with a capacity for 157. The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70.</p> <p>All critical systems are in service with appropriate documentation of service and inspections. The facility conducts fire drills 1 per shift per month and documents drills accordingly.</p> <p>The facility is in compliance with the Life Safety Code 2000 Edition as adopted by CMS. Following are the deficiencies cited as a result of this survey.</p> <p>The surveyor was:</p>  <p>Phil Cane Deputy State Fire Marshal</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

David Bellows

TITLE

JERRY BAHIANOVIC MAINT. SUPER.

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.