

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

Printed: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

1290

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2013
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NAME OF PROVIDER OR SUPPLIER BETHANY AT PACIFIC	STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE 3RD-5TH FLOORS EVERETT, WA 98201
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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 000	<p>INITIAL COMMENTS</p> <p>An unannounced Life Safety Code Survey was conducted at Bethany at Pacific, Everett, Washington, on May 21, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Oak Harbor Detachment. The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care.</p> <p>The LTC 111 bed facility with a census of 107, consisted of a TYPE I-443, 7 story structure, built in 1968 and has a basement area used for environmental services. The skilled nursing facility for this survey is located on floors 3, 4, and 5 of the hospital. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and have an all weather surface and lead to a public way.</p> <p>A Federal Life Safety Survey was conducted May 21, 2013. The Maintenance Director accompanied the Deputy State Fire Marshal throughout the facility tour and during the paperwork verification the hospital's facility manager was present from 9:15 AM to 2:30 PM. While conducting the survey on May 21, 2013, no deficiencies were found.</p> <p>The facility is in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p><i>Paul V. Schow</i> Deputy State Fire Marshal</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diana J. James</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>5/21/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.