

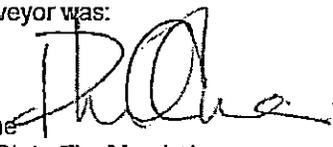
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

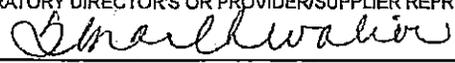
Printed: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505512	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GARDEN TERRACE B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2014
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NAME OF PROVIDER OR SUPPLIER GARDEN TERRACE ALZHEIMER'S CENTER O	STREET ADDRESS, CITY, STATE, ZIP CODE 491 SOUTH 338TH STREET FEDERAL WAY, WA 98003
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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
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K 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Garden Terrace, Federal Way WA on December 2, 2014 by a representative of the Washington State Patrol, Fire Protection Bureau Bellevue District Office.</p> <p>Garden Terrace at Federal Way has a total of 70 beds and at the time of this survey the census was 61.</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70.</p> <p>The facility is a 2 story structure of Type V-1hr construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way.</p> <p>All documentation of required system maintenance and testing was available for review. Fire Drills are being conducted at a rate of 1 drill per shift per month with appropriate documentation.</p> <p>The facility is in compliance with the 2000 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.</p> <p>The surveyor was:</p>  <p>Phil Cane Deputy State Fire Marshal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE DON	(X6) DATE 12-02-14
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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.