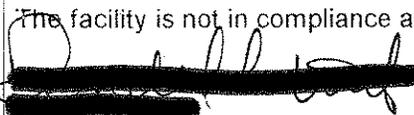


1352

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505270</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/28/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>PARK WEST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1703 CALIFORNIA AVENUE SOUTHWEST SEATTLE, WA 98116</b>
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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>Surveyor: 19192 On January 28, 2014 an unannounced fire and life safety code recertification survey was conducted at Park West Skilled Nursing Center located at 1703 California Ave SW Seattle WA 98116 by a representative of the Washington State Patrol, State Fire Marshal's Office. This survey was conducted using the 2000 life safety code in accordance with 42 CFR 483.70.</p> <p>This facility is a three story type V-A structure with a basement, the exiting is through rated stairwell enclosures and direct to grade from the main floor and basement, the building is protected throughout by a full NFPA 13 fire sprinkler system and automatic smoke detection in the corridors and common areas.</p> <p>The facility has a licensed capacity of 137 patients with a census today of 101.</p> <p>The facility is not in compliance at this time:</p> <p> Deputy State Fire Marshal</p>	K 000	<p><u>Disclaimer Clause</u></p> <p>Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</p> <p>K012 2/3/14 and ongoing</p> <p>The missing/ broken ceiling tiles in the laundry room have been replaced. The maintenance director will monitor the ceiling tiles for need of replacement during his preventative rounds. Ceiling tiles that are found to be in need of repair will be replaced in a timely manner.</p>	
K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Surveyor: 19192 During the facility tour on January 28, 2014 from</p>	K 012	<p>Variations will be forwarded to the Quality Assurance and Improvement Committee. Compliance will be assured by the Maintenance Director. 2/3/14 and ongoing</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>1/28/14</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.

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

Printed: 01/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505270</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/28/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>PARK WEST CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1703 CALIFORNIA AVENUE SOUTHWEST SEATTLE, WA 98116</b>		
(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 012	Continued From page 1 0830 to 1130 it was observed that the facility failed to maintain the fire resistive construction of the building, this has the potential for the spread of fire throughout the facility in the event of a fire. This finding was acknowledged at the time of the survey by the facility maintenance director.  The finding was but is not limited to:  1. In the laundry above the commercial dryers there are ceiling tiles that have holes in them and or are missing.	K 012		