

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

Printed: 12/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505270	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
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NAME OF PROVIDER OR SUPPLIER PARK WEST CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1703 CALIFORNIA AVENUE SOUTHWEST SEATTLE, WA 98116
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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>An unannounced Life Safety Code Complaint Investigation Survey was conducted at Park West Care Center, Seattle Washington, on December 3, 2014 by staff from the Washington State Patrol, Fire Protection Bureau, WSP- Bellevue District Office.</p> <p>The 2000 existing section of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care.</p> <p>Park West Care Center is a 137 bed facility with a census of 97 consisting of a Type II-A; 3 story structure built in 1961 and has 2 separate basements. 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>The complaint investigation was conducted in conjunction with the CMS Survey. During the Complaint Investigation the surveyor interviewed the facility Administrator, Maintenance Personnel and personnel in the area the fire occurred surveyor was also able to interview members of the Survey team that were present during the fire.</p> <p>The results of the Complaint Investigation are as follows:</p> <ol style="list-style-type: none"> 1) The fire occurred in a HVAC standalone unit, from an electrical short inside the unit itself. 2) Response to the emergency situation was prompt and per the facility emergency plan. 3) The unit was immediately removed from the area following assessment by the local AHJ. 	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J. Lindstrom</i>	TITLE <i>Payroll</i>	(X6) DATE <i>12-30-14</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.

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K 000

Continued From page 1
4) The unit has been replaced with a new HVAC, not refurbished or used.
5) No residents, staff or visitors were harmed during the event.

It appears this event could not have been prevented as it was an internal failure of the HVAC unit. The facility has an equipment maintenance program that was followed including this specific device. The response to this event by facility staff indicates to surveyor the fire drills are being conducted in a manner so as to adequately train staff to respond to fire emergencies.

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The Surveyor was:



Phil Cane
Deputy State Fire Marshal