

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

Printed: 05/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

1398

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505296</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>ST FRANCIS OF BELLINGHAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225</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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced Life Safety Code Survey was conducted at St Francis of Bellingham, Bellingham, Washington, on May 14, 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 120 bed facility with a census of 111, consisted of a Type V-111, 1 story structure which was built in 1984 and has no basement. 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 facility is in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>A Federal Life Safety Survey was conducted May 14, 2013. The Maintenance Director and Administrator accompanied the Deputy State Fire Marshal throughout the facility tour and the Maintenance Director was present for paperwork verification from 9:15 AM AM to 12:40 PM. While conducting the survey on May 14, 2013, no deficiencies were found.</p> <p><i>Paul V. Schou</i> Deputy State Fire Marshal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tonja Myers</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/14/13</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.