

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

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FORM APPROVED
OMB NO. 0938-0391

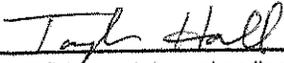
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 702 NORTH 16TH AVENUE YAKIMA, WA 98902
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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 a result of an unannounced Federal Life Safety re-certification survey conducted at Good Samaritan Health Care Center, 702 North 16th Avenue, Yakima, WA, on February 26, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Union Gap Detachment.</p> <p>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 Long Term Care 105 bed facility, census of 100 was provided by Administrator and verified by the Medical Records Staff. The facility consisted of construction type III (211) one story building. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade have been provided with an all weather surface and lead to a public way.</p> <p>The facility is in substantial compliance with the Life Safety Code 2000 Edition as adopted by C.M.S.</p> <p>The Surveyor was:  Deputy State Fire Marshal Nursing Home Surveyor 28058</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau 2715 Rudkin Road Union Gap, WA. 98903-1795 Telephone: (509) 575-2190 FAX: (509) 576-3002</p>	K 000	<p>RECEIVED</p> <p>MAR 08 2013</p> <p>FIRE PROTECTION BUREAU</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>2/26/13</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.