

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

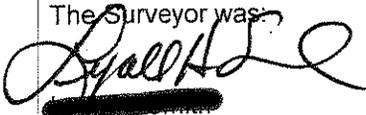
Printed: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

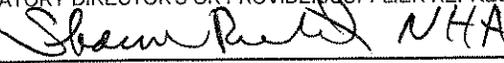
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2013
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NAME OF PROVIDER OR SUPPLIER PANORAMA CITY CONV & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 SLEATER KINNEY ROAD SE LACEY, WA 98503
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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 Fire and Life Safety re-certification survey conducted at the Panorama City Convalescent and Rehab Center on March 26, 2013, by a representative of the Washington State Fire Marshal. This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health and Services (DSHS).</p> <p>The new section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. This facility is a two story structure of type II-A. Construction with exits to grade and is protected by a Type 13 Fire Sprinkler system and an automatic fire alarm system with corridor smoke detection. The facility has 155 licensed beds and a current census of 146.</p> <p>There are no deficiencies noted at this time.</p> <p>The facility is in 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 08158</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau PO Box 42600 Olympia, WA 98504-2600 Telephone: (360) 596-3908 FAX: (360) 596-3934</p>	K 000	<p>RECEIVED MAR 27 2013 FIRE PROTECTION BUREAU</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  NHA	TITLE	(X6) DATE 3/26/13
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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.