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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A263	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2014
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NAME OF PROVIDER OR SUPPLIER LAKELAND VILLAGE NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE STATE HIGHWAY 902 & SALNAVE ROAD MEDICAL LAKE, WA 99022
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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>Surveyor: 28239 This report is a result of an unannounced Fire and Life Safety re-certification survey conducted on February 25, 2014 at Lakeland Village Nursing Facility SNF located at S 2320 Salnave Rd., Medical Lake, WA 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 Health and Human Services (DSHS).</p> <p>The existing section of the 2000 Life Safety Code was used in accordance with 42 CFR 483.70. This facility consists of seven single story structures of Type V (111) Construction with one of the structures attached as a wing off of the Administration Building. Exiting from all of the buildings is to grade. The census today is 84 with a capacity for 93. The building is protected throughout by a Type 13 Automatic Fire Sprinkler System and an Automatic Fire Alarm System with corridor smoke detection as well as smoke detection in the patient rooms of the SNF. Manual-pull stations are located at each exit.</p> <p>No deficiencies were cited as for this survey. The facility is found to be in compliance with 42 CFR Part 483, " Requirements for Long Term Care Facilities. "</p> <p>The Surveyor was: [Redacted Signature] Deputy State Fire Marshal Life Safety Code Inspector 28239</p> <p>The Surveyor was from: Washington State Patrol Fire Protection Bureau</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE FACILITY SERVICES ADMINISTRATOR	(X6) DATE 25 FEB 2014
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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: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

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K 000	Continued From page 1 2803 156th Ave SE Bellevue, WA. 98007 Telephone: (425) 401-7731 FAX: (425) 401-7842  28239	K 000		

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