STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055268	A. BUILDING 02 B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONOMA POST ACUTE	678 2ND STREET WEST SONOMA, CA 95476

(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
K 000	INITIAL COMMENTS Surveyor: 37135 K3 BUILDING: 01 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (000), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 37135 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 81	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Matt S | Administrator | 10/3/19

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.

Approved 10/15/19 per Janine Smith-Farmer

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K 161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by an unsealed penetration in the ceiling. This affected one of three smoke	K 161		

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K 161	Continued From page 2 compartments and could result in the spread of fire and smoke in the event of a fire. Findings: During a tour of the facility and interview with staff on 9/18/19, the walls and ceilings were observed. 1. At 10:30 a.m., the Director of Staff Development/Business Office was observed. There was a penetration located in the ceiling area near the southwest wall. The penetration was approximately 1 1/2 inch by 1 inch in size and had three gray cords and 3 blue cords going through it. Upon interview, the Maintenance Director confirmed this finding.	K 161		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review, observation, and interview, the facility failed to maintain the fire alarm system. This was evidenced by the absence of a charger test, a 30 minute discharge , and a load voltage test at installation for two of two sealed lead-acid back-up batteries on the fire	K 345		

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K 345	Continued From page 3 alarm control unit (FACU). This could potentially affect three of three smoke compartments and could result in system impairment during an emergency situation. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5 Testing Frequencies. 6. Batteries - fire alarm systems (d) Sealed lead-acid type (1) Charger test: Initial/Reacceptance and Annually (2) Discharge test (30 minutes): Initial/Reacceptance and Annually (3) Load voltage test: Initial/Reacceptance and Semiannually Findings: During document review, at tour of the facility and interview with staff on 9/18/19, the FACU back-up batteries were observed and records were requested.	K 345		

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K 345	Continued From page 4 At 8:40 a.m., the FACU was observed with two sealed lead-acid back-up batteries that were marked with the installation date of 8/2019. 1. At 9:30 a.m., there were no record provided that indicated that the batteries had a a charger test, a 30 minute discharge , and a load voltage test when they were installed in August of 2019. Upon interview, the Maintenance Director confirmed this finding and stated that they would be contacting the vendor to check if the test were completed. The facility was given until 5 p.m. on 9/18/19 to provide records for the battery testing to the California Department of Public Health (CDPH). At 5 p.m. on 9/18/19, CDPH did not receive battery testing records from the facility.	K 345		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by one extinguisher that was obstructed from accessing. This affected one of three smoke compartments and could result in the inability to locate and/or obtain the	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 5 extinguisher in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Extinguishers, 2010 Edition. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. Findings: During a tour of the facility and interview with staff on 9/18/19, the portable fire extinguishers were observed. 1. At 10:16 a.m., the ABC type portable fire extinguisher located in Dining Room 2 was observed. The extinguisher was obstructed from access by a portable fan that was stationed in front of the extinguisher. Upon interview, the Maintenance Director confirmed this finding and moved the fan.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		

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K 363	Continued From page 6 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility	K 363		

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K 363	Continued From page 7 failed to maintain the corridor doors. This was evidenced by one corridor door that did not latch when tested and one that was obstructed from closing. This could potentially affect two of three smoke compartments and could result in the spread of fire and/or smoke in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.6.3.10* Doors shall not be held open be devices other then those that release when the door is pushed or pulled. Findings: During a tour of the facility and interview with staff on 9/18/19, the corridor doors were observed. 1. At 10:10 a.m., the corridor door to Resident Room 3 was obstructed from closing by the foot of Bed A. Upon interview, the Maintenance Director confirmed this finding. 2. At 10:35 a.m., the corridor door to the Dirty Side of the Laundry Room did not latch when tested. The door was equipped with a self-closing device. Upon interview, the Maintenance Director confirmed this finding.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		

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K 511	Continued From page 8	K 511		

This REQUIREMENT is not met as evidenced by:
Surveyor: 37135

Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by an outlet adapter that was being used incorrectly. This affected one of three smoke compartments and could result in an electric fire.

NFPA 101, Life Safety Code, 2012 Edition.
19.5.1 Utilities.
19.5.1.1 Utilities shall comply with the provisions of Section 9.1.
9.1 Utilities
9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 70, National Electrical Code, 2011 Edition
110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. Informational Note: Accepted industry practices are described in ANSI/NECA 1-2006, Standard Practices for Good Workmanship in Electrical Contracting, and other ANSI-approved installation standards.

Findings:

During a tour of the facility and interview with staff on 9/18/19, the electric equipment was observed.

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K 511	Continued From page 9 1. At 10:22 a.m., the emergency double outlet located in the corridor area outside Resident Room 26 was observed. The outlet had a portable fan and a three outlet adapter plugged into it. The adapter had a portable speaker and a kiosk plugged into it. Upon interview, the Maintenance Director confirmed this finding.	K 511		

RECEIVED
By CDPH-LSC at 11:02 am, Oct 04, 2019

Sonoma Post Acute submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability.
The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders.
The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party.
Any changes to provider policy or procedures should be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.

K 161

What corrective action(s) have been accomplished for those residents found to have been affected by the deficient practice

The penetration in the ceiling was patched.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place

All other rooms were inspected for penetrations and none were identified.

What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur

The facility Maintenance Director will conduct weekly inspections of all rooms for penetrations. Any issues will be promptly addressed. Any penetrations identified by members of the team will be documented on the Maintenance request form located at the nurses station. This communication will ensure maintenance is notified and on each occasion a penetration is discovered.

How will the facility monitor its performance to make sure that solutions are sustained

The facility will monitor its performance to make sure the plan of correction is effective and sustained. The Maintenance Director will conduct weekly rounds in all rooms to inspect for penetrations. Any issues identified with this process will be submitted to the monthly Quality Assurance (QA) Committee for compliance review and recommendations.

Date of Correction: 10/5/19

K 345

What corrective action(s) have been accomplished for the deficient practice identified

The Maintenance Director was able to verify that a 30 minute discharge and load voltage test for the two sealed lead-acid back-up batteries was conducted upon installation.

How will the facility identify other areas that have the potential to be affected by the same deficient practice

No other areas have been affected.

What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur

The facility Maintenance Director will ensure all documents are collected for any project that takes place at the facility. This will include any and all tests required by CDPH.

How will the facility monitor its performance to make sure that solutions are sustained

The facility will monitor its performance to make sure the plan of correction is effective and sustained. The facility's Safety Committee will review each project closely to make sure all needed tests are completed and record is kept on file. Any issues identified with this process will be submitted to the monthly Quality Assurance (QA) Committee for compliance review and recommendations.

Date of Correction: 10/5/19

K 355

What corrective action(s) have been accomplished for the deficient practice identified

The Maintenance Director removed the fan on 9/18/19.

How will the facility identify other areas that have the potential to be affected by the same deficient practice

No other areas have been affected.

What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur

The facility Maintenance Director will inspect fire extinguishers daily to ensure nothing is obstructing access to them. Any issues will be resolved right away. Staff have been in-serviced to remove any obstructions blocking fire extinguishers as well.

How will the facility monitor its performance to make sure that solutions are sustained

The facility will monitor its performance to make sure the plan of correction is effective and sustained. The facility's Safety Committee will ensure all staff are aware of the importance of keeping fire extinguishers accessible at all times through in-services. Any issues identified with this process will be submitted to the monthly Quality Assurance (QA) Committee for compliance review and recommendations.

Date of Correction: 10/5/19

K 363

What corrective action(s) have been accomplished for the deficient practice identified

The Maintenance Director immediately removed the obstruction allowing the door to close. On 9/19/19 the Maintenance Director repaired the laundry room door allowing it to close and latch properly.

How will the facility identify other areas that have the potential to be affected by the same deficient practice

No other areas have been affected.

What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur

Staff were in-serviced to keep all doors free from obstruction so they are able to close when needed. Daily Room Rounds will be conducted by the management team to ensure doors are not blocked by any object.

The Maintenance Director will inspect all doors monthly to ensure the latching mechanism is working properly. Any issues will be fixed immediately and reported to the Safety Committee.

How will the facility monitor its performance to make sure that solutions are sustained

The facility will monitor its performance to make sure the plan of correction is effective and sustained. The facility's Safety Committee will review the Maintenance Directors inspections. Any issues identified with this process will be submitted to the monthly Quality Assurance (QA) Committee for compliance review and recommendations.

Date of Correction: 10/5/19

K 511

What corrective action(s) have been accomplished for the deficient practice identified

The Maintenance Director immediately removed the emergency outlet.

How will the facility identify other areas that have the potential to be affected by the same deficient practice

No other areas have been affected.

What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur

The facility Maintenance Director will conduct daily emergency outlet inspections to ensure no adapters are plugged into them. Any issues will be promptly corrected and reported to the Safety Committee. Staff have been in-serviced to document any issues on the maintenance request form located at the nurses station.

How will the facility monitor its performance to make sure that solutions are sustained

The facility will monitor its performance to make sure the plan of correction is effective and sustained. The facility's Safety Committee will ensure all staff are in-serviced on the importance of keeping emergency outlets maintained and used appropriately. Any issues identified with this process will be submitted to the monthly Quality Assurance (QA) Committee for compliance review and recommendations.

Date of Correction: 10/5/19