STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555268	A. BUILDING 01 B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE VILLAGE	5555 MONTGOMERY DRIVE SANTA ROSA, CA 95409

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1986 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V), 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 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 27893 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 49	K 000	Spring Lake Village Nursing Center (Facility) makes its best effort to operate in substantial compliance with both Federal and State Law. Nothing in this Plan of Correction is an admission otherwise. The facility has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. The facility is submitting this plan of correction as required by law as its written credible allegation of compliance for the alleged deficiencies noted.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by any of the findings on this life safety survey.	

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

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.

8/15/13 POC Acceptable per Robert Compton

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K 018	Continued From page 1 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their corridor doors. This was evidenced by two corridor doors that were obstructed from latching and one resident room door that was equipped with a door knob lock. This affected two of six smoke compartments and could result in a delay to contain smoke or fire to a room or a delay in accessing a room. Findings: During a facility tour with staff on 7/24/13, the doors in the facility were observed. 1. At 11:50 a.m., the corridor door to the Administrator's Office was equipped with a self-closing device and a magnetic hold-open device. The door was released from the hold-open device and allowed to close. The door failed to latch. The door was obstructed from latching by the door frame. 2. At 12:19 p.m., the corridor door to Physical Therapy (Room 141) was equipped with a	K 018	**How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected and therefore, the maintenance staff on August 2, 2013, adjusted the two doors in question to allow for proper closing and latching. The door handle in room 310 will be replaced with a non-locking handle. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Facilities Director will have the maintenance staff check all corridor doors as part of their monthly environmental rounds and adjustments will be made as necessary immediately to any doors out of compliance.	

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K 018	Continued From page 2 self-closing device. The door was opened to the fullest extent and allowed to close. The door failed to latch. The door was obstructed from latching by the door frame. 3. At 12:22 p.m., the corridor door to Resident Room 310 was equipped with a door handle key lock. The key slot was located on the room side of the door leaf. The corridor side of the door handle had no key slot or mechanism for operating the door lock.	K 018	**How facility plans to monitor its performance to make sure that solutions are sustained. The plan for ensuring that correction is achieved and sustained, the implementation date and evaluation of the plans effectiveness. The POC will be integrated into our quality assurance system.** Maintenance staff will report environmental rounds findings to the Facilities Director for review. Findings will be given to the facilities Quarterly Performance Improvement/Quality assurance meeting for evaluation of effectiveness and for any action plan that might be needed. **Date corrective action will be completed:** August 16, 2013	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain doors in a smoke barrier. This was evidenced by a pair of smoke barrier doors		**Corrective action for residents affected by alleged deficient practice:** No residents were affected by any of the findings on this life safety survey.	

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K 021	Continued From page 3 that failed to close upon activation of the fire alarm system. This affected two of six smoke compartments and could result in the spread of smoke or fire to other smoke compartments. Findings: During a facility tour with staff on 7/24/13, the smoke barrier doors in the facility were observed. 1. At 12:41 p.m., the smoke barrier doors separating the Garden Dining Room from the Mechanical Room Hall was observed. The doors had a 90 minute fire resistance rating and were located in a 2 hour rated fire wall. The doors were observed in the open position. The fire alarm system was activated at that time. The smoke barrier doors failed to close upon activation of the fire alarm system. Maintenance Staff 1 was interviewed at that time. Maintenance Staff 1 indicated the doors are delayed egress doors. Maintenance Staff 1 indicated that the area was originally designed to be a memory care wing.	K 021	**How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected in the event of a fire and the fact that these doors will not automatically close; therefore, until such time the facility can get the doors on our fire alarm system, these doors will remain closed. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Administrator, DON, Nursing Supervisors, DSD and Facilities Director will do periodic rounds to ensure compliance is upheld.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K029	**How facility plans to monitor its performance to make sure that solutions are sustained. The plan for ensuring that correction is achieved and sustained, the implementation date and evaluation of the plans effectiveness. The POC will be integrated into our quality assurance system.** Findings of environmental safety rounds will be brought to the Quarterly Performance Improvement/Quality Assurance Committee for evaluation and action plan as, or if needed. **Date corrective action will be completed:** August 2, 2013	

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a hazardous area. This was evidenced by one door to a hazardous area that was obstructed from latching. This affected one of six smoke compartments and could result in a delay to contain smoke or fire to a hazardous area. Findings: During a facility tour with staff on 7/24/13, the hazardous areas in the facility were observed. 1. At 12:11 p.m., the corridor door to the Refuse Room near Room 213 was equipped with a self-closing device. The door was opened to the fullest extent and allowed to close. The door failed to latch. The door was obstructed from latching by the door frame.	K 029	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by any of the findings on this life safety survey. **How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this and therefore; maintenance staff adjusted the door closure on the refuse room door to allow proper closure and latching on August 2, 2013. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Facilities Director will have the maintenance staff check all corridor doors as part of their monthly environmental rounds and adjustments will be made as necessary immediately to any doors out of compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic fire sprinkler system. This was evidenced by exterior sprinkler heads that had been painted. This affected six of six smoke compartments and could result in a failure	K 062		

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K 062	Continued From page 5 of the exterior automatic fire sprinkler heads. NFPA 25, 1998 edition 1-11.3 Corrective maintenance includes, but is not limited to, replacing loaded, corroded, or painted sprinklers; replacing missing or loose pipe hangers; cleaning clogged fire pump impellers; replacing valve seats and gaskets; restoring heat in areas subject to freezing temperatures where water-filled piping is installed; and replacing worn or missing fire hose or nozzles. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-4.1.8 Sprinklers shall not be altered in any respect or have any type of ornamentation, paint, or coatings applied after shipment from the place of manufacture. Findings: During a facility tour with staff on 7/24/13, the automatic fire sprinkler system was observed. 1. At 11:47 a.m., there were approximately 20	K 062	**How facility plans to monitor its performance to make sure that solutions are sustained. The plan for ensuring that correction is achieved and sustained, the implementation date and evaluation of the plans effectiveness. The POC will be integrated into our quality assurance system.** Maintenance staff will report environmental rounds findings to the Facilities Director for review. Findings will be given to the facilities Quarterly Performance Improvement/Quality assurance meeting for evaluation of effectiveness and for any action plan that might be needed. **Date corrective action will be completed:** August 2, 2013 **Corrective action for residents affected by alleged deficient practice:** No residents were affected by any of the findings on this life safety survey	

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K 062	Continued From page 6 sprinkler heads around the exterior of the building that were covered in a beige paint. The sprinkler heads were protecting the slotted wood beam overhangs. The entire sprinkler heads were covered in the beige paint.	K 062	**How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected and therefore, the Facilities Director had all of the sprinkler heads replaced on July 31, 2013, by Simplex Grinnell.	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their loosely hanging fabrics and decorations. This was evidenced by one loosely hanging fabric decoration that was not flame resistant and was not treated with a fire retardant substance. This affected one of six smoke compartments and could result in a fire to	~~K 074~~	**Measures or systemic changes made to ensure alleged deficient practice does not recur:** Facilities Director and or, his designee, will do rounds to ensure compliance following any contracted work that could affect the integrity of our sprinkler system. **How facility plans to monitor its performance to make sure that solutions are sustained. The plan for ensuring that correction is achieved and sustained, the implementation date and evaluation of the plans effectiveness. The POC will be integrated into our quality assurance system.** Facilities Director and or, maintenance staff will do environmental rounds monthly. Findings will be given to the facilities Quarterly Performance Improvement/Quality assurance meeting for evaluation of effectiveness and for any action plan that might be needed. **Date corrective action will be completed:** August 2, 2013	

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K 074	Continued From page 7 build and spread to other locations in the facility. NFPA 101, 2000 edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. Findings: During a facility tour with staff on 7/24/13, the facility's loosely hanging fabrics and decorations were observed. 1. At 12:12 p.m., there was one approximately four foot by four foot cloth tapestry decoration mounted to the corridor wall near the Beauty Salon. There were no records that indicated the decoration was made of fire resistant materials. There were no records that indicated the facility had treated the decoration with a fire retardant substance. Maintenance Staff 1 was interviewed at that time. Maintenance Staff 1 confirmed that the decoration had not been treated with a fire retardant substance.	K 074	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by any of the findings on this life safety survey. **How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Since all residents have the potential to be affected by this, the administrator will remove the tapestry off the wall as of August 16, 2013. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Facilities Director and or, administrator will monitor as part of monthly environmental rounds to ensure compliance. **How facility plans to monitor its performance to make sure that solutions are sustained. The plan for ensuring that correction is achieved and sustained, the implementation date and evaluation of the plans effectiveness. The POC will be integrated into our quality assurance system.** Administrator and or, Facilities Director will report environmental rounds findings to the facilities Performance Improvement/Quality Assurance meeting for evaluation of effectiveness and for any action plan that will needed. **Date corrective action will be completed:** August 9, 2013	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other	K 211		

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K 211	Continued From page 8 o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their installation of alcohol based hand rub dispensers. This was evidenced by the mounting of three alcohol based hand rub dispensers over ignition sources. This affected two of six smoke compartments and could result in an alcohol based hand rub ignited fire. Findings: During a facility tour with staff on 7/24/13, the alcohol based hand rub dispensers in the facility were observed. 1. At 12:29 p.m., an alcohol based hand rub dispenser in Room 305 was mounted on the wall approximately two feet above an electrical receptacle. The hand rub was 70 percent ethyl alcohol by volume. 2. At 12:33 p.m., an alcohol based hand rub dispenser in Room 302 was mounted on the wall approximately two feet above an electrical receptacle. The hand rub was 70 percent ethyl alcohol by volume.	K 211	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by any of the findings on this life safety survey. **How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected and therefore, the maintenance has relocated the three alcohol based dispensers to a location that meets the life safety standard as of August 9, 2013. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Facilities Director will have the maintenance staff monitor as part of their monthly environmental rounds.	

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K 211	Continued From page 9 3. At 12:41 p.m., an alcohol based hand rub dispenser in Shower Room 102 was mounted on the wall approximately three inches above an electrical receptacle. The hand rub was 62 percent ethyl alcohol by volume.	K 211	**How facility plans to monitor its performance to make sure that solutions are sustained. The plan for ensuring that correction is achieved and sustained, the implementation date and evaluation of the plans effectiveness. The POC will be integrated into our quality assurance system.** Maintenance staff will report environmental rounds findings to the Facilities Director for review. Findings will be given to the facilities Performance Improvement/Quality Assurance meeting for review. **Date corrective action will be completed:** August 9, 2013	