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

PRINTED: 06/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. BUILDING 01 B. WING	06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINE COUNTRY CARE CENTER	321 WEST TURNER ROAD LODI, CA 95240

(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 K3 BUILDING: 01 K6 PLAN APPROVAL: 1999 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE V WOOD FRAME CONSTRUCTION, 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: 27994 The facility is not in compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 83	K 000	WE ARE HEREBY SUBMITTING OUR PLAN OF CORRECTION FOR THE SURVEY COMPLETED ON JUNE 13, 2013. THIS IS OUR CREDIBLE ALLEGATION OF COMPLIANCE.	07/13/13
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of the building construction, as evidenced by unsealed	K 012	ALL WALL INTEGRITY WAS CHECKED DURING THE LIFE SAFETY SURVEY ON 06/13/13. 1. THE WALL PENETRATION IN ROOM 7 WILL BE SEALED BY MAINTENANCE PERSONNEL. AN OUTSIDE COMPANY WILL BE CONTRACTED TO ADD A CLOSET SPRINKLER. 2. CEILING SPRINKLER WILL BE SEALED IN ROOM 31	07/13/13

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

ADMINISTRATOR 06/28/13

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.

7/3/13 PoC Acceptable per Robert Compton, HFEIS II

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K 012	Continued From page 1 penetrations in the walls and ceilings. This affected 3 of 5 smoke compartments and could result in the increased potential for the spread of fire and smoke to other areas of the facility. Findings: During a facility tour and interview with staff on 6/13/13, the walls and ceilings were observed. 1. At 8:36 a.m., there was an approximately 1/8 inch penetration around a cable in the wall of Resident Room 7 behind bed Bed B. There was was also an approximately 41 1/2 inch by 16 inch cut-out in the closet with a screen mesh material tacked over the opening. The closet was 58 1/2 by 25 1/2 inches in size This Closet did not have a sprinkler in it. Maintenance Staff stated there was no sprinkler in the closet and was relying on the opening in the wall and the sprinkler in the bathroom for sprinkler coverage in the adjacent closet. 2. At 8:56 a.m., a sprinkler head was shifted to one side resulting in an approximately 1/4 inch penetration in the ceiling, in Room 31. 3. At 9:01 a.m., there were two approximately 1/8 inch penetrations behind the door, in the Dietary Storage Room. 4. At 9:05 a.m., there was an approximately 1/8 inch penetration in the ceiling, in the Kitchen Janitor Closet. 5. At 9:06 a.m., there was an approximately 1/4 inch penetration below a telephone plate in the wall, in the Kitchen.	K 012	CONTINUED FROM PAGE 1 BY AN OUTSIDE COMPANY, 3,4,&5: DIETARY STORE ROOM, KITCHEN PHONE, AND KITCHEN JANITOR CLOSET WILL BE SEALED BY THE MAINTENANCE DEPARTMENT. WALL PENETRATIONS AND SPRINKLER COVERAGE WILL BE ADDED TO THE MONTHLY MAINTENANCE CHECK LIST COMPLETED BY THE MAINTENANCE SUPERVISOR TO ENSURE WILL PENETRATIONS ARE REPAIRED WHEN THEY OCCUR. MONTHLY CHECK OFF LISTS WILL BE REVIEWED BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY FOR COMPLIANCE.	07/13/13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018	ROOM 38 AND THE ALZHEIMER DINING ROOM DOOR HAVE BEEN REPAIRED BY THE MAINTENANCE DEPARTMENT	07/13/13

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K 018	Continued From page 2 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 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 the corridor doors. This was evidenced by two doors that were obstructed and failed to latch. This affected 2 of 5 smoke compartments and could result in the inability to contain a fire quickly. Findings: During a tour of the facility with staff on 6/13/13, the corridor doors were observed. 1. At 9:24 a.m., the door to Room 38 failed to latch. 2. At 10:10 a.m., the self closing door to the Dining Room (Alzheimer Unit) failed to latch.	K 018	CONTINUED FROM PAGE 2 TO LATCH. ALL DOORS WERE CHECKED DURING THE SURVEY FOR CLOSING. ALL DOORS WILL BE CHECKED MONTHLY BY THE HOUSEKEEPING SUPERVISOR AND PLACED ON MONTHLY ROUND SHEETS. THE ROUND SHEETS WILL BE REVIEWED BY THE ADMIN-ISTRATOR MONTHLY. THE ROUND SHEETS WILL BE REVIEWED BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY FOR COMPLIANCE.	07/13/13

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K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, document review and interview, the facility failed to maintain their emergency exit signs. This was evidenced by emergency exit signs that were not tested for 90 minutes annually. This affected 5 of 5 smoke compartments, and could result in a delay in evacuation in the event of a power outage. NFPA 101, 2000 7.10.9.2 Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. A annual test shall be be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During tour, document review, and interview with	K 047	THE POLICY AND PROCEDURE FOR TESTING EXIT SIGNS WILL BE AMENDED TO ADD ANNUAL EXIT LIGHT TESTING BY THE ADMINISTRATOR. AN INSERVICE WILL BE DONE BY THE ADMINISTRATOR TO MAINTENANCE PERSONNEL FOR COMPLETED ANNUAL TESTING ON EXIT SIGNS. ANNUAL TESTS WILL BE REVIEWED BY THE QUALITY ASSURANCE COMMITTEE TO ENSURE ANNUAL TESTING OF EXIT SIGNS IS COMPLETE.	07/13/13

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K 047	Continued From page 4 staff on 6/13/13, the emergency exit signs were observed. 1. At 3:30 p.m., the facility had emergency exit signs throughout the building. The exit signs were observed with a test button on the side. 2. At 3:31 p.m., the documentation titled, "Exit Sign Log," indicated exit signs were tested monthly, but not annually. Maintenance stated that the facility did not do an annual test.	K 047		
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that their disaster manual provide a transfer agreement to other facilities for all residents in the event of a full evacuation of the facility. This was evidenced by the facility's failure to update their transfer agreement flow chart. This affected 83 of 83 residents, and could result in a delay in transferring resident to proper locations during an evacuation. Findings: During document review and interview with staff on 6/13/13, the transfer agreement was reviewed. At 2:50 p.m., the "Fire and Disaster Drills and Policies" for the "Casualty Flow Chart" indicated in the event of a critical situation, residents are to be transfer to an acute care hospital, and for	K 048	A NEW CONTRACT FOR NON-CRITICAL RESIDENTS WILL BE OBTAINED BY THE ADMINISTRATOR TO TRANSFER NON-CRITICAL RESIDENTS IN THE EVENT OF A DISASTER. THE CONTRACT WILL BE ADDED TO THE DISASTER MANUAL BY THE ADMINISTRATOR. THE DISASTER MANUAL WILL BE REVIEWED BY THE RESIDENT CARE COMMITTEE FOR APPROVAL OF THE POLICY. THE QUALITY ASSURANCE COMMITTEE WILL REVIEW POLICY AND PROCEDURE OF THE FACILITY QUARTERLY INCLUSIVE OF THE TRANSFER AGREEMENT.	07/13/13

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K 048	Continued From page 5 non-critical situations, residents are to be transfered to other health facilities. The fire disaster manual only list one hospital and an ambulance service, and no transfer agreement with other health facilities. Maintenance Staff stated that the manual did not list other health facilities, only the hospital.	K 048		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to	K 051	THE PULL STATION BY CENTRAL SUPPLY HAS BEEN REPLACED BY AN OUTSIDE CONTRACTOR. PULL STATIONS WILL BE ADDED TO THE MONTHLY MAINTENANCE CHECK LIST TO CHECK FOR PROPER OPERATION COMPLETED BY THE HOUSEKEEPING SUPERVISOR. THE ADMINISTRATOR WILL REVIEW MONTHLY MAINTENANCE LISTS AND REPORT FINDINGS TO THE QUALITY ASSURANCE COMMITTEE QUARTERLY FOR COMPLIANCE.	07/13/13

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K 051	Continued From page 6 maintain the fire alarm system devices. This was evidenced by a pull station handle that was partially sticking out of the box. This affected 1 of 5 smoke compartments, and could result in a delay in notification in the event of a fire. NFPA 101, 2000 9.6.2.6 Each manual fire alarm box on a system shall be accessible, unobstructed, and visible. Findings: At 8:30 a.m., a pull station by Central Supply corridor had the pull handle partially sticking out of the box.	K 051		
K 062 SS=D	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 the integrity of the automatic sprinkler heads. This was evidenced by sprinkler heads that had paint and dirt build up. This affected 3 of 5 smoke compartments, and could result in the ineffective operation of the automatic sprinkler system in the event of a fire. NFPA 25, 1998 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paints, and physical	K 062	ALL SPRINKLER HEADS WITH PAINT ON THEM WILL BE REPLACED BY AN OUTSIDE COMPANY. ANY DIRTY SPRINKER HEADS WILL BE CLEANED BY THE MAINTENANCE DEPARTMENT . SPRINKLER HEAD INTEGRITY WILL BE PLACED ON THE MAINTENANCE CHECK LIST FOR MONTHLY INSPECTIONS TO ENSURE SPRINKLERS ARE FREE OF DIRT AND PAINT. THE ADMINISTRATOR WILL REVIEW THE MONTHLY MAINTENANCE INSPECTIONS AND REPORT FINDINGS TO THE QUALITY ASSURANCE COMMITTEE QUARTERLY FOR MONITORING OF SPRINKLER HEADS.	07/13/13

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K 062	Continued From page 7 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. NFPA 13, 1999 3-2.6.3 Unless applied by the manufacture, sprinklers shall not be painted, and any sprinklers that have been painted shall be replaced with new listed sprinklers of the same characteristics, including orifice size, thermal response, and water distribution. Findings: During a tour of the facility with staff on 6/13/13, the sprinkler heads were observed. 1. At 8:35 a.m., a red bulb type sprinkler head in the Medical Record office had dirt build up. 2. At 8:47 a.m., a corridor sprinkler by Room 12 had paint on the spoke. 3. At 9:02 a.m., one of eight sprinkler heads in the Social Dining Room had lint build up in the spoke. 4. At 9:03 a.m., a sprinkler head in the outside Social Dining Room had a dirt build up. 5. At 9:04 a.m., three of six sprinkler heads in the Kitchen had paint on the frame and spoke. 6. At 9:06 a.m., a sprinkler head by the Kitchen corridor had paint on the deflector plate. 7. At 9:15 a.m., one of three sprinkler heads in the Dining Room (Alzheimer Unit) had a dirt and thread build up. 8. At 9:16 a.m., a sprinkler head by Room 45 had paint on the spoke. 9. At 9:35 a.m., one of four sprinkler heads in the	K 062		

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K 062	Continued From page 8 Main Office had paint on the spoke. 10. At 9:50 a.m., one of two sprinkler heads in the exterior Kitchen celling had a dirt build up.	K 062		
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the kitchen range exhaust hood system. This was evidenced by failing to have the dietary exhaust hood system cleaned, inspected, and serviced at least every six months, or more frequently, if necessary. This affected 1 of 5 smoke compartments, and could result in increased potential for ignition of the accumulated grease particulate matter in the dietary hood exhaust system. Findings: During document review with staff on 6/13/13, the dietary hood exhaust system record were reviewed. At 3:25 p.m., the "Maintenance Binder" indicated that the cleaning was conducted 8 month apart instead of every 6 months. Documentation showed that the cleaning was done on 3/15/13 and 7/11/12.	K 069	THE EXHAUST HOOD SCHEDULING WILL BE CHANGED BY THE DIETARY SERVICE SUPERVISOR TO OCCUR EVERY SIX MONTH INTERVALS TO ENSURE GREASE PARTICULATE MATTER IS NOT PRESENT. THE KITCHEN HOOD CLEAMING WILL BE REVIEWED BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY TO ENSURE CLEANING OCCURS AT THE CORRECT INTERVAL.	07/13/13
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072	CORRIDOR FURNITURE WILL BE RELOCATED BY MAINTENANCE PERSONAL TO RESIDENT ROOMS AND/OR DINING AREAS FREEING CORRIDORS FROM ANY FURNI-TURE.	07/13/13

Paul Abell Administrator 7/5/13

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K 072	Continued From page 9 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the full width of the corridors. This was evidenced by items that were stored in the corridors, obstructing the corridors, and impeding the path of egress. This affected 3 of 5 smoke compartments, and could result in the potential delay in evacuating the facility, in the event of an emergency. Findings: During a tour of the facility with staff on 6/13/13, the corridors were observed. At 11:13 a.m., there three approximately four foot long love seats stationed in the Alzheimer corridor for a long period of time obstructing egress and the handrail.	K 072	CONTINUED FROM PAGE 9 AN INSERVICE WILL BE DONE BY THE DIRECTOR OF STAFF DEVELOPMENT TO ALZHEIMER UNIT STAFF TO MOVE SITTING AREAS. CHARGE NURSES WILL MONITOR UNOBSTRUCTED HALLS DAILY DURING MEDICATION PASSES. THE HOUSEKEEPING SUPERVISOR WILL REVIEW ALZHEIMER UNIT FURNITURE DURING MONTHLY ROUND CHECKS. THE ROUND CHECKS WILL BE REVIEWED BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY FOR COMPLIANCE.	07/13/13
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that decorations were flame retardant. This was evidenced by two rooms that had combustible decorations on the walls. This affected 2 of 5 smoke compartments, and could	K 073	A SURVEY WAS DONE ON PERSONAL HOME LIKE ITEMS IN RESIDENT ROOMS. SADLY FOR THE RESIDENTS THEY WILL BE REMOVED IN ROOM 9 AND ROOM 23. AN INSERVICE WILL BE DONE BY HOUSEKEEPING SUPERVISOR TO NURSING STAFF AND SOCIAL SERVICES THAT FLAMMABLE ITEMS CANNOT BE HUNG ON WALLS.	07/13/13

Administrator 7/7/13

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K 073	Continued From page 10 result in a fire to build and spread to other locations of the facility. Findings: During a tour and interview with staff on 6/13/13, furnishings and decorations were observed. 1. At 8:46 a.m., there were four T-shirts tacked on the wall, near Bed B Room 9. Maintenance stated the four T-shirts were not tested for flame retardant. 2. At 8:50 a.m., there was a large banner size fabric tacked to the wall behind Bed A Room 23. Maintenance stated the fabric was not tested for flame retardant.	K 073	CONTINUED FROM PAGE 10 ROOMS WILL BE MONITORED DAILY DURING RESIDENT ROUNDS TO ENSURE NO FLAMMABLE ITEMS ARE ON WALLS. ROOM DECORATIONS WILL BE MONITORED AND REMOVED IF FLAMMABLE. ITEMS REMOVED WILL BE REPORTED BY THE HOUSEKEEPING SUPERVISOR TO THE QUALITY ASSURANCE COMMITTEE QUARTERLY.	07/13/13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their oxygen storage. This was evidenced by empty and full oxygen cylinders that	K 076	AN OXYGEN SIGN HAS BEEN PLACED ON THE ALZHEIMER OXYGEN STORAGE AREA. CYLINDERS WERE SEPARATED IN THE SURVEY. AN INSERVICE WILL BE DONE BY THE DIRECTOR OF STAFF DEVELOPMENT TO NURSING STAFF ON SEPARATED EMPTY AND FULL OXYGEN CONTAINERS. THE OXYGEN CLOSETS WILL BE PLACED ON MONTHLY ROUND SHEETS FOR MONITORING OF FULL AND EMPTY OXYGEN CONTAINERS. THE ROUND SHEETS WILL BE REVIEWED BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY FOR COMPLIANCE.	07/13/13

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	055289	A. BUILDING 01 B. WING	06/13/2013

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K 076	Continued From page 11 were stored together. This affected 2 of 5 smoke compartments, and could result in staff being unable to differentiate between empty and full cylinder, in the event of a emergency. NFPA 99, 4-3.5.2.2 (2) If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. Findings: During a tour of the facility with staff on 6/13/13, the oxygen storage were observed. 1. At 8:43 a.m., there were three full E tanks mixed with one empty E tank, in the Oxygen Storage Room near Room 8. It is acceptable to have empty and full cylinders in the same enclosure, but they should be physically separated. 2. At 9:14 a.m., there was no "No Smoking" sign on the Oxygen Storage Room door in the Alzheimer unit.	K 076		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	AN OUTSIDE COMPANY WILL BE CONTACTED BY THE ADMINISTRATOR TO REPROGRAM THE COMPUTER TO HAVE THE GENERATOR RUN UNDER FULL LOAD FOR 30 CONTINUOUS MINUTES WHEN THE EXERCISE OF THE GENERATOR OCCURS. THE MAINTENANCE SUPERVISOR WILL CONTINUE TO LOG GENERATOR TESTS TO ENSURE 30 MINUTE	07/13/13

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K 144	Continued From page 12 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that their emergency power was maintained in accordance with NFPA 110, 1999 edition. This was evidenced by no monthly full load test for a 12 months period. This affected 83 of 83 residents, and could potentially result in a generator failure during an emergency. NFPA 110, 1999 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes. Findings: During document review and interview with staff on 6/13/13, the generator records were requested. At 2:13 p.m., documentation titled, "Generator Weekly Exercise" indicated that tests were conducted two times a month for 15 minute each. The documentation failed to indicate if the generator was run under load. The documentation show the dates and initials of the person performing the test. Maintenance stated that the generator comes on by itself bi-weekly and it is run for 15 minute each time, to get the 30 minutes for the month.	K 144	CONTINUED FROM PAGE 12 OPERATION. THE ADMINISTRATOR WILL REVIEW THE MONTHLY REPORT FOR CORRECTIONS AND TIME ADJUSTMENTS IF NEEDED. THE MONTHLY REPORTS AND MAINTENANCE OF THE GENERATOR WILL BE REPORTED TO THE QUALITY ASSURANCE COMMITTEE BY THE ADMINISTRATOR QUARTERLY TO ENSURE CORRECT OPERATION.	07/13/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	THE SURGE PROTECTORS, ADAPTER OUTLETS, AND	07/13/13

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K 147	Continued From page 13 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the electrical safety. This was evidenced by the use of extension cords, powerstrips that were chained together, and surge protectors being used for medical devices and personal items. This affected 2 of 5 smoke compartments, and could result in an increased risk of an electrical fire. NFPA 70, 1999 110-12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (c) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or	K 147	CONTINUED FROM PAGE 13 EXTENSION CORD HAVE BEEN REMOVED FROM THE AFFECTED AREAS. AN AUDIT OF THE BUILDING FOR ANY OF THESE DEVOCES WAS COMPLETED 06/13/13 DURING THE SURVEY. SURGE PROTECTORS SHOULD NOT BE USED AT ANY TIME. THE MAINTENANCE SUPERVISOR ON MONTHLY ROUNDS WILL REMOVE ANY OF THE ABOVE MENTIONED DEVICES AND PLUG EQUIPMENT DIRECTLY INTO OUTLETS. THE REMOVAL OF ITEMS WILL BE REVIEWED MONTHLY BY THE ADMINISTRATOR THE EQUIPMENT MONITORING WILL ALSO BE EVALUATED BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY UPON THE ADMINISTRATOR REPORT TO ENSURE COMPLIANCE.	07/13/13

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K 147	Continued From page 14 floors. (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. 400-10. Flexible cords and cables shall be connected to devices and to fittings so that tension will not be transmitted to joints or terminals. Findings: During a tour of the facility with staff on 6/13/13, the electrical wiring and utilities were observed. 1. At 9:00 a.m., a lamp, a phone, and an oxygen concentrator were plugged into a three plug adapter in Room 39. 2. At 9:40 a.m., a white surge protector was plugged into a gray wall surge protector that was connected to a white refrigerator on the left side of the room. A white surge protector was plugged into a gray wall surge protector on the right side of the wall in the Main Office. 3. At 9:43 a.m., a light was plugged into a white extension cord in Room 3.	K 147		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler	K 154	THE FIRE WATCH POLICY AND PROCEDURE WILL BE AMENDED BY THE ADMINISTRATOR TO INCLUDE THE NOTIFICATION TO THE DEPARTMENT OF PUBLIC HEALTH IF THE SPRINKLER OR ALARM SYSTEM IS UNOPERATIONAL	07/13/13

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K 154	Continued From page 15 system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that the authority having jurisdiction was notified in the event that their automatic sprinkler system was out of service for four or more hours in a 24 hour period. This was evidenced by a lack of documentation and staff knowledge for this requirement. This affected all staff and residents in 5 of 5 smoke compartments within the facility and could potentially result in the AHJ being unable to exercise oversight in the event of a fire alarm system shut down. Findings: During document review and interview with staff on 6/13/13, the fire watch sprinkler policy was reviewed. At 2:55 p.m., documentation provided for an approved fire watch did not include guidance for the notification of the California Department of Public Health (CDPH) if the fire sprinkler system was out of service for four or more hours in a 24 hour period. Maintenance stated that the policy did not provide information for notification to CDPH in the event of a sprinkler system issue.	K 154	CONTINUED FROM PAGE 15 FOR MORE THAN 4 HOURS. THE POLICY WILL BE REVIEWED BY THE RESIDENT CARE COMMITTEE AND ADOPTED INTO THE REVIEW BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY TO ENSURE CORRECT FIRE WATCH COMPLIANCE POLICY AND PROCEDURE.	07/13/13
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the	K 155	THE FIRE WATCH POLICY AND PROCEDURE WILL BE AMENDED BY THE ADMINISTRATOR TO INCLUDE THE NOTIFICATION OF THE DEPARTMENT OF	07/13/13

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K 155	Continued From page 16 building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that the authority having jurisdiction was notified in the event that their fire alarm system was out of service for four or more hours in a 24 hour period. This was evidenced by a lack of documentation and staff knowledge for this requirement. This affected all staff and residents in 5 of 5 smoke compartments within the facility and could potentially result in the AHJ being unable to exercise oversight in the event of a fire alarm system shut down. Findings: During document review and interview with staff on 6/13/13, the fire watch fire alarm policy was reviewed. At 2:55 p.m., the documentation provided for an approved fire watch did not include guidance for the notification of the California Department of Public Health (CDPH) if the fire alarm system was out of service for four or more hours in a 24 hour period. Maintenance stated that the policy did not provide information for notification to CDPH in the event of a fire alarm issue.	K 155	CONTINUED FROM PAGE 16 PUBLIC HEALTH IF THE SPRINKLER OR ALARM SYSTEM IS UNOPERATIONAL FOR MORE THAN 4 HOURS. THE POLICY WILL BE REVIEWED BY THE RESIDENT CARE COMMITTEE AND ADOPTED INTO THE REVIEW BY THE QUALITY ASSURANCE COMMITTEE QUARTERLY TO ENSURE CORRECT FIRE WATCH COMPLIANCE POLICY AND PROCEDURE.	07/13/13