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

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	02/18/2015

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

(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: 12/4/1986 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (III), 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: 31201 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 64	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 obligations 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 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations	K 018	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by this alleged deficient practice and the door latch to room 109 was adjusted to meet the standard immediately after the finding.	

[redacted] TIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/9/15

ABORATOR

...ny deficiency ...ciency which the institution may be excused from correcting providing it is determined th... ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 ...ys ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosabl... ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continu... rogram participation.

3/16/15 - POC Acceptable per Robert Compton

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K 018	Continued From page 1 in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its corridor doors. This was evidenced by a corridor door that failed to close and positively latch. This could result in the passage of smoke in the event of a fire, and affected one of six smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with	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:** Since all of our residents have the potential to be affected, the door latch to room 109 was adjusted to be in compliance immediately. Facility Administrator and or a designee will ensure compliance through monthly management rounds. Facility Director will have the doors evaluated for compliance through routine maintenance rounds that happen twice a week. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** All of the doors in the Health Care Center have been re-evaluated for compliance. Any doors found out of compliance through Administrative and Maintenance rounds will be fixed immediately. **How facility plans to monitor its performance to make sure the solutions are sustained, evaluation of the plans effectiveness and the integration of the POC into our quality assurance program:** Monitoring will be done by Facility Administrator and or the Facility Director, or designee through daily and monthly rounds. Any patterns of non-compliance	

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K 018	Continued From page 2 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. Findings: During a tour of the facility with the Director of Facilities on 2/18/15, the corridor doors were observed. At 1:37 p.m., the door to Room 109 failed to latch when manually tested. When interviewed, the Director of Facilities confirmed the finding and stated that the striker plate needed adjusting.	K 018	with this recommendation will be submitted to the Quality Assurance Committee for review and recommendations as needed. **Completion Date:** March 18, 2015 **K 062** **Corrective action for residents affected by alleged deficient practice:** No residents were affected by this alleged deficient practice. The box was immediately removed to ensure compliance of the standard. **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 the Administrator will have the Certified Nursing Assistants re-educated by March 18 2015 to this standard as part of their daily room and resident care.	3/18/15
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	K 062		

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K 062	Continued From page 3 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 and interview, the facility failed to maintain its sprinklers as evidenced by a sprinkler that did not have at least 18 inch clearance between the deflector and the top of the storage. This could result in a sprinkler malfunction in the event of a fire and affected one of six smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection System, 1998 Edition 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	K 062	**Measures or systemic changes made to ensure alleged deficient practice does not recur:** Facility Administrator and Director of Staff Development will ensure compliance through monthly environmental and safety rounds. **How facility plans to monitor its performance to make sure the solutions are sustained, evaluation of the plans effectiveness and the integration of the POC into our Quality Assurance Program:** Monitoring will be conducted through monthly rounds by the Administrator and or, DSD to ensure compliance. Reports of rounds will be given to the monthly Quality Assurance Committee to track and trend compliance. Any findings that are not in compliance will be corrected immediately and staff education provided. **Completion Date:** March 18, 2015	3/18/15

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FORM APPROVED
OMB NO. 0938-0391

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K 062	Continued From page 4 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. NFPA 13, Installation of Sprinkler Systems, 1999 Edition 5-5 6" Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Exception No. 1: Where other standards specify greater minimums, they shall be followed. Exception No. 2: A minimum clearance of 36 in. (0.91 m) shall be permitted for special sprinklers. Exception No. 3: A minimum clearance of less than 18 in. (457 mm) between the top of storage and ceiling sprinkler deflectors shall be permitted where proven by successful large-scale fire tests for the particular hazard. Exception No. 4: The clearance from the top of storage to sprinkler deflectors shall be not less than 3 ft (0.9 m) where rubber tires are stored. Findings: During a tour of the facility with the Director of Facilities on 2/18/15, the sprinklers in the facility were observed. At 1:43 p.m., a box was approximately 12 inches below the sprinkler deflector in closet B of Room 105. When interviewed, the Director of Facilities confirmed the finding and removed the box.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	**K 147** **Corrective action for residents affected by alleged deficient practice:** No residents were affected by this alleged deficient practice. All of the rooms in question were corrected February 19, 2015 by removing the medical equipment from the Universal Power Supply directly into a wall outlet and the face plate was installed in room 113 where it was missing.	

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K 147	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its electrical wiring and equipment. This was evidenced by the use of Universal Power Supply (UPS)/Surge Protectors and a missing faceplate. This deficient practice affected two of six smoke compartments and could result in the ignition of an electrical fire. NFPA 101, Life Safety Code, 2000 Edition 4 6 12 Maintenance and Testing 4 6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used	K 147	**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 capacity to be affected, all Nursing staff will be educated to this life safety code by March 18, 2015. Monitoring for compliance will be conducted by the Administrator and or DSD as part of monthly environmental/safety rounds. Findings will be fixed immediately and education given. **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Education to all Nursing staff will be given in regards to this life safety code by March 18, 2015, to ensure that equipment is plugged in safely and to notify Maintenance of any damage found in Residents room to electrical plate coverings for prompt repair.	

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K 147	Continued From page 6 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 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 410-56(e) After installation, receptacle faces shall be flush with or project from faceplates of insulating material and shall project a minimum of 0.015 in. (0.381 mm) from metal faceplates. Faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Findings: During a tour of the facility with the Director of Facilities on 2/18/15, the electrical wiring and equipment were observed. 1. At 11:20 a.m., a Feeding Machine was plugged into a Universal Power Supply/Surge Protector instead of directly into the wall outlets, in Room 310 by Bed A. 2. At 1:18 p.m., an Oxygen Concentrator was plugged into a Universal Power Supply/Surge Protector instead of directly into the wall outlets, in Room 305 by Bed B.	K 147	**How facility plans to monitor its performance to make sure the solutions are sustained, evaluation of the plans effectiveness and the integration of the POC into our Quality Assurance Program:** Findings of Administrative, or DSD rounds will be submitted to the QAPI Committee monthly for three months to ensure compliance and quarterly thereafter for review and recommendations. **Completion Date:** March 18, 2015 3/18/15	

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K 147	Continued From page 7 3. At 1:33 p.m., there was a missing faceplate, in Room 113. When interviewed, the Director of Facilities confirmed the finding and stated that he was not aware of the missing faceplate.	K 147		