PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

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
	555772	A. BUILDING 01 B. WING	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT MANOR	8515 CHOLLA AVE YUCCA VALLEY, CA 92284

(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: 2001 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE V (111), FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification 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: Surveyor: 21101 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 56	K 000	Braswell's (Desert Manor) (hereafter referred to as "BDM" makes its best effort to operate in full compliance with both Federal and State law. Nothing included in this plan of correction is an admission otherwise. BDM 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 of any allegations contained herein. Although there is no plan to do so at this time, please note that Braswell's Desert Manor may contest the merits/and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them.	
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	K 021	**K 021** **It is the policy and practice of BDM to maintain the magnetic door hold open devices, to be tested and functional.** **Corrective action(s) taken for the alleged deficient practice:** **On 2-12-13 the magnetic door hold open devices was repaired by an outside service company to properly release door when the fire alarm system is activated.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bricitta Grimaldi   TITLE: Adm   (X6) DATE: 2-18-13

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.

2/19/13 POC Acceptable per Maxine McKaig, HFES

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K 021	Continued From page 1 c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain horizontal exit doors equipped with magnetic hold-open devices. This was evidenced by one door that failed to release and close automatically upon activation of the fire alarm system. This affected one of two smoke compartments and could allow the passage of smoke and fire to other locations in the facility. Findings: During the testing of the fire alarm system with maintenance on 2/5/13, the doors equipped with hold-open devices were observed. At 2:15 p.m., the corridor door to the dining/television room was equipped with a magnetic hold-open device. The door failed to release from the magnetic hold-open device when the fire alarm system was activated. This was acknowledged by maintenance during the testing of the fire alarm system.	K 021	**How other items having the potential to be affected by the same alleged deficient practice will be identified:** **No other magnetic hold open device was affected by the deficient practice.** **What measures or systemic changes will be implemented to prevent recurrence of the alleged deficient practice?** **Starting on 2-28-13 under the supervision of the Administrator systemic change will be achieved by the adoption of a monthly monitoring process of conducting visual audits by maintenance to assure magnetic release device is functioning as required.** **How the facility will monitor its performance for ongoing compliance and who will oversee this plan: .** **On a quarterly basis the Administrator will be responsible to present audits to the QA Committee for oversight and review to assure that the deficient practice does not recur.** **Date corrective action will be completed:** **2-28-2013.**	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches	K 027		

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K 027	Continued From page 2 from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke barriers doors. This was evidenced by one of one smoke barrier doors that failed to latch. This affected two of two smoke compartments and could result in the spread of fire and smoke from one smoke compartment to another. Findings: During the testing of the fire alarm system with maintenance on 2/5/13, the smoke barrier doors were observed. At 2:23 p.m., the smoke barrier door leaf near resident room 105 failed to latch upon activation of the fire alarm system. This was acknowledged by maintenance during the fire alarm testing.	K 027	K 027 It is the policy of BDM to maintain and monitor the smoke barrier doors to latch upon activation of the fire alarm system. Corrective action(s) taken for the alleged deficient practice: On 2-6-2013 the Maintenance Man repaired the smoke barrier door near room 105 to latch upon activation of the fire alarm system. The Fire door latches freely as required by NFPA Life Safety Code. How other items having the potential to be affected by the same alleged deficient practice will be identified. No other smoke barrier doors were affected by this deficient practice. What measures of systemic changes will be implemented to prevent recurrence of the alleged deficient practice: Starting on 2-28-13 under the supervision of the Administrator systematic change will be achieved by the adoption of a monthly monitoring process of conducting a visual audit of smoke barrier door by maintenance Supervisor to ensure proper latching of doors as required. How the facility will monitor its performance for ongoing compliance and who will oversee this plan: On quarterly basis the Administrator will be responsible to present audit to the QA Committee for oversight and review to assure that the deficient practice does not recur.	
K 051 SS=E	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	K 051		

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K 051	Continued From page 3 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 maintain their fire alarm system. This was evidenced by the failure of an audible device and one smoke detector. This affected two of two smoke compartments and could result in a delayed notification of a fire in the facility. NFPA 101, Life Safety Code (2000 Edition) 19.3.4.3.1 Occupant Notification. Occupant notification shall be accomplished automatically in accordance with 9.6.3. 9.6.3 Occupant Notification. 9.6.3.2 Notification shall be provided by audible and visible signals in accordance with 9.6.3.3 through 9.6.3.12 Findings:	K 051	**Date corrective action was/will be completed: 2-28-13** **K 051** **It is the policy of BDM to maintain and monitor the fire alarm system to prevent malfunctioning of fire alarm chimes and smoke detectors.** **Corrective action(s) taken for the alleged Deficient practice:** **1. On 2-12-13 the fire alarm chime was replaced by outside service company to continuously provide an audible alarm when activated.** **2. on 2-12-13 the smoke detector located in the corridor near residents room 111 was replaced by outside service company and is activating fire alarm system as required.** **How other fire alarm chimes and smoke detectors having the potential to be affected by the same alleged deficient practice:** **No other fire alarm chimes and smoke detectors were identified to be affected by this deficient practice.** **What measures of systemic changes will be implemented to prevent recurrence of the alleged deficient practice:** **Starting on 2-28-13 under the supervision of Administrator the fire alarm chime bell and smoke detectors will be tested monthly by Maintenance Supervisor to ensure proper functioning with the fire alarm system.**	

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K 051	Continued From page 4 During the testing of the fire alarm system with maintenance on 2/5/13, the fire alarm system devices were observed. 1. At 2:16 a.m., the fire alarm chime in the dining/television room failed to continuously provide an audible alarm. The device chimed once the stopped. This was acknowledged by maintenance during the testing of the fire alarm system. 2. At 2:20 p.m., the smoke detector located in the corridor near resident room 111 failed to activate the fire alarm system when tested. Three attempts were made by maintenance to activate the smoke detector. Three of three attempts failed to activate the device.	K 051	**How the facility will monitor it performance for ongoing compliance and who will oversee plan:** **On quarterly basis the administrator will be responsible to present audits to the QA Committee for oversight and review to assure that the deficient practice does not recur.** **Date corrective action will be completed:** **2-28-2013**	
K 061 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based observation and interview, the facility failed to ensure staff are instructed in life safety procedures and devices. This was evidenced by staff that were not familiar with the procedures or function of the tamper alarm. This affected two of two smoke compartments and could result in staff not knowing what to do in the event of an interruption of water supplied to the automatic fire	K 061	**K 061** **It is the policy of BDM to instruct and educate staff members in the life safety procedures and devices.** **Corrective action(s) taken for the alleged deficient practice:** **Staff members will be in serviced by administrator on the function of the tamper switch and sound of alarm in the event the alarm was activated on the main fire sprinkler riser by 2-25-13**	

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K 061	Continued From page 5 sprinkler system. NFPA 101 Life Safety Code 2000 Edition 9.7.2 Supervision. 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility 19.7 Operating Features 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. Findings: During the testing of the automatic fire sprinkler system with maintenance on 2/5/13, staff was interviewed. At 2:34 p.m., the tamper alarm on the main fire sprinkler riser was activated. This simulated the suspension in water supplied to the facility's automatic fire sprinkler system. A faint audible alarm annunciated at the fire alarm sub-panel	K 061	**How other staff having the potential to be affected by the same alleged deficient practice will be identified.** **All staff will be in serviced on the function of the tamper switch and sound of alarm in the event alarm was activated on the main fire sprinkler riser.** **What measures of systemic changes will be implemented to prevent recurrence of the alleged deficient practice.** **Starting immediately new hired staff will be oriented to the function of the tamper switch. Staff will be in serviced quarterly by DSD on emergency fire procedures and function of the tamper switch on the main fire sprinkler riser and will be able to identify sound of alarm of the tamper switch.** **How the facility will monitor its performance for ongoing compliance and who will oversee this plan:** **On quarterly basis the Director of Staff development will be responsible to present results of audits of interview of staff members to QA Committee for oversight and review to assure that the deficient practice does not recur.** **Date corrective action will be completed:** **2-25-2013**	

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K 061	Continued From page 6 located at the nurse station. Three staff members were interviewed at that time. Three of three staff members interviewed were unaware of the function of the alarm. Three of three staff members interviewed did not know what emergency procedures to follow in the event the alarm was active.	K 061	**K 144** **It is the policy of BDM to inspect generators weekly and exercise under full load 30 minutes per month.**	
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. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the emergency generator. This was evidenced by incomplete documentation for weekly visual inspections of the generator and by the failure to exercise the generator for 30 minutes once per month. This affected two of two smoke compartments and could result in a emergency generator malfunction Findings: During document review and interview with maintenance on 2/5/13, the emergency generator logs were reviewed.	K 144	**Corrective action(s) taken for the alleged deficient practice.** **Maintenance Supervisor was instructed immediately to assure that generator is exercised under full load for 30 minutes and record test on generator log accordingly. Written procedure was given to Maintenance Supervisor by Administrator.** **How other staff having the potential to be affected by the same alleged deficient practice will be identified.** **No other staff members are involved in the testing and recording of generator tests.** **What measures of systemic changes will be implemented to prevent recurrence of the alleged deficient practice.** **Administrator will review generator log on a monthly basis to assure generator is exercised under full load for 30 minutes and time is recorded on generator log.**	

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K 144	Continued From page 7 1. At 11:42 a.m., the facility failed to provided documentation for the visual inspection of the emergency generator during the week of 4/1/12 through 4/7/12. 2. At 11:42 a.m., there was no documentation that indicated the emergency generator was exercised for a full 30 minutes during four of the past twelve months. The emergency generator logs indicated that the generator was exercised for 25 minutes on 7/25/12, for 20 minutes on 9/3/12, for 20 minutes on 12/12/12, and for 25 minutes on 1/9/13. During an interview, maintenance stated he had no additional records for review.	K 144	**How the facility will monitor its performance for ongoing compliance and who will oversee the plan:** **On quarterly basis the Administrator will be responsible to present the generator log to the QA Committee for oversight and review** **To assure that the deficient practice does not recur.** **Date corrective action will be completed: 2-28-2013.**	
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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their electrical equipment and wiring. This was evidenced by a broken electrical receptacle faceplate and by a missing electrical receptacle faceplate. This affected one of two smoke compartments and could increase the risk of electrical shock or fire. NFPA 70, National Electrical Code (1999) Edition 370 - Outlet, Device, Pull and Junction Boxes, Conduit Bodies and Fittings 370-25 Covers and Canopies. In completed installations, each box shall have a cover, faceplate, or fixture canopy.	K 147	**K 147** **It is the policy of the facility to maintain the facilities electrical equipment and wiring in accordance with NFPA 70.** **Corrective action(s) taken for the alleged deficient practice:** **On 2-6-13 the Maintenance Supervisor replaced the electrical receptacle, next to bed C in room 107 and the electrical receptacle on the left side of the wall behind the dryers in laundry room.** **How other electrical receptacles have the potential by the same alleged deficient practice will be identified.** **Maintenance Man audited facility to assure no further broken electrical receptacles exist.**	

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K 147	Continued From page 8 Findings: During a tour of the facility with maintenance on 2/5/13, the facility's electrical equipment and wiring were observed. 1. At 12:46 p.m., the electrical receptacle, next to bed C in room 107, was broken and missing the bottom half. 2. At 1:07 p.m., the electrical receptacle, on the left side of the wall behind the dryers in the laundry room, was missing a faceplate.	K 147	**What measures of systemic changes will be implemented to prevent recurrence of the alleged deficient practice:** **Starting on 2-28-13 under the supervision of the Administrator systematic change will be achieved by the adoption of a monthly monitoring process of conducting a visual audit of receptacles in facility by Maintenance Supervisor.** **How the facility will monitor its performance for ongoing compliance and who will oversee this plan:** **On quarterly basis the Administrator will be responsible to present audits to the QA Committee for oversight and review to assure that the deficient practice does not recur.** **Date corrective action will be completed:** **2-28-2013**	