STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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: 1962 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 = 114	K 000	a. The doors for the employee break room, emergency food storage room, human resource and room 20 were adjusted so that these doors would latch upon closure. These adjustments to the above doors occurred on August 21, 2013. b. The maintenance staff will checked all corridor doors within the facility to ensure that doors latch. This check and adjustment of doors occurred on August 22, 23, and 24, 2013. c. The administrator to inservice the maintenance staff on K018. The latching of all corridor doors shall be checked once per month during the first week of the month when maintenance staff check Life Safety Code inspections are conducted. A form will be specifically developed which documents proper door latching. The administrator shall review the documentation quarterly.	9/15/13
K 018 SS=E	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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/5/13

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.

9/10/13 POC acceptable per Robert Compton, HFES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 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 doors. This was evidenced by four corridor doors that were obstructed from latching. This affected four of seven smoke compartments and could result in a delay to contain smoke or fire to a room. Findings: During a facility tour with staff on 8/21/13, the doors in the facility were observed. 1. At 10:56 a.m., the corridor door to the Employee Break Room was missing a latching barrel. The door failed to latch when in the closed position. 2. At 11:11 a.m., the corridor door to the Emergency Food Storage Room by Room 42 was equipped with a self-closing device. The door was held open to the fullest extent and allowed to close. The door failed to latch. The door was obstructed from latching by the door frame.	K 018	d. This procedure shall be sustained by the maintenance staff. This shall be completed by the maintenance. The administrator shall monitor the latching of doors by reviewing the form and checking quarterly. The results of the quarterly checking shall be forwarded to the quality assurance and assessment committee for review and action. e. This corrective action shall be completed by September 15, 2013.	9/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 018	Continued From page 2 3. At 11:24 a.m., the corridor door to the Human Resources Office was equipped with a self-closing device. The door was held open to the fullest extent and allowed to close. The door failed to latch. The door was obstructed from latching by the door frame. 4. At 11:31 a.m., the corridor door to Room 20 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 when in the closed position. The door was obstructed from latching by the door frame.	K 018	a. The laundry door and frame were adjusted so that the door would latch. The door and frame to the copy/medical records room was adjusted so that it would latch. b. The maintenance staff checked all corridor doors and hazardous areas to ensure that all doors latch properly on August 22, 2013. c. The administrator shall inservice the maintenance staff on K029. The latching of all corridor doors shall be checked once per month during the first week of the month when Life Safety Code inspections are conducted. A form will be specifically developed which documents proper door latching.	9/15/13
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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to protect their hazardous areas. This was evidenced by two doors to hazardous areas that were obstructed from latching. This affected two of seven smoke compartments and could result in a delay to contain smoke or fire to a hazardous	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 029	Continued From page 3 area. Findings: During a facility tour with staff on 8/21/13, the hazardous areas in the facility were observed. 1. At 11:00 a.m., the west most of three corridor doors to the Laundry Room was observed. The door was equipped with a self-closing device. The door was held open to the fullest extent and allowed to close. The door failed to latch. The door was obstructed from latching by the door frame. The Laundry Room was greater than 100 square feet in area. 2. At 11:37 a.m., the corridor door to the Copy/Medical Records Room 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.	K 029	d. This procedure shall be sustained by the maintenance staff. This procedure shall be completed by the maintenance staff. The administrator shall monitor the latching of doors by reviewing the form and checking quarterly. The results of the quarterly checking shall be forward to the quality assurance and assessment committee for review and action. e. This corrective action shall be completed by September 15, 2013.	9/15/13
K 047 SS=E	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 and record review, the facility failed to maintain their exit signs. This was evidenced by the facility's failure to perform monthly and annual tests on their exit signs	K 047	a. All exit signs that have battery back up were tested for 90 minutes. The battery back up form will be changed to include specific time in minutes that lapsed for testing. Testing shall be done monthly for 30 seconds and 1.5 hours annually for the battery back up. This shall be documented on the log.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 047	Continued From page 4 equipped with battery back-up. This affected seven of seven smoke compartments and could result in a delayed evacuation due to limited exit sign visibility. NFPA 101, 2000 edition 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. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1.5 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. 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. Findings: During record review and a facility tour with staff on 8/21/13, the exit signs in the facility were observed. 1. At 9:37 a.m., the facility was observed to have exit signs equipped with battery back-up. The test records for the exit signs was reviewed. The test records indicated that the exit signs were being tested on a quarterly basis. There were no records that indicated the exit signs had been tested monthly for 30 seconds. There were no records that indicated the exit signs had been tested for a 90 minute duration during the past 12 months.	K 047	b. This procedure will be reviewed with the maintenance department. c. The administrator to in-service the maintenance staff on K047. The Life Safety Code inspections will be conducted the first week of the month. The inspections shall be documented on the new form. d. The administrator shall monitor the testing by reviewing the form quarterly. Results of the monitoring form shall be forwarded to the quality assurance and assessment committee for review and action. e. This corrective action shall be completed by September 15, 2013.	9/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain their fire alarm system. This was evidenced by the facility's failure to have an annual fire alarm system inspection completed during the past 12 months. This affected seven of seven smoke compartments and could result in a delayed notification of a malfunctioning fire alarm system. NFPA 72, 1999 edition Table 7-3.2 Testing Frequencies Findings: During record review with staff on 8/21/13, the fire alarm system was observed. 1. At 10:00 a.m., the facility's most recent annual fire alarm system test/inspection record was requested. Maintenance Staff 2 was interviewed at that time. Maintenance Staff 2 indicated that the facility had recently had their annual	K 052	a. The annual inspection was conducted on 8/23/13. All documentation for prior years will be available for CDPH review. b. A contract was initiated and signed with a Fire Testing service for annual inspections on August 22, 2013. c. The administrator shall inservice the maintenance staff on K052. The inspections shall be available and on file for Department review. d. The annual inspections shall be monitored by the maintenance supervisor. The inspection shall be reviewed by the administrator. The effectiveness of this implementation plan shall be forwarded to the quality assurance committee for review and action. e. This corrective action shall be completed by September 15, 2013.	9/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 052	Continued From page 6 test/inspection completed but had not yet received the report. The facility was given the opportunity to fax the report for review. On 8/23/13 at 2:59 p.m., the facility faxed a copy of an annual fire alarm test and inspection report. The annual fire alarm test and inspection report was dated and completed on 8/23/13. The facility did not provide documentation that indicated the fire alarm system was tested and inspected within the past 12 months from the date of survey (8/21/13).	K 052	a. The sensitivity test records will be retrievable for Department review. The sensitivity test was conducted on August 26, 2013. The prior sensitivity test was conducted on 8/29/11. A smoke detection device for the medication room will be scheduled for installation. b. All records shall be accessible and kept orderly for Department review. c. The administrator shall inservice the maintenance staff on K054. A contract was initiated and signed with a fire testing service for the required inspections and testing on August 22, 2013.	9/15/13
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to maintain their smoke detectors. This was evidenced by the facility's failure to have their smoke detectors tested for smoke sensitivity during the past two years and the fire alarm control panel room that was not protected by a smoke detection device. This affected seven of seven smoke compartments and could result in delayed notification of a fire due to a malfunctioning, dirty, or nonexistent smoke detector. NFPA 72, 1999 edition 1-5.6 Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to	K 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 054	Continued From page 7 provide notification of fire at that location. 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply	K 054	d. The sensitivity testing documentation will be monitored by the maintenance department and reviewed by the administrator annually. The effectiveness of the implemented plan will be submitted to quality assurance and assessment committee for review and comment. e. This corrective action shall be completed by September 15, 2013.	9/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 054	Continued From page 8 to single station detectors referenced in 7-3.3 and table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. Findings: During record review and a facility tour with staff on 8/21/13, the smoke detectors were observed. 1. At 9:55 a.m., the facility's smoke detector sensitivity test records were requested. The facility had their smoke detectors tested for smoke sensitivity on 8/17/10. There were no other records that indicated the facility had tested their smoke detectors for smoke sensitivity during the past two years. The facility was approximately one year overdue for a smoke detector sensitivity test. Maintenance Staff 1 was interviewed at that time. Maintenance Staff 1 indicated that all the smoke detectors had been replace at some point since 8/17/10. Maintenance Staff 1 indicated that he thought the smoke detectors had been replaced in June 2012. The facility did not have any records that confirmed all smoke detectors had been replaced since 8/17/10. The facility was given the opportunity to locate any smoke detector replacement records or past smoke sensitivity test records for review. No records were received as of 8/26/13 that confirmed all smoke detectors had been replaced. On 8/23/13 at 2:59 p.m., the facility communicated via fax that a smoke detector sensitivity test was completed on 8/23/13. No report was received as of 8/26/13 that confirmed the smoke detectors	K 054		9/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 054	Continued From page 9 were tested for smoke sensitivity. 2. At 11:34 a.m., the main fire alarm control panel was observed. The main fire alarm control panel was located in the Med Room for Nurse Station 1. The room was not equipped with a smoke detection device.	K 054	a. The control valve was tested on 8/21/13 at approximately 5pm. The system provided a audible and visual signal when in the closed position. A fire watch log was initiated until a licensed fire services contractor was able to assess and repair the following day on August 22, 2013. b. The control valve will be checked quarterly to ensure that it provides an audible and visual signal when in the closed position. c. The administrator shall inservice the staff on K061. As part of the on-going systems check, the control valve shall be closed and checked to ensure that the system provides evidence of visual and audible signals. A new contract was signed to include system checks on all phases of the fire alarm control panel and control valves. This will be checked at a minimum annually.	9/6/13
K 061 SS=F	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 on observation and interview, the facility failed to maintain their control valve. This was evidenced by one control valve equipped with a tamper switch that failed to emit an audible alarm or visual signal when in the closed position. This affected seven of seven smoke compartments and could result in a delayed notification of a suspension in water supplied to the automatic fire sprinkler system. NFPA 101, 2000 edition 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	K 061		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 061	Continued From page 10 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. NFPA 72, 1999 edition 2-9 Supervisory Signal-Initiating Devices. 2-9.1 Control Valve Supervisory Signal-Initiating Device. 2-9.1.1 Two separate and distinct signals shall be initiated: one indicating movement of the valve from its normal position and the other indicating restoration of the valve to its normal position. The off-normal signal shall be initiated during the first two revolutions of the hand wheel or during one-fifth of the travel distance of the valve control apparatus from its normal position. The off-normal signal shall not be restored at any valve position except normal. 2-9.1.2 An initiating device for supervising the position of a control valve shall not interfere with the operation of the valve, obstruct the view of its indicator, or prevent access for valve maintenance. Findings: During a facility tour with staff on 8/21/13, the automatic fire sprinkler system was observed. 1. At 1:38 p.m., the control valve located on the main automatic fire sprinkler riser was observed. The control valve was equipped with a tamper	K 061	d. The maintenance supervisor shall monitor the system checks and document that the functional status. The administrator shall report the effectiveness of the plan to the quality assurance and assessment committee for review and action. e. This corrective action shall take place by September 15, 2013.	9/15/13

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

PRINTED: 08/27/2013
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
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 061	Continued From page 11 switch. The control valve was tested by staff at that time. After the control valve was closed, the fire alarm control panel was observed. There were no audible alarms or visual signals that indicated the control valve was in the closed position. Administrative Staff 1 was interviewed at that time. Administrative Staff 1 indicated that the facility would initiate a fire watch until the tamper switch on the control valve was repaired.	K 061	a. The 3 corroded fire sprinkler heads were replaced on 082313. b. All fire sprinklers within the facility were inspected and replaced if corroded. c. The administrator shall inservice the maintenance staff on K062. All fire sprinklers shall be checked from the ground level to ensure that there exists no corrosion on the fire sprinklers. This shall be an annual check of all sprinklers from the ground level. d. The maintenance supervisor shall monitor the evaluation of all sprinkler heads annually. The administrator shall report the effectiveness of the plan to the quality assurance and assessment committee for further review and action. e. This corrective action shall take place by September 15, 2013.	9/15/13
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. 19.7.5, 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 three sprinklers that were corroded. This affected two of seven smoke compartments and could result in a delay to extinguish a fire due to a corroded sprinkler head. NFPA 25, 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. 2-2.2 Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and	K 062		

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

PRINTED: 08/27/2013
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
	555673	A. BUILDING 01 B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 062	Continued From page 12 fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Findings: During a facility tour with staff on 8/21/13, the automatic fire sprinkler system was observed. 1. At 10:54 a.m., the sprinkler heads above the Kitchen dish wash area were observed. Two of three sprinkler heads at that location were green in color and corroded. 2. At 11:48 a.m., the sprinkler heads in the Shower Room near Room 11 were observed. One of five sprinkler heads in that room were green in color and corroded. The sprinkler was located in the second shower stall from the corridor door.	K 062	K147 a. The office equipment in the admissions office was unplugged from the surge protector multi facility outlet extension cord. The computer equipment in the conference room (50) was unplugged from the multi outlet extension cord. The computer equipment on the North end was unplugged from the multi extension cord. The aquarium was unplugged from the multi extension surge protector. The aquarium will be plugged directly into an electrical outlet. This was all done on August 21, 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 the facility's use extension cords as a substitute for fixed wiring. This affected two of seven smoke compartments and could result in an electrical fire to occur. NFPA 70, 1999 edition	K 147	b. The maintenance department staff of 4, inspected the entire facility to ensure that there were no additional power surge protectors used inappropriately. c. The administrator shall inservice the maintenance department on K147. The maintenance department shall conduct monthly rounds during the first month to ensure that all extension cords and appliances are used appropriately.	

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

PRINTED: 08/27/2013
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
	555673	A. BUILDING 01 B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 147	Continued From page 13 240-4 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 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 Findings: During a facility tour with staff on 8/21/13, the facility's electrical equipment and wiring were observed. 1. At 10:43 a.m., office equipment in the Admissions Office was plugged into a surge protected multi-outlet extension cord that was plugged into an orange non-surge protected	K 147	d. This inspection shall be documented by the maintenance staff monthly and reviewed with the administrator. The administrator shall report findings to the quality assurance and assessment committee for further review and recommendations. e. This shall be accomplished by September 15, 2013.	9/6/13

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

PRINTED: 08/27/2013
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
	555673	A. BUILDING 01 B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 147	Continued From page 14 extension cord. 2. At 10:46 a.m., computer equipment on the south end of the Conference Room (Room 50) was plugged into a surge protected multi-outlet extension cord that was plugged into another surge protected multi-outlet extension cord. 3. At 10:48 a.m., computer equipment on the north end of the Conference Room (Room 50) was plugged into a surge protected multi-outlet extension cord that was plugged into another surge protected multi-outlet extension cord. 4. At 11:01 a.m., an aquarium in the Dining Room was plugged into a surge protected multi-outlet extension cord that was plugged into another surge protected multi-outlet extension cord.	K 147		9/15/13