STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055316	A. BUILDING 01 B. WING _____	04/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTHCARE CENTER	2530 SOLACE PLACE MOUNTAIN VIEW, CA 94040

(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: 1970 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (000), 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: 29753 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 105	K 000	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to meet requirements established by state and federal law.	
K 012 SS=D	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, the facility failed to	K 012	**Corrective Action:** 1 ½ inch penetration in the right wall ceiling in Station 1 Medication room, 3 ½ inch penetration exposing the escutcheon plate in Room 2 and 2 ½ inch penetration in the right wall near the ceiling have been sealed as of 4/3/2013 by the Maintenance Supervisor	

STATE BRANCH
PUBLIC HEALTH
2013 APR 22 PM 2:07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/19/201.

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.

4/25/13 Poc Acceptable per Khalla Zeada, HFE I

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K 012	Continued From page 1 maintain the integrity of the building's construction, as evidenced by penetrations in walls and ceilings. This could result in the passage of smoke in the event of a fire, and affected two of six smoke compartments. NFPA 101, 2000 Edition 8.2.3.2.4.2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Insulation and coverings for pipes and ducts	K 012	**Measures to prevent recurrence:** Maintenance Supervisor and department heads doing daily rounds will check all unsealed penetrations thus ensuring that the facility meets the integrity of the building construction **Monitoring corrective action and responsibility:.** Maintenance supervisor has the primary responsibility for monitoring the corrective action and compliance of the POC. The administrator shall monitor the measures put into place by doing daily rounds. **Plan of correction date:** 5/03/2013	

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K 012	Continued From page 2 shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. Findings: During a tour of the facility with Maintenance Staff on 4/3/13, the walls and ceiling were observed. 1. At 10:44 a.m., in the Station 1 Medication Room, there was an approximately 1 1/2-inch penetration in the right wall near the ceiling. 2. At 10:52 a.m., in Room 2, the escutcheon plate was not flush with the ceiling, and exposed an approximately 3 1/2-inch penetration. 3. At 1:25 p.m., in the Therapy Room closet, there was an approximately 2 1/2-inch penetration in the right wall near the ceiling. The penetration surrounded a 1-inch conduit.	K 012		
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	K 018	**Corrective Action:** The latch in Room 44 was fixed right away. In room 52 the privacy curtain was moved so that it would not obstruct closing of doors. Nursing staff was inserviced regarding this on 4/5/013. The striker plate was removed from Room 56 right away as of 4/3/2013.	

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K 018	Continued From page 3 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, as evidenced by doors that were obstructed from closing or that failed to latch. This could result in the passage of smoke and flames in the event of a fire, and affected two of six smoke compartments. Findings: During a tour of the facility with Maintenance Staff on 4/3/13, the corridor doors were observed and tested. 1. At 11 a.m., the latching mechanism caused the door to Room 44 to not latch. 2. At 11:20 a.m., a privacy curtain obstructed the door to Room 52 from closing. 3. At 11:21 a.m., the striker plate caused the door to Room 56 to not latch.	K 018	**Measures to prevent recurrence:** The Maintenance supervisor is responsible for monitoring measures and areas of non-compliance; this will be done during daily rounds and follow the preventive maintenance checklist **Monitoring corrective action and responsibility:** Maintenance supervisor has the primary responsibility for monitoring the corrective action and compliance of the POC. Areas of non-compliance will be addressed immediately with the administrator and or members of the safety committee during monthly meetings. These findings will be reported to the monthly QA&A committee meetings for compliance. **Plan of correction date:** 5/03/2013	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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K 050	Continued From page 4 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review, the facility failed to conduct fire drills as required, as evidenced by missing one of four fire drills for the PM shift. This could result in staff's inability to promptly evacuate the residents in the event of a fire, and affected all residents in six of six smoke compartments. Findings: During document review with Maintenance Staff on 4/3/13, the fire drill documents were requested and reviewed. At 4:20 p.m., documents revealed that one of twelve fire drill was not conducted. The fire drill for the second quarter 2012, P.M. Shift was not conducted.	K 050	**Corrective Action:** The fire drill paperwork could not be located at the time of life safety survey; was later found by contacting the company. The paperwork did show that PM shift was in serviced as required by the regulation. **Measures to prevent recurrence:** Maintenance supervisor will ensure along with the DSD that all paperwork's for fire drills are monitored and kept in order. Will also ensure that all staff are regularly in serviced to meet the requirement **Monitoring corrective action and responsibility:** Maintenance supervisor has the primary responsibility for monitoring the corrective action and compliance of the POC. The administrator shall monitor the measures put into place by doing audits and checking for compliance. **Plan of correction date:** 5/03/2013	
K 054 SS=E	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	K 054		

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K 054	Continued From page 5 This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the smoke detectors, as evidenced by the absence of documentation indicating that sensitivity tests were performed within NFPA 72 standards. This could result in the smoke detectors malfunctioning in the event of a fire, and affected all staff and patients at the Cancer Center. NFPA 72 72 National Fire Alarm Code, 1999 edition 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 and 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	K 054	**Corrective Action:** Maintenance supervisor has contacted the present company who checks our smoke detector system and laid specific parameters such as (sensitivity range which should be noted when technicians test the system every alternate year as per NFPA guidelines. **Measures to prevent recurrence:** Maintenance supervisor will ensure that all smoke detectors testing is done as per NFPA guidelines and all paperwork must include parameters mentioned along with the specific sensitivity range **Monitoring corrective action and responsibility:** Maintenance supervisor has the primary responsibility for monitoring the corrective action and compliance of the POC. The administrator shall monitor the measures put into place by doing audits and checking for compliance. **Plan of correction date:** **5/3/2013**	

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K 054	Continued From page 6 purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed 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 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 document review with the Maintenance Staff on 4/3/13, the smoke detector sensitivity report was requested and reviewed. At 4:25 p.m., a vendor's document titled, "Fire Alarm Smoke Detector Sensitivity Testing Report" dated 2/10/11 indicated only "Twelve (12) Common area smoke detectors" were tested, and that "All fire system common area smoke detectors functioned properly during testing." A second document titled, "Bi-Annual Smoke Detector Sensitivity Testing" indicated the	K 054		

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K 054	Continued From page 7 sensitivity testing was conducted 1/18/13 by the facility's Maintenance Department. The report included the locations of the smoke detectors, and that all smoke detectors passed. No sensitivity range was included in the report, other than the notation of "2.4 Pass" for all smoke detectors.	K 054		
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 automatic sprinkler system, as evidenced by items stored less than 18 inches below a sprinkler's deflector, and by paint on sprinkler heads. This could result in an obstruction to the sprinklers' spray patterns, which could lead to the sprinklers malfunctioning in the event of a fire, and affected two of six smoke compartments. NFPA 13, 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. 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	K 062	**Corrective Action:** Items from the Business office were removed right away as of 4/3/2013 thus preventing blocking from sprinkler head. Statcomm a company who takes care of facility sprinkler systems was contacted and they will be replacing the entire sprinkler with paint on deflector heads from Station 1 Medication room, Room 7 bathroom, and MDS bathroom. **Measures to prevent recurrence:** Environmental rounds by Maintenance supervisor and or designee will be conducted daily and preventive maintenance will be done to ensure that the sprinkler heads are free from corrosion, foreign materials, paint and other physical damage and blockage of any materials	

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K 062	Continued From page 8 orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.1.2 Unacceptable obstructions to spray patterns shall be corrected. 2-4.1.8 Sprinklers shall not be altered in any respect or have any type of ornamentation, paint, or coatings applied after shipment from the place of manufacture. Findings: During a tour of the facility with Maintenance Staff on 4/3/13, the automatic sprinkler system was observed. 1. At 10:42 a.m., in the Business Office, cartoned items were stored approximately 9 1/2 inches below the deflector. 2. At 10:44 a.m., in the Station 1 Medication Room, there was paint on the deflector. 3. At 10:50 a.m., in Room 7, there was paint on the deflector in the bathroom. 4. At 2:10 p.m., in the MDS Office bathroom, there was paint on the frame and the deflector.	K 062	**Monitoring corrective action and responsibility:** Maintenance supervisor and Administrator have primary responsibility for monitoring corrective action and compliance of POC. The Maintenance supervisor will bring all quarterly inspection records to the QA&A committee to check any areas of non-compliance **Plan of correction date:** 5/03/2013	

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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 staff interview, the facility failed to maintain the generator, as evidenced by the lack of documentation of the required weekly checks of the generator. This could result in failure of the generator in the event of an emergency, and affected six of six smoke compartments. NFPA 110 Standard for Emergency and Standby Power Systems, 1999 Edition 6-3 Maintenance and Operational Testing 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS [Emergency Power Supply System] shall be established. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel	K 144	**Corrective Action:** The Maintenance supervisor going forward as of 4/3/2013made a log explaining the following parameters for Generator testing; date of testing; time run; corrective action for any unsatisfactory conditions and lastly running time for generator as per state NFPA regulations which is weekly and under load for 30 minutes per month. **Measures to prevent recurrence:** The Maintenance supervisor is responsible for monitoring measures and areas of non-compliance; this will be done during weekly and monthly tests and will follow the preventive maintenance checklist created for compliance. **Monitoring corrective action and responsibility:** Maintenance supervisor has the primary responsibility for monitoring the corrective action and compliance of the POC.Administrator will do random audits to check compliance if the preventive checklist for generator is followed and maintained. Areas of non-compliance will be addressed immediately and or members of the safety committee during monthly meetings. These findings will be reported to the monthly QA&A committee meetings for compliance.	

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K 144	Continued From page 10 (c) Notation of any unsatisfactory condition and the corrective action taken, included parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer Findings: During document review with Maintenance Staff on 4/3/13, the generator maintenance records were requested and reviewed. At 3:52 p.m., there were no documents provided for the weekly visual inspections of the generator. During an interview, the Maintenance Supervisor stated that the weekly inspections were performed but not documented, and that the generator is exercised under load every two weeks.	K 144	**Plan of correction date:** 5/03/2013	
K 147 SS=E	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 the electrical wiring and equipment, as evidenced by the use of surge protectors for motorized items and medical equipment. This could result in the increased risk of fire, and affected three of six smoke compartments. NFPA 70, 1999 Edition 400-8. Uses Not Permitted. Unless specifically permitted in Section 400-7, flexible cords and	K 147	**Corrective Action:** Surge protectors were removed from both A & B beds in Room 40; From the physicians lounge and from Room 30 and Room 21. All items (concentrators, nebulizer, suction machine, feeding pump and mattress) were removed from surge protectors and plugged into a receptacle as of 4/3/2013 **Measures to prevent recurrence:** Maintenance supervisor will ensure along with the DSD that staff do not use surge protectors in the buildings. In-service was given to all nursing staff as of 4/5/2013 explaining not to use any kind of surge protector. During daily rounds Maintenance supervisor will ensure and check for compliance..	

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K 147	Continued From page 11 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (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 tour of the facility with Maintenance Staff on 4/3/13, the electrical wiring and equipment were observed. 1. At 10:56 a.m., in Room 40, Beds A and B and two oxygen concentrators were plugged into a surge protector beneath Bed A. 2. At 1:20 p.m., in the Physician's Office,a surge protector with computer equipment plugged into it was connected to a multioutlet adapter. 3. At 1:43 p.m., in Room 30, Bed B, an oxygen concentrator, a nebulizer, and a suction machine were plugged into a surge protector near Bed B.	K 147	**Monitoring corrective action and responsibility:** Maintenance supervisor has the primary responsibility for monitoring the corrective action and compliance of the POC. The administrator shall monitor the measures put into place by doing audits and checking for compliance. All areas of non-compliance will be monitored in monthly QA&A meetings **Plan of correction date:** 5/03/2013	

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MOUNTAIN VIEW HEALTHCARE CENTER	2530 SOLACE PLACE MOUNTAIN VIEW, CA 94040

(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 12 4. At 2:13 p.m., in Room 21, Bed C, a mattress, and a feeding pump were plugged into a surge protector located between Beds B and C.	K 147		