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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING _____	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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: 1987 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 = 86	K 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations.**	
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	**K 012 – PENETRATION OF CEILING IN PT ROOM** -Maintenance director repaired hole in ceiling with fire rated caulking on 9/5/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Moore — TITLE: Administrator — (X6) DATE: 10/7/13

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.

10/7/13 Poc Acceptable per Robert Compton, HFES

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 012	Continued From page 1 maintain the integrity of their building construction. This was evidenced by one unsealed penetration in a facility ceiling. This affected one of six smoke compartments and could result in the spread of smoke or fire to other locations in the facility. Findings: During a facility tour with staff on 9/4/13, the walls and ceilings in the facility were observed. 1. At 2:00 p.m., there was one approximately two inch diameter unsealed penetration in the ceiling of the Therapy Room. The penetration was located on the northeast end of the room above the wall mounted television.	K 012	-no other penetrations were identified - Staff in-serviced on documenting maintenance issues in the maintenance logs for timely follow up by maintenance. -Maintenance log books checked regularly by maintenance personnel/designee and signed off when completed. -Maintenance director/designee to audit maintenance log books and findings will be brought to QA for compliance monthly x 3 months.	9/20/13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**K 018 – FACILITY INTERIOR DOORS** -Maintenance director fixed corridor door to medical records storage room, corridor door to shower room A, corridor door to wheelchair storage room near room 23, and corridor door to utility room A by room 39 on 9/6/13. -no other doors were identified to be obstructed from latching.	

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their corridor doors. This was evidenced by four corridor doors that were obstructed from latching. This affected three of six smoke compartments and could result in a delay to contain smoke or fire to a room. Findings: During a facility tour with staff on 9/4/13, the doors in the facility were observed. 1. At 1:40 p.m., the corridor door to the Medical Records Storage Room 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 Medical Records Storage Room was located near the Oxygen Storage Room. 2. At 1:54 p.m., the corridor door to Shower Room A 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. 3. At 2:27 p.m., the corridor door to the Wheelchair Storage Room near Room 23 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	-Staff in-serviced on documenting maintenance issues in the maintenance logs for timely follow up by maintenance. -Maintenance director/designee to perform random audit of facility doors to ensure proper latching. -Maintenance director/designee to report findings to QA committee monthly X 3 months.	9/20/13

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 3 4. At 2:40 p.m., the corridor door to Utility Room A by Room 39 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	**K 050 – FIRE DRILLS** -Fire drill schedule updated by maintenance director to ensure all shifts receive the appropriate number of fire drills per year. -Each shift rotating as follows, AM one month then PM the next month then NOC shift, then coming back to AM repeating as follows. -Maintenance director/designee to report fire drill compliance through QA committee monthly X 6 months	9/2/13
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under 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 record review, the facility failed to conduct fire drills at least quarterly for each shift. This was evidenced by the facility's failure to conduct one quarterly PM shift fire drill and one quarterly NOC shift fire drill during the past 12 months. This affected six of six smoke compartments and could result in a delayed staff response to a fire emergency. Findings: During record review with staff on 9/4/13, the fire drill records were reviewed. 1. At 10:56 a.m., the facility had conducted three	K 050		

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 050	Continued From page 4 PM shift fire drills during the past 12 months. There was no documentation that indicated the facility had completed a PM shift fire drill during the second quarter of 2013. 2. At 10:56 a.m., the facility had conducted three NOC shift fire drills during the past 12 months. There was no documentation that indicated the facility had conduct a NOC shift fire drill during the third quarter of 2012 or 2013.	K 050		
K 061 SS=C	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 prepare staff to respond to localized sprinkler alarms. This was evidenced by a facility staff member that silenced an automatic fire sprinkler tamper alarm without knowledge of the alarm purpose. This affected one of six smoke compartments and could result in a delayed notification of a suspension in water supplied to the automatic fire sprinkler system. Findings: During a facility tour with staff on 9/4/13, the automatic fire sprinkler system shut off valves were observed.	K 061	**K 061 – SPRINKLER ALARM SYSTEM** -1:1 in-service with staff member regarding automatic sprinkler tamper alarm purpose and procedure when it sounds. -Staff in-service regarding automatic tamper alarm purpose and procedure for when it sounds. -Maintenance director/designee to perform random audit of staff knowledge of purpose and procedure of automatic sprinkler tamper alarm. -Maintenance director/designee to report findings to QA committee monthly X 3 months	9/20/13

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 5 1. At 3.15 p.m., the post indicator valve (PIV) tamper alarm was tested by staff. The facility had two nurse stations. Each nurse station was equipped with a fire alarm system annunciator panel. The fire alarm system annunciator panel at Nurse Station B was observed. No audible alarm was emitting from the fire alarm system annunciator panel at Nurse Station B. Nurse Staff 1 was interviewed at that time. Nurse Staff 1 indicated that she had heard the alarm and flipped the silence switch on the annunciator panel. A yellow sign near the alarm annunciator panel silence switch was observed. The yellow sign indicated that the silence switch must remain in the ON position. Nurse Staff 1 did not know the purpose of the alarm. Nurse Staff 1 was asked what she would do if she heard that alarm during a work shift. Nurse Staff 1 responded that she would walk around the facility to see if anything was wrong. Nurse Staff 1 indicated that she had never been in-serviced on the function or purpose of the tamper alarm. Nurse Staff 1 did not know that the water supplied to the automatic fire sprinkler system had been suspended.	K 061		
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 their automatic fire sprinkler system. This was evidenced by one automatic fire	K 062	**K 062 – AUTOMATIC FIRE SPRINKLER SYSTEM** -Hot water heater closet sprinkler head that was corroded was replaced -No other sprinkler heads were identified as being corroded. -Maintenance director/designee to perform regular rounds to identify	

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 6 sprinkler head that was corroded. This affected one of six smoke compartments and could result in a delayed response of the automatic fire sprinkler system. 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 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 9/4/13, the automatic fire sprinkler system was observed. 1. At 2:34 p.m., the water heater closet located in the southwest corner of the center courtyard was observed. The sprinkler head in the water heater closet was green in color and corroded.	K 062	potential issues with fire sprinkler heads. -Sprinkler heads to be found with corrosion or other issues to be replaced as soon as possible -Maintenance director/designee to report findings of sprinkler head rounds to QA committee monthly X 3 months.	9/20/13
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	**K 064 – PORTABLE FIRE EXTIGUISHERS**	

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 064	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguishers. This was evidenced by the facility's failure to perform monthly inspections on one portable fire extinguisher. This affected one of six smoke compartments and could result in a delayed notification of a malfunctioning portable fire extinguisher. NFPA 10, 1998 edition Section 4-3.1 Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30 day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Findings: During a facility tour with staff on 9/4/13, the portable fire extinguishers were observed. 1. At 1:43 p.m., the portable fire extinguisher located in the Front Office was observed. The service tag on the extinguisher indicated that it had last been serviced on 10/26/12. The reverse side of the service card had dates and initials corresponding to monthly visual inspections. The last monthly visual inspection was completed on 3/4/13. The portable fire extinguisher had not been visually inspected during the past six months.	K 064	-Maintenance performed visual inspection of portable extinguisher identified and documented inspection appropriately. -No other portable fire extinguishers were identified with incomplete service tags -Maintenance to perform regular inspection of all portable fire extinguishers and document inspections appropriately to ensure proper function and compliance -Maintenance/designee to present appropriate portable extinguisher documentation log to QA committee monthly X 3 months	9/20/13
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067	**K 067 – FIRE DAMPERS** -Appointment set up with local HVAC company to service CRCC fire dampers	

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

PRINTED: 08/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 067	Continued From page 8 with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire/smoke dampers. This was evidenced by the facility's fire/smoke dampers that had not been inspected within the past four years. This affected six of six smoke compartments and could result in the spread of smoke or fire to other locations of the facility due to a malfunctioning fire/smoke damper. NFPA 90A, 1999 edition 3-4.7 At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Findings: During a facility tour with staff on 9/4/13, the fire/smoke dampers in the facility were observed. 1 At 12:05 p.m., the facility was observed to have fusible link type fire/smoke dampers. Maintenance Staff 1 was interviewed at that time. Maintenance Staff 1 did not know if the fire/smoke dampers had been tested, cleaned, or lubricated during the past four years. Maintenance Staff 1 indicated that he was unaware of that requirement.	K 067	-Documentation of this scope of work will be kept, filed and completed every 4 years to ensure compliance. -Maintenance director/designee to perform random audits of damper maintenance compliance. -Maintenance director/designee to report findings to QA committee annually. - 6 month waiver requested on 10/7/13 to source vendor to complete inspection.	9/20/13

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 144 K 144 SS=F	Continued From page 9 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 record review and interview, the facility failed to maintain their emergency generator. This was evidenced by the facility's failure to conduct approximately 15 weekly visual inspections on their emergency generator during the past 12 months and the facility's failure to accurately document generator inspections. This affected six of six smoke compartments and could result in a extended loss of power due to a generator malfunction. NFPA 110, 1999 Edition 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 (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer 6-4.1 Level 1 and Level 2 EPSSs, including all	K 144 K 144	**K 144 – GENERATOR INSPECTIONS** -New documentation has been put in place by maintenance to ensure weekly visual and bi-weekly 30 min runs test are documented appropriately. -no other issues identified with generator check documentation -Maintenance director/designee to perform random audits of generator check inspections -Maintenance director/designee to report findings to QA to ensure compliance monthly x 3 months.	9/20/13

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 144	Continued From page 10 appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly Findings. During record review with staff on 9/4/13, the facility's emergency generator test and inspection records were reviewed. 1. From 11:24 a.m. to 11:40 a.m., the facility's emergency generator test and inspection records were reviewed. The facility conducts bi-weekly load tests and bi-weekly visual inspections on the emergency generator. There were many instances where the load tests and inspections fell on the same day or within two to three days of each other. There were approximately 15 instances where the facility had exceeded 1 week (7 days) without performing a visual inspection or load test on their emergency generator. The longest time span between generator tests or inspections occurred during 7/17/13 to 8/2/13 which was approximately 16 days. 2. At 11:40 a.m , the facility's emergency generator load test records were reviewed. The load test records were documented in the facility's "TELS" computer system. The load test records indicated that Maintenance Staff 2 had completed all the load tests during the past 12 months. Maintenance Staff 1 was interviewed at that time. Maintenance Staff 1 indicated that he had been filling in for Maintenance Staff 2 since approximately April 2013. Maintenance Staff 1 indicated that Maintenance Staff 2 has been on leave since approximately April 2013. The "TELS" emergency generator load test record did not accurately reflect the testing personnel.	K 144	**Page intentionally left blank**	

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	395 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 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 their electrical equipment and wiring. This was evidenced by the facility's use of extension cords as a substitute for fixed wiring. This affected four of six smoke compartments and could result in an electrical fire to occur. NFPA 70, 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 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,	K 147	**K 147 – ELECTRICAL WIRING AND EQUIPMENT** -Maintenance director removed extension cord from vista main dining room, surge protector from front office, surge protector from MDS office, extension cord from medical records office and surge protector from regency dining room of 9/4/13. -no other surge protectors or extension cords were identified to be in use. -Staff in-service on extension cords and surge protectors and where they can and can't be used. -Maintenance director/designee to perform regular audit of facility to ensure compliance -Maintenance director/designee to report findings to QA committee monthly X 3 months	9/20/13

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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 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 9/4/13, the facility's electrical equipment and wiring were observed. 1. At 1:28 p.m., television equipment in the Vista Main Dining Room was plugged into a white non-surge protected multi-outlet extension cord. 2. At 1:44 p.m., a miniature refrigerator in the Front Office was plugged into a surge protected multi-outlet extension cord. 3. At 2:14 p.m., office equipment on the south side of the MDS Office was plugged into an uninterrupted power supply unit that was plugged into a surge protected multi-outlet extension cord. 4. At 2:31 p.m., a miniature refrigerator in the Medical Records Office was plugged into a non-surge protected extension cord that was plugged into a surge protected multi-outlet extension cord. 5. At 2:33 p.m., a microwave oven in the Regency Room was plugged into a surge protected multi-outlet extension cord.	K 147		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide	K 211	**K 211 – ALCOHOL BASED HAND RUB**	

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

PRINTED: 09/11/2013
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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 211	Continued From page 13 o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their installation of alcohol based hand rub dispensers. This was evidenced by the mounting of one alcohol based hand rub dispenser over an ignition source. This affected one of six smoke compartments and could result in an alcohol based hand rub ignited fire. Findings: During a facility tour with staff on 9/4/13, the alcohol based hand rub dispensers in the facility were observed. 1. At 1:36 p.m., an alcohol based hand rub dispenser in the corridor across from the Oxygen Storage Room was observed. The alcohol based hand rub dispenser was mounted on the wall approximately three feet above an electrical receptacle. The hand rub was 62 percent ethyl alcohol by volume.	K 211	-Maintenance director removed alcohol based hand sanitizer and installed it in a proper location on 9/5/13. -No other alcohol based hand rub was identified to be located near an ignition source. -Installation of all new hand sanitizers to be coordinated through maintenance to ensure compliance -Maintenance director/designee to perform random audits of facility hand sanitizers to ensure compliance. -Maintenance director/designee to report findings to QA committee monthly X 3 months.	9/20/13

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
	555283	A. BUILDING 01 B. WING	09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIDGE CARE CENTER	396 DORSEY DRIVE GRASS VALLEY, CA 95945

(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
			Page intentionally left blank	