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

PRINTED: 09/09/2011
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
	555639	A. BUILDING 01 B. WING _____	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF NAPA VALLEY	1900 ATRIUM PARKWAY NAPA, CA 94559

(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: 1995 K7 Survey under: 2000 Existing Code Structure Type: One story, Construction Type V protected wood frame, fully sprinklered The following reflects the findings of the California Department of Public Health, during an annual Recertification Life Safety Code 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. The facility is not in substantial compliance with 42 CFR part 483.70(a) for Long Term Care Facilities. Representing the Department of Public Health Life Safety Code Unit Health Facilities Evaluator 25385 Census: 61	K 000	K 000 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42C.F.R. 405.1907. _____. Initials	
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:	K 012	K 012 • The two (2) inch penetration in the gypsum wallboard (36 inches from the floor on the east wall of the Biohazard Room) was repaired and completed on 9/8/11.	10/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wayne D. TITLE: Ex. Director (X6) DATE: 9/21/2011

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.

POC acceptable per Marie de Mars 9/22/11

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K 012	Continued From page 1 Based on observation, the facility failed to maintain the walls of the building in a condition that would resist the passage of smoke and fire. This was evidenced by unsealed penetrations observed in the fire-rated sheeting. This deficient practice affected staff and residents in one of six smoke compartments within the facility, and could result in the spread of smoke and/or fire. Findings: During a tour of the facility with Maintenance Staff on 9/7/11, the building construction was observed. At 1:35 p.m., there was an approximately two inch penetration in the gypsum wallboard approximately 36 inches from the floor, on the east wall in the Biohazard Room.	K 012	The maintenance staff will be directly responsible for the corrective action(s) for maintaining the walls/ceilings of the building in a condition that will resist the passage of smoke and fire. The maintenance staff will audit the building walls and ceilings on a monthly basis to ensure any and all penetrations are detected and sealed with fire rated material. • The monthly wall/ceiling penetrations audit will be reviewed by the Facilities Services (FS) Director and then reported to and monitored by the monthly CQI/QA committee for sustained compliance.	
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 • The corridor door to the Activities Storage Closet (by Resident Room 507) now closes completely. A box was impeding or preventing the corridor door from closing and latching. The box was promptly removed and the door now closes and latches. • The Activities Director will be responsible for checking the Activities	10/7/11

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain all corridor doors free from obstructions to closing. This was evidenced by a corridor door that failed to close and latch when tested. This deficient practice affected staff and residents in one of six smoke compartments, and could result in the spread of smoke or fire to other areas in the facility. Findings: During a tour of the facility with Maintenance Staff and the Administrator on 9/7/11, corridor doors were tested: At 2:39 p.m., the corridor door to the Activities Storage Closet near Resident Room 507 did not positive latch when tested by releasing it from an open position. Administrative Staff stated that there was a box in the closet that kept the door from latching.	K 018	Storage Closet and ensuring there are no obstructions that prevent the door from closing and latching. The activities staff will be in-serviced and trained on proper storage in all closets and reminded of the reason; to prevent the spread of smoke and fire. • Maintenance will audit all door closures monthly to ensure that they positively latch shut. The audit will be reviewed by the Facilities Services Director and then reported to and monitored by the monthly CQI/QA committee for sustained compliance.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K 038 • The facility will ensure that all exits are readily accessible at all times and that a means of egress is continuous and unobstructed. All egresses shall be continuously maintained free of all obstructions. An exterior awning (other object), was partially impeding the exit door leading outside (near Res. Room 101). The awning was promptly moved, thus allowing the exit door to completely open (completed on 9/8/11). The door leading to the outside from Physical Therapy was impeded from opening by a chair. The chair was promptly moved at the time of the survey (9/7/11).	10/7/11

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that exits are readily accessible at all times as evidenced by exit doors that were impeded from opening. This deficient practice affected all staff and patients in two of six smoke compartments, and could result in a delay in egress in the event of an emergency. 3.3.121* Means of Egress. A continuous and unobstructed way of travel from any point in a building or structure to a public way consisting of three separate and distinct parts: (1) the exit access, (2) the exit, and (3) the exit discharge. 3.3.121.1 Means of Egress, Accessible. A path of travel, usable by a person with a severe mobility impairment, that leads to a public way or an area of refuge. 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2 Furnishings and Decorations in Means of Egress. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. Findings: During a tour of the facility with Maintenance Staff on 9/7/11, means of egress were observed impeded in the following locations:	K 038	• The maintenance staff will be responsible for ensuring that all egresses are unobstructed from impediments and that exit doors open completely. Daily visual observations will be done by maintenance staff on all exit doors to ensure that they are not obstructed. In addition, the sidewalk areas immediately outside the Physical Therapy and the Staff Break room will be painted to state: "keep area clear". • A monthly Audit will be done of all exit doors to ensure they are unobstructed. The results of daily visual observations and monthly egress audit will be provided to the FS Director for review and compliance. • The FS Director will report to the status of the visual observations and egress audit to and monitored by the monthly CQI/QA committee and the Quarterly Quality Assurance and Assessment Committee for completion and sustained compliance. K 062 • The facility did test the Quarterly Sprinkler Flow Tests (QSFT) on four of four (4/4) previous quarters (see attached hand written page numbers 1-14). Simplex-Grinnell (SG) is contracted to perform the, Inspection, Testing and Servicing of our facility	10/7/11

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K 038	Continued From page 4 1. At 1:37 p.m., the exit door leading to the outside near Resident Room 101 was partially impeded by a window shade/awning that was attached to the wall within the travel area of the door. Administrative Staff stated that the awning would be moved, or removed. 2. At 3:05 p.m., the door leading to the outside from the Physical Therapy Room was impeded from opening by a chair placed directly outside of the door. Administrative Staff moved the chair at that time.	K 038	automatic fire sprinkler system (AFSS) in accordance with 2000 NFPA 101 and 1998 NFPA 25. The QSFT (see attached documentation) were tested on the following dates over the last year: 8/13/10 passed with 28 seconds, 11/13/10 passed with 28seconds, 2/9/11 passed with 28 seconds, and 5/26/11 passed with 30 seconds. SG designates the QSFT as "Alarm Devices"; tolerance is less than 90 seconds. SG recorded the results of the QSFT on section (2.1) of the Annual Frequency Testing (AFT) documentation, instead of on line item (1.5) for Quarterly Frequency Testing (QFT) The QSFT are recorded on line 1.5 as inspected, while the results of the testing are recorded on the (AFT)s line 2.1, as tested and passed. SG has been instructed to record all future QSFT results on line 2.1 as (Quarterly Alarm Devices with test results). On September 19 the adjustments were made on the sensitivity to the Flow Switch at the ITV. The documented time for the ITV alarm occurred at 33 seconds, within tolerance of 90 second maximum time allowed (see hand written page numbers 12-14).	
K 062 SS=E Changed per IDR 9/22/11	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 record review and staff interview, the facility failed to test and maintain its automatic sprinkler system in accordance with 2000 NFPA 101, and 1998 NFPA 25, Table 2-1. This was evidenced by a lack of documentation for three of four quarterly sprinkler flow tests, and the water flow alarm failing to alarm within the required 90 seconds. This deficient practice affected all staff and residents in six of six smoke compartments within the facility, and could result in the spread of smoke and/or fire. 4.6.12 Maintenance and Testing. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be	K 062	• The facility asserts that we were in compliance with the required Quarterly Sprinkler Flow Tests (QSFT) as required by the NFPA regulations. SG refers to this as Alarm Devices (see Item 2.1 in attachments provided by	

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K 062	Continued From page 5 tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.4 Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. 2-3.3.1* Testing the waterflow alarms on wet pipe systems shall be accomplished by opening the inspector ' s test connection. Fire pumps shall not be turned off during testing unless all impairment procedures contained in Chapter 11 are followed. Exception: Where freezing weather conditions or other circumstances prohibit use of the inspector ' s test connection, the bypass connection shall be permitted to be used. Findings: During a facility tour with facility staff on 9/7/11, the automatic sprinkler system was observed. 1. During record review at 11:03 a.m., the facility failed to provide documentation for three of four quarterly sprinkler inspections. Documentation for the quarterly sprinkler inspections by a certified vendor stated that the water flow was being tested annually, instead of quarterly in accordance with 1998 NFPA 25. Administrative	K 062	SG). We have changed the documentation for the QSFT to show under Item 2.1 as a "Quarterly" requirement, (see page 13, test results, 9/19/11 Alarm Devices test=33secs). The documentation was available at the time of the survey, however recorded under the frequency Annual results, rather than Quarterly results, All QSFT are complete and within the 90 second tolerance limit. • The ITV testing was re-done on 9/19/11 after adjusting the sensitivity of the Flow Switch and the result was 33 seconds (see page 13 documentation for the re-testing of ITV). Up to the time of the survey the QSFT has been in compliance. • The FS Director will be responsible for ensuring that the proper testing and function of the automatic sprinkler system, including the QSFT documentation. SG our contracted provider who does the testing has promptly changed the documentation to be more clear and concise. The FS Director shall ensure the QSFT will be documented on the appropriate line item frequency (item 2.1, Alarm Devices is now documented on the "Quarterly" frequency schedule, see 9/19/11revised report). • The completion of this POC (and future quarterly testing of AFSS) will	

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K 062	Continued From page 6 Staff contacted the vendor, who confirmed that the quarterly flow testing was done annually. 2. During flow testing with the Administrator at the Inspector's Test Valve (ITV), at 3:55 p.m., the ITV was opened, and the time to activate the alarm was documented. The ITV flow activated the alarm after 118 seconds, instead of the required 90 seconds. The Assistant Administrator confirmed that the timed flow was greater that 90 seconds.	K 062	be reviewed a monitored by the Facilities Director; and reported to the Quarterly Quality Assurance Committee. The QAAC will ensure monitoring and sustained compliance. **Informal Dispute Resolution** • In accordance with 488.331 we are formally asking for an IDR with the above K-Tag (062). The facility was in compliance with the cited deficiency, but received it due to a documentation issue by our contract provider (Simplex-Grinnell). We have promptly corrected the documentation issue and re-tested the "Alarm Devices", that is the QSFT. The results were within the tolerance of the 90 second time rule. The facility respectfully asks the Scope/Severity (SS) be reduced to a level commensurate with a documentation issue that is a S/S of level C.	10/7/11
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 test its generator in accordance with 1999 NFPA 99. This was evidenced by incomplete testing for three of twelve required monthly load tests in a twelve month period. This deficient practice affected all staff and residents in six of six smoke compartments within the facility, and could result in deficiencies with the generator going unnoticed and not functioning properly during a loss of normal power.	K 144	**K 144** • The facility shall test the generator in accordance with 1999 NFPA 99. The monthly 30 minute full load test on the generator will be exercised and documented as required.	10/7/11

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K 144	Continued From page 7 Findings: During a facility tour with facility staff on 9/7/121, the generator testing documentation was reviewed. At 11:03 a.m., documentation provided indicated that the monthly load tests were missing for April, June, and July of 2011. During an interview with the Administrator and Maintenance Personnel, Maintenance Personnel confirmed that the load testing had not been done for that time period.	K 144	• The maintenance staff will be directly responsible for running the monthly full load tests for 30 minutes and will clearly document the results. Maintenance staff will be re-trained and in-serviced on running the generator on the full load requirement each month. In addition, documentation will be modified and set up so that maintenance staff will not be able to omit running the generator with a full load. The generator testing log (documentation) will be monitored by the Maintenance Supervisor for compliance. • The results of the required monthly full load tests (30 minutes) will be reviewed/monitored by the FS Director for compliance. The documented results will then reported to and monitored by the monthly CQI/QA committee for sustained compliance.	
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 comply with the regulations regarding electrical wiring and utilities in accordance with 1999 NFPA 70. This was evidenced by a power strip that was suspended above the floor. This deficient practice affected all staff and residents in one of six smoke compartments, and could result in the ignition of fire. 400-10 Flexible cords and cables shall be connected to devices and to fittings so that tension will not be transmitted to joints or terminals. 110-12 requires that electrical equipment be installed in a neat and workman like manner. Findings:	K 147	K 147 • The power strip in the Physical Therapy room was promptly placed on the floor and no longer suspended, thereby ensuring the cord does not have tension transmitted to joints or terminals. • The maintenance staff (MS) are responsible for ensuring the proper use of all electrical devices, including the	10/7/11

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K 147	Continued From page 8 During a tour of the facility with Maintenance Staff and the Administrator on 9/7/11, the electrical equipment and utilities were inspected. At 3:05 p.m., the Physical Therapy Room had a power strip suspended above the floor, that transmitted tension to its joint and terminals.	K 147	use of power strips. MS has surveyed the entire facility to ensure that all power strips are installed in a neat and workman like manner. • Facility staff (including MS) will be in-serviced and educated on the proper use and installation of power strips.	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to provide a written protocol to insure that if the fire alarm system was out of service for four or more hours in a 24 hour period that the authority having jurisdiction (AHJ) would be notified. This was evidenced by a lack of documentation provided for this requirement. This deficient practice affected all staff and residents in six of six smoke compartments within the facility, and could result in the AHJ being unable to exercise oversight. Findings: During a review of the facility's records on 9/7/11, the fire watch policy was reviewed.	K 155	• Monthly audits will be done by maintenance staff to monitor the proper installation and use of power strips. The FS Director will review and monitor the electrical/power strip audits. The documented results will then be reported to and monitored by the monthly CQI/QA committee for sustained compliance. **K 155** • The Authority Having Jurisdiction (AHJ) is the Licensing and Certification Office (Dept. Of Public Health) in Santa Rosa, California. The Fire Watch Policy and Procedure (P&P) will be updated to add the mandatory notification of the local AHJ, in the event the Fire Alarm/Sprinkler System is out of service for more than 4 hours in a 24 hour period. • The Fire Watch P&P will instruct notification to the Dept. Public Health	10/7/11

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K 155	Continued From page 9 At 11:03 p.m., documentation provided for an approved fire watch did not include guidance for the notification of the Department of Public Health if the fire alarm or sprinkler system was out of service for four or more hours in a 24 hour period. Administrative Staff confirmed that the fire watch policy did not give instruction to notify the Department of Public Health when a fire watch is initiated. The facility's approved fire watch stated that the fire watch could not be terminated without permission from the AHJ.	K 155	(AHJ) in the event a Fire Watch is initiated per the guidelines. The notification will occur by telephone (707-576-6775, and by written notification via Fax (707-576-2418). • The facility Administrator will be responsible for modifying the Fire Watch P&P to include instruction and subsequent notification of the DPH local AHJ. In addition, any Fire Watch initiated will not be terminated without permission from the AHJ, per the facilities policy. • The POC for this deficiency will be implemented by the Administrator. On a monthly basis the Administrator will report to the CQI/QA committee all instances when a Fire Watch was initiated and the subsequent reporting of said FW to the DPH. In addition, the Administrator will report to the Quarterly Quality Assurance Committee the POC, for sustained monitoring and compliance. **"This Plan of Correction constitutes our written Credible allegation of Compliance for the Deficiencies noted."**	