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

PRINTED: 11/13/2012
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
	555342	A. BUILDING 01 B. WING	11/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY VIEW MANOR	22445 CUPERTINO ROAD CUPERTINO, CA 95014

(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: 7/1/1989 K7 SURVEY UNDER: 2000 Existing STRUCTURE TYPE: ONE STORY, TYPE III CONSTRUCTION, FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes Representing the California Department of Public Health Life Safety Code Unit: 31201 The facility is not in compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 45	K 000	POC acceptable per Cynthia Lee 12/3/12	
K 012 SS=F	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 maintain the integrity of the building construction as evidenced by unsealed wall and ceiling penetrations. This affected 3 of 6 smoke compartments, and could result in the passage of	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/S/ SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Kerr

TITLE: Executive Director

(X6) DATE: 11/30/2012

(X4) ID PREFIX TAG: 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.

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K 012	Continued From page 1 smoke in the event of a fire Findings: During the facility tour with the Director of Environmental Services on 11/6/12, the walls and ceilings were observed 1. At 10:35 a.m., in the MDS Coordinator Room closet, there was an approximately 1/8 inch circular penetration in the ceiling. 2. At 10:42 a.m., in the Wheelchair and Walker Storage room, there was an approximately 1/4 inch circular penetration in the ceiling around four wires. 3. At 10:43 a.m., in resident room 3, there was an approximately 1/8 inch circular penetration in the ceiling around a thermostat wire molding. 4. At 10:44 a.m., in resident room 5, there was an approximately 1/8 inch circular penetration in the ceiling around a thermostat wire molding. 5. At 10:55 a.m., in resident room 9, there was an approximately 1/8 inch circular penetration in the ceiling around a thermostat wire molding. 6. At 10:58 a.m., in resident room 10, there was an approximately 1/8 inch circular penetration in the ceiling around a thermostat wire molding.	K 012	**K012** Items #1 – 6: Penetrations were patched with fire caulking and painted on 11/6/12. Maintenance will add this task to Preventative Maintenance Checklist. Maintenance staff will check the rooms monthly for penetrations and patch them as needed.	11/6/12
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	K 018		

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K 018	Continued From page 2 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. This STANDARD is not met as evidenced by Based on observation, the facility failed to maintain its corridor doors. This was evidenced by doors that were obstructed from closing or that failed to close and latch. This could result in the passage of smoke in the event of a fire, and affected 2 of 6 smoke compartments. Findings: During the facility tour with the Director of Environmental Services on 11/6/12, the corridor doors were observed. 1. At 11:03 a.m., in the Shower room by resident room 6, the door failed to close and positively latch. The door was tested three times. 2. At 11:06 a.m., in the Locker room, a door	K 018	**K018** 1. Door opener repaired and tested for proper function. — 11/6/12 2. Door stop removed and Nursing and Housekeeping staff in-serviced not to use door stop in front of fire doors. — 11/6/12 Maintenance and Housekeeping staff will check the doors weekly for malfunction and call Maintenance staff to repair if needed. — 11/15/12 Revised the procedure to keep a copy of the Central Station's printout to be kept with our test documents. Environmental Services Director to monitor monthly for proper record keeping.	

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K 018	Continued From page 3 wedge obstructed the door from closing and positively latch.	K 018		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain their fire alarm system. This was evidenced by failing to verify that the fire alarm monitoring company received a fire alarm signal for 11 of 12 months. This could result in a delay in notification in the	K 051	**K051** Maintenance staff was in-serviced with new regulation, and a test was conducted on 11/16/2012. The central station alarm log was updated to maintain our test log. Attached is a copy of the central station report after our test. Director and Assistant Director of Environmental Services will monitor monthly for log compliance.	11/16/12

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K 051	Continued From page 1 event of a fire, and affected 6 of 6 smoke compartments. Findings: During the facility tour with the Director of Environmental Services on 11/6/12, the fire alarm system was observed and testing documentation was reviewed. At 12:00 p.m., the documentation for the fire alarm system testing was reviewed. The Director of Environmental Services did not have evidence that the fire alarm monitoring company received a signal for the following months in 2012: January, February, March, April, May, June, July, August, September, October, and 2011: November and December. Staff stated that the documents would be faxed by noon tomorrow, 11/7/12. The only document received was for November 2012.	K 051		
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 and document review, the facility failed to maintain the required sprinkler system. This was evidenced by escutcheon rings that had shifted or were not flush to the wall, debris on a sprinkler head and by not conducting one of four required quarterly sprinkler inspections. These conditions affected 6 of 6	K 062		

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K 062	Continued From page 3 smoke compartments and could result in the spread of smoke from one compartment to another NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, 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. 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. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. 2-2.7 Hydraulic Nameplate. The hydraulic nameplate, if provided, shall be inspected quarterly to verify that it is attached securely to the sprinkler riser and is legible. 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. 9-2.7 Waterflow Alarm. All waterflow alarms shall	K 062		

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K 062	Continued From page 6 be tested quarterly in accordance with the manufacturer's instructions. 9-5.1.1 All valves shall be inspected quarterly. The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken 9-5.2.1 All valves shall be inspected quarterly. The inspection shall verify the following: (a) The handwheel is not broken or missing (b) The outlet hose threads are not damaged (c) There are no leaks. (d) The reducer and the cap are not missing 9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly. Findings: During the facility tour with the Director of Environmental Services on 11/6/12, the sprinkler system was observed: 1. At 10:10 a.m., in the Utility Room by the	K 062	**K062** **Items #1-9:** The escutcheon ring around the sprinkler was lifted around the sprinkler head to completely cover the penetration on all designated rooms on 11/6/12. Housekeeping and maintenance staff was in-serviced to report changes in escutcheon rings around sprinklers to maintenance. Assistant Director/Director of Environmental Services will maintain monthly inspection of all sprinklers for regulatory compliance. All quarterly automatic fire sprinkler records will be kept in accordance to regulation. **Item #10:** The missing record was during the change of Alarm Monitoring Companies. The test was conducted late and considered to be for two quarters. Maintenance Department created a spreadsheet and will check the spreadsheet for compliance quarterly.	11/10/12

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K 062	Continued From page 7 Garden Dining Room, the escutcheon ring was not flush to the wall and was exposing 1/8 inch penetration below the ceiling. 2. At 10:18 a.m., in resident room 18, the escutcheon ring was not flush to the wall and was exposing 1/8 inch penetration below the ceiling. 3. At 10:30 a.m., in the Tub Room, there were two escutcheon rings that were not flushed to the wall leaving 1/8 inch penetration each from the ceiling. 4. At 10:46 a.m., in the Medical Supply Room, there were cob webs on the sprinkler. 5. At 10:53 a.m., in the Social Services closet, the escutcheon ring had shifted to one side and exposed a 1/8 inch penetration in the ceiling surface. 6. At 11:00 a.m., in resident room 8, the escutcheon ring was not flush to the wall and was exposing 1/8 inch penetration below the ceiling. 7. At 11:04 a.m., in resident room 4, the escutcheon ring was not flush to the wall and was exposing 1/4 inch penetration below the ceiling. 8. At 11:23 a.m., in resident room 109, the escutcheon ring was not flush to the wall and was exposing 1/4 inch penetration below the ceiling. 9. At 11:25 a.m., in resident room 103, the escutcheon ring was not flush to the wall and was exposing 1/4 inch penetration below the ceiling. 10. At 11:35 a.m., the facility's automatic fire	K 062		

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K 062	Continued From page 8 sprinkler system test and inspection records were reviewed. The facility has an automatic fire sprinkler system vendor test and inspect their facility semi-annually. There were no records that indicated the facility had conducted a quarterly automatic fire sprinkler system test and inspection during the first quarter of 2012. The facility was missing one of four quarterly automatic fire sprinkler system tests and inspections.	K 062		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the storage for the oxygen cylinders. This was evidenced by empty and full oxygen cylinders that were stored together without being separated by signs. This could lead to staff being unable to identify full cylinders quickly in the event of a emergency. NFPA 99, (1999) 4-3.1.1.1 Cylinder and	K 076		

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K 076	Continued From page 9 Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. NFPA 99, (1999) 4-3.1.1.1 (b) Cylinder contents shall be identified by attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained. NFPA 99, (1999) 4-3.5.2.2 (2) If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. Findings During the facility tour with the Director of Environmental Services on 11/6/12, the oxygen storage area in the facility was observed. At 11:10 a.m., one full cylinder was mixed with 21 empty cylinders. There were no signs indicating full and empty. The Director of Environmental Services Staff acknowledged that there was one full cylinder mixed in with 21 empty cylinders.	K 076	**K076** Oxygen room will be separated with a partition wall in two sections; each section will have bottle storage rings, and signage indicating empty bottles and full bottles. Signage and storage bottles ordered and will be completed by 12/5/2012. Care Center staff is using printed signs to temporarily designate full and empty tanks until ordered official labels and stencils are received. Care Center staff and Maintenance staff will be in-serviced on new system by 12/5/12. Charge Nurse staff will check monthly for regulatory compliance of container storage and labeling.	12/5/12
K 144 SS=L	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	K 144		

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K 144	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their emergency generator. This was evidenced by no emergency lighting provided in the generator area. This could lead to decreased visibility in the event of an emergency and affected 6 of 6 smoke compartments. NFPA 110, (1999) 5-3 Lighting. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Findings: During the facility tour with the Director of Environmental Services on 11/6/12, the emergency generator area was observed. At 10:04 a.m., there was no emergency light observed by the generator area. Upon interview, the Director of Environmental Services opened a container and pulled out a small flashlight. The generator is located in the rear of the building. This deficiency was not corrected from the last year inspection, 10/21/11.	K 144	**K144** For emergency light, a flashlight was added after last year's inspection inside the generator. A 12 volt battery backup lighting system is scheduled to be installed by an electrical contractor before 12/15/12.	12/15/12
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147		

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K 147	Continued From page 1 with NFPA 70, National Electrical Code 9-1-2 This STANDARD is not met as evidenced by Based on observation and interview, the facility failed to maintain its electrical wiring and equipment, as evidenced by a receptacle faceplate not flush to the wall, and by the use of surge protectors, extension cords and multi-plug adapters. This could result in the increased risk of fire, and affected 4 of 6 smoke compartments. 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.	K 147	K147 **Item #1 and #4**: Metal plug removed and returned to Resident. Maintenance will have a weekly checklist for multi plugs compliance. **Item #2**: Refrigerator was plugged directly into outlet. Maintenance Staff will monitor the appliances monthly to be directly plugged into outlet. **Item #3**: Broken face plate was replaced and penetration was covered. Maintenance Staff will add to Preventative Maintenance Checklist and monitor monthly to be in compliance. **Item #5**: Extension Cord was removed. Maintenance Staff will monitor monthly to make sure extension cords are not used. Nursing and Housekeeping in-serviced on correct usage of cords and outlets.	11/6/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555342	A. BUILDING 01 B. WING	11/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY VIEW MANOR	22445 CUPERTINO ROAD CUPERTINO, CA 95014

(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 (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 410.56(e) After installation, receptacle faces shall be flush with or project from faceplates of insulating material and shall project a minimum of 0.015 in. (0.381 mm) from metal faceplates. Faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Findings: During the facility tour with the Director of Environmental Services on 11/6/12, the electrical wiring and equipment were observed. 1. At 10:21 a.m., in resident room 121, a clock and a lamp were plugged into a multi-plug adapter. Staff acknowledged the multi plug adapter, removed it during the inspection and stated he was not aware this multi-plug adapter was in use in this room. Staff stated the resident's family may have brought in the multi-plug adapter. 2. At 10:32 a.m., in the Utility Clean room, a refrigerator was plugged into a surge protector. 3. At 10:38 a.m., the electrical faceplate behind the water dispenser by the Garden Dining Room was not flush to the wall and exposed an approximately 3 inch penetration.	K 147		

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

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K 147	Continued From page 13 4. At 10:58 a.m., there was a multi-plug adapter by Bed B, in resident room 10. 5. At 11:22 a.m., in resident room 108, a radio clock, charger and decoration lights were plugged into an extension cord	K 147		