PRINTED: 01/22/2015
FORM APPROVED
OMB NO. 0938-0391

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
	055750	A. BUILDING 01 B. WING	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD GARDENS	1601 PETERSEN AVENUE SAN JOSE, CA 95129

(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: 02 K6 PLAN APPROVAL: 7/1/1978 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V) (111), 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: 29670 Census: 239	K 000	This POC is not an agreement by the facility as to the validly or lack thereof to any element of the listed deficiencies. It is intended as a Plan of Correction to the DHS as required by law. This plan of correction constitutes a written credible allegation of compliance for the deficiencies noted.	
K 012 SS=D	The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. 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 interview and observation, the facility	K 012	K102 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. Building construction type and height meets required section. The facility shall be free of wall penetrations.	2/9/15

[redacted]

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.

2/6/15 Poc Acceptable per Jeanette Hurrell, HFES

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K 012	Continued From page 1 failed to maintain their building free of penetrations, as evidenced by penetrations in the facility wall. This could lead to the spread of smoke or fire from one area of the building into the corridor, and affected one of six smoke compartments. Findings: During a tour of the facility with the Facility Manager on 01/13/15, the building construction was observed. At 10:29 a.m., multiple penetrations were observed on all walls of the Janitor's closet in the Alzheimer's Unit near the floor. One penetration near the floor was approximately 3 ft. by 1 ft. wide, the sheetrock was broken, and tiles were removed. The other two walls had smaller penetrations measuring approximately 1/2 ft. to 2 ft. by 4 inches each. The walls of the janitors closet were shared with the laundry room and the Janitors closet opened into the corridor. Upon interview, staff stated the facility had a flood from the Laundry Room about one month ago, which led to the water coming into the janitors closet and into the carpet in the corridor. Staff stated they were in the process of repairing the penetrations in the sheetrock.	K 012	The facility shall and has repaired the penetrations noted on the statement of deficiencies in the Janitor's closet located in station 5. The repair and replacement of the sheetrock was accomplished by the facility maintenance staff. The Maintenance Director shall review the whole of the facility to ensure that there are no other unrepaired penetrations present within the facility. Said Director shall with the help of his staff be responsible for the continuing observation of the facility to ensure that any penetration that should occur is promptly eliminated. This shall be accomplished by daily rounds by the Maintenance Director and his observations for same. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is	K 018		

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K 018	Continued From page 2 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 interview and observation, the facility failed to maintain their doors, as evidenced by doors that failed to latch through out the facility. This could lead to an increased risk for the spread of smoke or fire in the event of an emergency and affected four out of six smoke compartments. Findings: During a tour of the facility with the Facility Manager on 01/13/14, the doors in the facility were observed. 1. At 10:32 a.m., the exit door in the Alzheimer's Unit by the Laundry Room failed to positively latch when tested. Staff confirmed the exit door failed to latch after testing the door 3 times. 2. At 10:35 a.m., the door to the Ice Machine Room in the Alzheimer's Unit failed to latch. Staff confirmed the door hit the frame when the door	K 018	K018 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. There shall be no impediment to the closing of the doors. The exit door in station 5 by the Laundry room was adjusted so as to positively latch as was the door to the Ice Machine Room in station 5. The Physical Therapy room, back door, at station 1 had a new latching device installed so as to allow positive latching, the hold open objects associated with the door to the Inspector Test Valve room in Station 2 have been removed, the	2/9/15

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K 018	Continued From page 3 was closed which prevented it from latching. 3. At 11:13 a.m., the back door to the Physical Therapy Room in Station 1 failed to positively latch. Upon inspection, staff stated the door had no latching hardware installed. The latching hardware place in the door was hollow. Staff stated he was not aware there was no latching hardware on the door. 4. At 11:48 a.m., the door to the Inspectors Test Valve (ITV) room in Station 2, near the Oxygen Storage Room, was observed to be held open by approximately 5 ceramic tiles wrapped around a cloth towel. Staff confirmed the door was being held open and removed the tiles with the towel. 5. 11:54 a.m., the door to the Clean Linen Closet near Room 10 in station 1 failed to positively latch when tested. Staff confirmed the door failed to latch. 6. At 12:28 p.m., the door to the DSD office near the Employee Lounge was observed to be held open by a door stopper. Staff confirmed the door was being held open by the door stopper and removed it. 7. At 12:29 p.m., the exit door near the Beauty Shop and Employee Lounge failed to positively latch when tested. Staff confirmed the door failed to latch after testing the door 3 times. 8. At 12:30 p.m., the door to the Employee lounge by the DSD office failed positively latch when tested. Staff confirmed the door failed to latch.	K 018	Linen Closet door near room 10 has had the latch adjusted to ensure positive latching, the door to the DSD office has had the door stopper removed, and the Employee lounge door had the latch adjusted so as to ensure positive latching. The DSD shall provide an in-service to all staff with reference to the need to ensure that doors are not held open by device, failure to latch or broken attachments. They shall report any noted item to the Maintenance Director for proper remedial action. The Maintenance team shall be responsible for continuing compliance. This shall be done be their response to reports of individual door issues and the daily rounds of the Maintenance Director to observe for issues. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	

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K 018	Continued From page 4	K 018		
K 029 SS=D	2 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their hazardous areas, as evidenced by penetrations, and doors held open in hazardous areas. This could lead to an increased risk for the spread of smoke and fire from hazardous areas into other parts of the building and affected one of six smoke compartments. Findings: During a tour of the facility with the Facility Manager on 1/13/15, the hazardous areas in the facility were observed. 1. At 10:20 a.m., an approximately 1 inch penetration was observed on the wall of the	K 029	K029 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. The penetrations were repaired and the paper ball preventing door latching was removed. The DSD shall provide an in-service to all staff with reference to the need to ensure that doors are not held open by device, failure to latch or broken attachments. They shall report any noted item to the Maintenance Director for proper remedial action. The Maintenance team shall be responsible for continuing compliance. This shall be done be their response to reports of individual door issues and the daily rounds of the Maintenance Director to observe for issues.	2/9/15

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K 029	Continued From page 5 Laundry Room inside the Alzheimer's Unit, by the soiled linen exit door. Upon interview, staff confirmed the penetration and stated it may have been caused by a portable fire extinguisher that was installed on that wall. 2. At 10:21 a.m., the door to the soiled linen area of the Laundry Room in the Alzheimer's Unit was observed to be held open by a paper ball inside of the latching hardware. Staff confirmed the paper ball was keeping the door from closing, and removed the paper ball. 3. At 10:27 a.m., the door to the Clean Linen area of the Laundry Room in the Alzheimer's Unit failed to latch when tested. The door was being help open by a door stopper. Staff confirmed the door failed to latch and removed the door stopper.	K 029	Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution. K047 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. All Exit and directional signs shall be displayed and illuminated per requirements. The Exit sign in station 5 leading to the breezeway was repaired. The DSD shall in-service the maintenance staff with reference to ensuring that all requires Exit and directional signs are in working order at all times. The Maintenance Director shall be responsible for ongoing compliance by his daily rounds and noting any item in need of repair or bulb replacement.	2/9/15
K 047 S8=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their exit signs, as evidenced by one exit sign that failed to illuminate when tested. This could lead to a delay in accessing exits in the event of an emergency evacuation, and affected one out of six smoke compartments. Findings:	K 047		

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K 047	Continued From page 6 During a tour of the facility with the Facility Manager on 01/13/15, the exit signs in the facility were observed. At 11:00 a.m., the exit sign leading into the "Breezeway" from the Alzheimer's Unit failed to turn on when tested by staff. Upon interview, staff stated he was aware this exit sign was not working and they are in the process of repairing the exit sign.	K 047	Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their fire alarm system, as evidenced by two of three Fire Alarm Control Panels (FACP) that had expired batteries. This could lead to a malfunction of the fire alarm system in the event of an emergency and affected two out of six smoke compartments. Findings:	K 052	K052 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. The fire alarm system backup batteries shall not have expired exchange dates upon them and shall be replaced prior to said date to ensure their freshness. These batteries noted in the summary of deficiency have been replaced. The DSD shall in-service the Maintenance staff about the need to ensure that backup batteries are maintained in a fresh and compliant manor. The Maintenance Director	2/9/15

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K 052	Continued From page 7 During a tour of the facility with the Facility Manager on 01/13/15, the Fire Alarm system and components were observed. 1. At 10:53 a.m., the batteries inside the FACP located in the Alzheimer's Unit Station 5, were expired. Writing on the FACP batteries read: "New 8/31/09 Replace 8/31/13". Upon interview, staff stated he had not realized the batteries had expired. Staff stated vendor had checked and replaced batteries in the main FACP, but may have not checked these batteries. 2. At 12:11 p.m., the batteries inside the FACP located in the clean linen closet in Station 2 were expired. Writing on the FACP batteries read : "New 8/31/09 Replace 8/31/13". Upon interview, staff stated he was unaware these batteries had expired and they may have been overlooked when the batteries from the main control panel were replaced.	K 052	shall be charged with maintaining this system in accordance with requirements. He shall maintain a log of all batteries "change by" dates on cause any expiring battery to be changed the month prior to said event and listing a new date in the log at that time. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution. K054	2/9/15
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their smoke detectors as evidenced by one smoke detector that was completely covered in blue masking tape. This could lead to a delay in the activation of the fire alarm system, and notification to staff in the event	K 054	This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. All required smoke detectors shall be approved, maintained, inspected and tested in accordance with the requirements. The tape covering the smoke detector has been removed. The Maintenance Director shall provide	

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K 054	Continued From page 8 of an emergency and affected one out of six smoke compartments. Findings: During a tour of the facility with Facility Manager on 01/13/2015, the smoke detectors in the facility were observed. At 10:43 a.m., the Smoke Detector located in patient Room 218, in the Alzheimer's Unit, was observed to be completely covered with blue masking tape. Upon interview, staff stated a vendor had recently been doing some plumbing work inside the room, and had covered the smoke detector, but forgot to remove it when the work was completed.	K 054	and in-service his staff with reference to the need to ensure that any device put in place during a maintenance period are removed immediately upon completion and that all detectors are in functional order. The Maintenance Director shall maintain ongoing compliance by daily rounds of the facility and specific inspections of work areas after completion of the specific tasks. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	
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 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their portable fire extinguishers, as evidenced by one portable fire extinguisher in the facility that wasn't secured and by one portable fire extinguisher that was obstructed from access. This could lead to a delay in accessing the portable fire extinguishers in the event of an emergency and affected one of six smoke compartments.	K 064	K064 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. All portable fire extinguishers shall be provided in accordance with the requirements. The fire extinguisher that came lose, screws removed from wall, has been	2/9/15

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K 064	Continued From page 9 NFPA 101, Life Safety Code, 2000 Edition 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 ½ ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). Chapter 4 Inspection, Maintenance and Recharging 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of a least the following items: (a) Location In designated Place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) *Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage,	K 064	replaced and properly located on the laundry room wall. The rolling cart partially obstructing the fire extinguisher has been moved so as not to obstruct said fire unit. The DSD shall provide an in-service to the facility staff with reference to the need to ensure that the facilities fire extinguishers are in their proper place and always present. Also direction to the effect that fire extinguishers and alarm pull stations are not to be blocked or obscured by any item or items. The Maintenance Director shall be responsible for ongoing compliance. This thru his and staff daily rounds observation and reports. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	

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K 064	Continued From page 10 corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place Findings: During a tour of the facility with the Facility Manager on 01/13/15, the portable fire extinguishers in the facility were observed. 1. At 10:22 a.m., a portable fire extinguisher was observed sitting unsecured, directly on the floor of the soiled linen area in the Laundry Room in the Alzheimer's Unit. Staff confirmed the fire extinguisher was sitting on the floor unsecured and stated that the fire extinguisher may have fallen off the wall where it was mounted. 2. At 10:25 a.m., the portable fire extinguisher in the Laundry area of the Laundry Room was observed to be obstructed by a laundry cart. The cart was placed directly in front of the portable fire extinguisher blocking 50% of its access and visibility. Staff confirmed the fire extinguisher was obstructed and moved the linen cart.	K 064	K073 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. The facility shall not use furnishing or decorations of highly flammable character. The items noted in room 41 were removed and are in keeping with this requirement. The facility requested that the family remove the items and refrain from the profusion of decorations in the future, as the presence of such items could be problematic. The DSD shall provide an in-service to the Nursing and Social Service staff with reference to flammable item/decoration being placed in individual resident rooms. While we absolutely encourage a homelike environment we need to maintain the facility within requirements and provide fire safety. The Social	2/9/15
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their building free of flammable	K 073		

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	055750	A. BUILDING 01 B. WING	01/13/2015

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K 073	Continued From page 11 decorations, as evidenced by one patient room in the facility with walls and ceilings that were covered with flammable decorations. This could lead to an increased risk for fire in a patient room and affected one of six smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. Findings: During a tour of the facility with the Facility Manager on 01/13/15, the decorations in the building were observed. At 12:27 p.m., in patient Room 41, the walls and ceilings of Bed A, and part of B were observed to be covered in multiple combustible decorations. More than 9 flammable decorations made out of paper and plastic, including piñata's were observed hanging from the ceiling. The walls of Bed A were 70% covered with flammable decorations, including pictures, hats, wreaths. Upon interview, staff stated he wasn't sure if the decorations on the wall were flame retardant, and stated the patient likes to have piñata's in her room.	K 073	Service Director shall in-service (speak with) the daughter of the individual resident about this issue. The Social Service Director shall be responsible for continuing compliance thru her daily room rounds, observation and staff reports. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	K 104	K104 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. All smoke barriers and ducts shall be free from penetration and maintained in accordance with all requirements.	2/9/15

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K 104	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and observation, the facility failed to maintain their smoke barriers, as evidenced by one smoke barrier wall that had an unsealed penetration around cable wiring. This could lead to an increased risk of smoke or fire from one smoke compartment to another, and affected one of six smoke compartments. Findings: During a tour of the facility with the Facility Manager, on 01/13/15, the smoke barrier walls were observed. At 2:14 p.m., an unsealed 2 inch penetration was exposing 3 cables on the right side of the smoke barrier wall in the Alzheimer's Unit, Station 5. Upon interview, staff stated vendor had done some cable work and must have forgotten to seal the penetration by the cables.	K 104	The penetration in the smoke barrier wall in station 5 was repaired. The Administrator shall in-service the maintenance department with reference to the need to maintain the integrity of barrier walls. The Maintenance Director shall be responsible for continuing compliance thru a review of barrier walls no less often than every other month and after any and all work in the attic of the facility. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	
K 144 SS=D	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	K144 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. Facility Generators shall be maintained in accordance with the requirements.	2/9/15

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K 144	Continued From page 13 This STANDARD is not met as evidenced by: Based on interview, document review and observation, the facility failed to maintain their generators, as evidenced by the failure to provide an annual load bank test on a diesel powered generator, and generator emergency back up lighting that failed when tested. This could lead to a malfunction of the generator, or a delay in accessing the generators in the event of an emergency, and affected six of six smoke compartments. NFPA 99, Standard for Health Care Facilities, 1999 Edition 3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1.* Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2. Test Conditions. The scheduled test under load	K 144	The facility has maintained the same emergency generators for Decades and the Diesel since 2006, never until this inspection has a "Load Bank" test on the Diesel Generator been requested or required. However we have scheduled such a test with our generator service and shall do so on an annual basis. The light associated with this generator shall be fixed at that time. The facility replaced the non-functioning "flashlights" which seem to have succumbed to the weather conditions. The Maintenance team shall check them at least monthly (turning them on/off) to ensure that they function as well as weekly observation that they are present. The Administrator shall give an in-service to the Maintenance team with reference to the need to ensure that the generator test is accomplished annually and that the lights work. The Maintenance	

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K 144	Continued From page 14 conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. Findings: During a tour of the facility and document review	K 144	Director shall be charged with continuing compliance thru his daily rounds, weekly observation, physical function checks and annual log requirement. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	

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K 144	Continued From page 15 with the Facility Manager, the generators in the facility were observed. 1. At 9:37 a.m., the documentation for the annual load bank test on the diesel powered generator was requested. No documentation was provided. Upon interview, staff stated a total of 4 generators serviced the facility. Staff stated 3 of 4 generators were powered by natural gas and 1 was a Diesel powered generator. Staff stated he was unaware of the 30% nameplate rating on the diesel powered generator and stated he was unaware of the annual load bank test requirement. Staff stated he was completing the monthly test on the generator under full load, and this was verified with documentation. 2. At 10:06 a.m., the emergency back up lights by Generator 1 (Diesel powered generator) located outside, failed to illuminate when tested. Upon interview, staff stated he didn't know why the emergency lights were not turning on. 3. At 10:17 a.m., the portable flashlight by Generator 2 (natural gas generator) by Station 3, failed to illuminate when the staff tried to turn on the flashlight. Upon interview, staff stated that they are doing weekly inspections on the flashlights, and wasn't sure why they were not working. Staff stated these served as their emergency back up lighting for the natural gas generators. 4. At 10:18 a.m., the flashlight by Generator 3 (natural gas generator) by station 2, failed to illuminate when staff tried to turn on the flashlight. Upon interview, staff confirmed the flashlight was not working.	K 144		

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K 144	Continued From page 16 5. At 10:19 a.m., staff confirmed the portable flashlight by Generator 4 (natural gas generator) by Station 5 also failed when tested.	K 144		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to maintain their fire watch policy, as evidenced by the failure to provide a fire watch policy in the event an automatic sprinkler system is out of service more than 4 hours in a 24-hr period. This could lead to staff not knowing the procedure in the event of a sprinkler system failure and a delay in notifying the proper authorities. This affected six of six smoke compartments. Findings: During document review with DSD and Facility Manager on 01/13/2015, the fire watch policy for the facility was reviewed. At 12:18 p.m., no fire watch policy was provided in the event the automatic sprinkler system is out of service more than 4 hours in a 24-hr period.	K 154	K154 This facility shall be in substantial compliance with 42 CFR for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD. This facility shall provide a fire watch system and report implementation of same to DPH, should it be required. Said "watch" should the automatic sprinkler system be out of service for more than 4 hours in a 24-hour period. The DSD shall in-service the facility staff with reference to the Fire Watch and reporting system and requirements. The Administrator shall ensure that the fire policy manual is updated to include this requirement. The Administrator, Director of Nursing and Maintenance Director shall be charged with the continuing compliance of the requirements	2/9/15

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K 154	Continued From page 17 Upon interview, staff confirmed the automatic sprinkler system failure was not included as part of their current fire watch policy for the fire alarm system failure.	K 154	thru review of any and all power outages, water outages, alarm issues of any type to ensure proper notifications were made and "Fire Watch" implemented and maintained as required. Should any issue arise from the resolution to this issue shall be referred to the Quality Assurance Team at their daily (M-F) morning meeting for action and resolution.	