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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING _____	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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: K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TYPE (V) (III), 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. Representing the California Department of Public Health: 31070 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 83	K 000		
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 no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6	K 018	K018 • Self-closing door to Maintenance Supervisor's Office, Employee Breakroom and Executive Directors Office will be serviced by third party /outside provider. • Obstructions to Door of Room 1 and 2 were moved. • An outside provider will service all deficient self-closing doors. Wheelchair and Walker were relocated to an area of the room that did not obstruct doors. • Environmental Services Supervisor will monitor self-closing doors monthly and do preventative maintenance as needed. Director of Staff Development will do an Inservice with nursing and environmental staff regarding obstructions of doors by 10/11/12. Director of Staff Development and Environmental Services Supervisor will monitor all rooms for items that may obstruct doors. • Facility will create and maintain a log with self-closing doors, which will be checked monthly for compliance. Environmental Services Supervisor to do daily rounds to check for obstruction of doors. Project Manager and Administrator will do periodic checks to ensure full compliance. • Log will be created by 10/10/12 and Servicing of all deficient doors will be completed by 10/12/12. Inservice completed by 10/11/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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.

10/11/12 POC Accepted Per Joel Galvez HFES II

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING _____	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 1	K 018		

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 their doors as evidenced by self-closing doors that failed to latch when released and doors that were obstructed from closing. This deficient practice could result in the faster spread of fire and/or smoke in the event of a fire. This affected 2 of 2 smoke compartments.

Findings:

On 9/24/12, during facility tour with the Maintenance Supervisor, the doors were observed.

1. At 2:13 p.m., the self-closing door to the Maintenance Supervisor's office failed to latch. The door was held open to the fullest extent and released. The Maintenance Supervisor confirmed the door failed to latch.

2. At 2:50 p.m., the self-closing door in the Employee Breakroom near the courtyard failed to latch. The Maintenance Supervisor confirmed the door failed to latch.

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 3. At 2:59 p.m., the door to Room 1 was obstructed by a wheelchair. The Maintenance Supervisor moved the wheelchair. 4. At 3:01 p.m., the door to Room 2 was obstructed by a walker. The Maintenance Supervisor moved the walker. 5. At 3:23 p.m., the self-closing door to the Executive Director's office failed to latch. The door was held open to the fullest extent and released. The Maintenance Supervisor confirmed the door failed to latch.	K 018		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.3. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke barrier doors as evidenced by 1 fire door that failed to latch during fire alarm testing. This deficient practice could result in the faster spread of fire and/or smoke in the event of a fire. This affected 1 of 1 smoke compartments.	K027 K 027	• Station 2 Fire Door and panic hardware will be serviced by an outside provider. • An outside provider will service all fire doors. • Environmental Services Supervisor will monitor fire doors monthly during generator checks. An outside provider will service all fire doors on a semi-annual basis to ensure deficient practice does not reoccur. • Facility will include a log for fire doors, which will be checked quarterly for compliance. Project Manager and Administrator will do periodic checks to ensure full compliance. • Log will be created by 10/10/12 and Servicing of all deficient doors will be completed by 10/12/12.	

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING _____	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 027	Continued From page 3 NFPA 101 Life Safety Code, 2000 edition 7.2.4.3.8* All fire doors in horizontal exits shall be self-closing or automatic-closing in accordance with 7.2.1.8. Horizontal exit doors located across a corridor shall be automatic-closing in accordance with 7.2.1.8. Exception: Where approved by the authority having jurisdiction, existing cross-corridor doors in horizontal exits shall be permitted to be selfclosing. Findings: On 9/24/12, during fire alarm testing with the Project Manager, the fire doors were observed. At 12:06 p.m., the fire door located by Station 2 released from the magnetic holding device but failed to latch. The fire door was re-tested two times. The panic hardware was hard to push open.	K 027		
K 029 SS=E	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	K 029	K029 • Environmental Services Supervisor moved laundry cart, installed a self-closing device on Medical Records door and repaired latch on Oxygen storage room. • Director of Staff Development to do inservice on obstruction of doors with all laundry personnel. Environmental Services Supervisor will monitor latches on deficient doors for compliance. • Environmental Services Supervisor to do quarterly checks on deficient latches to ensure compliance. Project Manager and Administrator to do periodic checks to ensure full compliance. • All laundry staff to by inserviced by Director of Staff Development by 10/11/12 on obstruction of doors. Plan of correction completed by 10/11/12.	

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 029	Continued From page 4	K 029		

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to protect hazardous areas, as evidenced by one storage room door that was not self-closing, one door that was held open to prevent closing and one self-closing door that failed to latch. This deficient practice could result in the faster spread of fire and/or smoke in the event of a fire. This affected 2 of 2 smoke compartments.

Findings:

On 9/24/12, during facility tour with the Maintenance Supervisor, the hazardous areas were observed.

1. At 2:32 p.m., the self-closing door to the Laundry room was held open with the laundry cart.

2. At 2:47 p.m., the door to the Medical Records room was not equipped with a self-closing device. The room was greater than 50 square feet. The room was 12 ft by 11 ft. There was an excessive amount of combustibles. There were approximately 100 cardboard boxes of medical records. The Maintenance Supervisor confirmed the door was not self-closing.

The Project Manager confirmed that there were approximately 100 cardboard boxes of medical records. The Project Manager stated "I stopped counting after 50 boxes".

3. At 3:31 p.m., the self-closing door to the Oxygen Storage near Room 10 failed to latch.

K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064	

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 SS=E	Continued From page 5 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 observation, the facility failed to maintain their fire extinguishers as evidenced by 1 extinguisher that had a missing safety seal on the extinguisher pull pin and 1 portable fire extinguisher that was overcharged. This deficient practice could result in the pin being able to be removed and the locking mechanism being discharged and the portable fire extinguisher being non-operable in the event of a fire. This affected 1 of 4 smoke compartments. NFPA 10, 1998 Edition, Sec 1-6.2 Portable fire extinguishers shall be maintained in a fully charged and operable condition, and kept in their designated places at all time when they are not being use. 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at 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 K064	• Deficient extinguishers serviced by outside provider. Safety seal replaced and break room extinguisher correctly charged. • Facility will create log for monitoring of servicing of fire extinguishers to ensure deficient practice does not reoccur. • Environmental Services Supervisor will monitor servicing of fire extinguishers on a monthly basis. Project Manager and Administrator to do periodic checks to ensure full compliance. • Plan of correction completed by 10/11/12.	

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 6 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: On 9/24/12, during facility tour with the Maintenance Supervisor, the fire extinguishers were observed. 1. At 2:40 p.m., the K Class extinguisher in the Kitchen was missing the safety seal on the extinguisher pull pin. 2. At 2:44 p.m., the portable ABC fire extinguisher in the Employee Breakroom was overcharged. The needle pointed to the red zone marked overcharged.	K 064		
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 document review and interview, the facility failed to maintain their emergency lighting, as evidenced by no written records for the monthly and annual testing of the emergency lighting. This deficient practice could lead to a malfunction of the emergency lighting going undetected and affected 4 of 4 smoke compartments.	K 147	K147 • Emergency lighting logs were created by the Project Manager on 9/25/12. • Logs will be kept for monthly and annual checks. • Environmental Services Supervisor will monitor logs monthly for compliance. Project Manager to do periodic checks to ensure full compliance. • Plan of correction completed 9/26/12.	

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

PRINTED: 09/26/2012
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
	555792	A. BUILDING 01 B. WING _____	09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVALE HEALTH CARE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

(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 7 NFPA 101, Life Safety Code, 2000 Edition 7.9.3.: Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An Annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 ½ hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. Findings: On 9/24/12, during document review, the emergency lighting documents were requested.. At 11:02 a.m., there were no logs for the testing of the emergency lighting. Upon interview, the Maintenance Supervisor stated "I was not aware a log had to be kept, no one has every asked for that before. I did not know the lights need to be check 30 seconds monthly and 90 minutes annually.	K 147		