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

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
	055292	A. BUILDING 01 B. WING	03/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIELDS RICHMOND NURSING CENTER	1919 CUTTING BLVD RICHMOND, CA 94804

(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: 9/1/1967 K7 Survey Under: 2000 Existing K12 Structure Type: One Story, Type V (III), 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 Department of Public Health: 31203 Census: 71 The facility is not in compliance with 42 CFR 483.70 (a) for Long Term Care Facilities.	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 in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE Administrator (X6) DATE 3-25-2015

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. 3/26/15 Toc Acceptable per Jeanette Harkell, HFES

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K 012	Continued From page 1 Based on observation and interview, the facility failed to ensure the integrity of the building construction as evidenced by an unsealed penetrations in the walls. This affected one of three smoke compartments, which could result in the passage of smoke or fire to other locations in the event of a fire. NFPA 101, Life Safety Code, 2000 edition 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures	K 012	K 012 ***What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.*** 1. The approximately ½ inch circular unsealed penetration in the wall near the fire extinguisher across from Nurse Station1that affected one of three smoke compartments was sealed on 3/02/2015 with 3M fire barrier sealant. 2. The approximately 3 ½ feet by 1 foot unsealed penetration in the wall in DSD office was sealed on 3/03/2015 with 5/8 fire rated sheet rock. ***How other patients having the potential to be affected by the deficient practice will be identified, and what corrective action will be taken.*** All residents have the potential to be affected. The penetrations have been sealed. ***What immediate measures and systemic changes will be put into place to ensure the deficient practice does not recur.*** Administrator and Maintenance Director will do monthly environmental/physical plant check. Any noted penetrations during these checks will be repaired immediately.	

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K 012	Continued From page 2 of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) *Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:	K 012	***How the facility plans to monitor its performance to ensure corrections achieved and sustained.*** ***A QA review will be conducted by the QA/CQI Committee on April 8, 2015 and then every 3 months (quarterly) and as needed to monitor for the completion of the monthly environmental/physical plant checks and the correction of any indicated penetrations.***	

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K 012	~~Continued From page 3~~ a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. Findings: During the facility tour and interview with the Maintenance Director on 3/2/15, the walls were observed. 1. At 9:23 a.m., there was an approximately 1/2 inch circular unsealed penetration in the wall near the fire extinguisher across from Nurse Station 1. 2. At 9:37 a.m., there was an approximately 3 1/2 feet by 1 foot unsealed penetration in the wall in the Director of Staff Development (DSD) office. The Maintenance Director stated that the sheet rock was cut due to a leak in the shower room near the DSD office, and they are in the process of repairing.	K 012		
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	K 018	**K 018** ***What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.*** 1.The approximately ½ inch circular penetration above the break room door knob that affected two of three smoke compartments was sealed with 3M fire sealant on 3/02/15.	

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K 018	Continued From page 4 in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain corridor doors to resist the passage of smoke. This was evidenced by a corridor that required force to open, and by a door that had an unsealed penetration. This affected two of three smoke compartments, and could result in the passage smoke and flames in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised	K 018	2. The corridor to Room 16 that was hard to open once in closed position that affected two of three smoke compartments was repaired on 3/18/15 by having the bottom part of the door panel trimmed to ensure proper opening and closing of the door. ***How other patients having the potential to be affected by the deficient practice will be identified, and what corrective action will be taken.*** All residents have the potential to be affected. The penetration has been sealed and door repaired to open and close properly. ***What immediate measures and systemic changes will be put into place to ensure the deficient practice does not recur.*** Maintenance Director has log to check all facility doors monthly for proper operation. Administrator and Maintenance Director will do monthly environmental/physical plant check. Any noted penetrations as well as corridor doors that aren't opening and closing properly during these checks will be repaired immediately.	

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K 018	~~Continued From page 5~~ automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. Findings: During a tour of the facility and interview with the Maintenance Director on 3/2/15, the corridor doors were observed. 1. At 9:58 a.m., the Break Room door had an approximately 1/2 inch circular penetration above the door knob. This finding was confirmed by the Maintenance Director. 2. At 10:11 a.m., the door to Room 16 was hard to open once in closed position. The Maintenance Director used force to open the	K 018	***How the facility plans to monitor its performance to ensure corrections achieved and sustained.*** A QA review will be conducted by the QA/CQI Committee on April 8, 2015 and every 3 months (quarterly) and as needed to monitor for the completion of the monthly logging and environmental/physical plant checks and the correction of any indicated penetrations and/or doors that aren't opening or closing properly.	

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K 018	Continued From page 6	K 018		
	door. This finding was confirmed by the Maintenance Director.			
K 054 SS=E	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 observation, document review, and interview, the facility failed to maintain their smoke detectors. This was evidenced by failure to provide documentation for the testing and maintenance of single station smoke detectors in accordance with manufacturer's specifications. This affected three of three smoke compartments, and could result in a delay in residents and staff notification in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition 9.6.1.3* The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be	K 054	**K 054** ***What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.*** To provide documentation for the testing and maintenance of single station smoke detectors that affected three of three smoke compartments, a weekly log has been created to provide documentation for the weekly testing for the single station smoke detectors that require weekly testing per the manufacturers specifications. ***How other patients having the potential to be affected by the deficient practice will be identified, and what corrective action will be taken.*** All residents have the potential to be affected. Log has been created to ensure proper documentation of weekly testing. ***What immediate measures and systemic changes will be put into place to ensure the deficient practice does not recur.*** Maintenance Director and/or his staff, starting the week of 3/23/15 will check the single station smoke detectors weekly according to the manufactures specifications and this will be logged for supporting documentation of the weekly checks.	

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K 054	Continued From page 7 continued in use, subject to the approval of the authority having jurisdiction. NFPA 72, National Fire Alarm Code, 1999 Edition. 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system. Findings: During observation, document review and interview with the Maintenance Director on 3/2/15, the single station smoke detectors were observed. At 9:51 a.m., the facility failed to provide documentation for the testing of single station smoke detectors. The Maintenance Director stated that the single station smoke detectors are tested monthly, but not tested weekly as per the manufacturers recommendation.	K 054	***How the facility plans to monitor its performance to ensure corrections achieved and sustained.*** ***A QA review will be conducted by the QA/CQI Committee on April 8, 2015 and every 3 months (quarterly) and as needed to monitor that the weekly logging is being done to provide documentation that the single station smoke detectors are being check weekly according to the manufactures specifications.***	
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	K 076	**K 076** ***What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.*** The empty E-cylinder that was marked empty and stored in the same rack as eleven marked full E-cylinders which affected one of three smoke compartments and could result in confusion and delay if a full cylinder is needed in the event of an emergency was put in the empty rack immediately on 3/02/15 the day of the survey.	

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K 076	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the storage of oxygen gas cylinders as evidenced by failure to segregate empty cylinders from full cylinder. This affected one of three smoke compartments, and could result in confusion and delay if a full cylinder is needed in the the event of an emergency. NFPA 101, Life Safety Code 2000 Edition 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than	K 076	***How other patients having the potential to be affected by the deficient practice will be identified, and what corrective action will be taken.*** All residents have the potential to be affected. The empty E-cylinder was placed in the empty rack. ***What immediate measures and systemic changes will be put into place to ensure the deficient practice does not recur.*** Staff in-servicing will be done on 3/25/15 to make sure that staff is instructed on proper placement of E-cylinder in correct rack depending on if empty or full. Administrator and Maintenance Director will do monthly environmental/physical plant check which will include making sure E-cylinders are placed in correct rack. Any misplaced E-cylinders will be immediately placed correctly. ***How the facility plans to monitor its performance to ensure corrections achieved and sustained.*** A QA review will be conducted by the QA/CQI Committee on April 8, 2015 and every 3 months (quarterly) and as needed to monitor for the completion of the monthly environmental/physical plant checks and the correction of any misplaced E-cylinders. This will also determine if more in-servicing is required.	

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K 076	Continued From page 9 those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Healthcare Facilities 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 16 Nursing Home Requirements 16-3.8 Gas Equipment Requirements. 16-3.8.1 Patient. Equipment shall conform to requirements for patient equipment in Chapter 8. Chapter 8 Gas Equipment 8-3-1.11.1 Storage Requirements 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft.3 (85 m3). (h) Cylinder or container restraint shall meet 4-3.5.2.1 (b) 27 4-3.5.2.1 Gases in Cylinders and Liquefied Gases in Containers- Level 1 (b) Special Precautions- Oxygen Cylinders and Manifolds. Great care shall be exercised in handling oxygen	K 076		

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K 076	Continued From page 10 to prevent contact of oxygen under pressure with oils, greases, organic lubricants, rubber, or other materials of an organic nature. The following regulations, based on those of the CGA Pamphlet G-4, Oxygen, shall be observed: 27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. NFPA 99 Standard for Health Care Facilities, 1999 Edition 4-5.5.2.2 Storage of Cylinders and Containers (b) Nonflammable Gases. 1. Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 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 a tour of the facility with the Maintenance Director on 3/2/15, the oxygen storage rooms were observed. At 10:00 a.m., in the Oxygen Storage room across from the Dining room, there was one marked empty E-cylinder stored in the same rack as eleven marked full E-cylinders.	K 076		
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	K 147		

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

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
	055292	A. BUILDING 01 B. WING	03/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the electrical wiring, as evidenced by the use of a surge protector. This affected one of three smoke compartments, and could result in the ignition of an electrical fire. NFPA 101, Life Safety Code, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (a) Unused Openings. Unused openings in boxes, raceways, auxiliary gutters, cabinets, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. 400-7 Uses Permitted (a) Uses. Flexible cords shall be used only for the following: 1) Pendants 2) Wiring of fixtures 3) Connection of portable lamps, portable and mobile signs or appliances 4)Elevator cables 5) Wiring of cranes and hoists 6) Connection of stationary equipment to facilitate their frequent interchange 7) Prevention of the transmission of noise or	K 147	**K 147** ***What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.*** The water cooler system that was plugged into a surge protector instead of directly into the wall outlet in the Sports Bar that affected one of three smoke compartments was unplugged from the surge protector on 3/02/15 the day of the survey and plugged directly into the wall electrical outlet. ***How other patients having the potential to be affected by the deficient practice will be identified, and what corrective action will be taken.*** All residents have the potential to be affected. The water cooler system was unplugged from the surge protector and plugged directly into the wall electrical outlet.	

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K 147	Continued From page 12 vibration 8) Appliances where the fastening means and mechanical connections are specifically designed to permit ready removal for maintenance and repair, and the appliance is intended or identified for flexible cord connection\ 9) Data processing cables as permitted by Section 645-5 10) Connection of moving parts 11) Temporary wiring as permitted in Sections 305-4 b)& 305-4 c) 400-8. Uses not Permitted. Unless specifically permitted in Section 400-7, flexible cords 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. Findings: During a tour of the facility with the Maintenance Director on 3/2/15, the electrical wiring in the facility was observed. At 10:15 a.m., there was a water cooler system plugged into a surge protector instead of directly into the wall outlet in the Sports Room. This finding was confirmed by the Maintenance Director.	K 147	***What immediate measures and systemic changes will be put into place to ensure the deficient practice does not recur.*** Staff in-servicing will be done on 3/25/15 to make sure that staff is instructed on understanding that such device such as water cooler system should be plugged directly into wall electrical outlet and they should check with Maintenance Director if unsure. Administrator and Maintenance Director will do monthly environmental/physical plant check which will include making sure that the water cooler system continues to be plugged directly into wall electrical outlet. ***How the facility plans to monitor its performance to ensure corrections achieved and sustained.*** A QA review will be conducted by the QA/CQI Committee on April 8, 2015 and every 3 months (quarterly) and as needed to monitor for the completion of the monthly environmental/physical plant checks to make sure the watercolor system continues to be plugged directly in the wall electrical outlet.	