STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055249	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(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: 1970 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE (V) (111), PARTIALLY 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: 29752 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 71	K 000	K 000 Country Villa Merced Nursing & Rehabilitation submits this response and Plan of Correction as part of the requirements under state and federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are replied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party.	3/19/14
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	K 018		

[redacted] ATURE [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. [redacted]

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K 018	Continued From page 1 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 corridor doors. This was evidenced by doors that were obstructed from closing or latching. This affected one of three smoke compartments and could result in a delay in containing smoke or fire to a room. Findings: During a facility tour with Maintenance Staff 1 on 2/19/14, the corridor doors were observed. 1. At 11:20 a.m., the self closing door to the beauty shop was obstructed from closing by a rubber door wedge that was placed between the floor and the door in the fully open position. 2. At 4:47 p.m., the corridor door to Room 20 failed to close completely. The door was obstructed from closing completely due to the door's strike plate that was loose. 3. At 4:49 p.m., the door for the Social Services office was obstructed from closing. The door was equipped with a self closer but was held in a fully open position by a rubber wedge that was placed between the floor and the door.	K 018 K 018	The facility will ensure that each corridor door will correctly self-close completely and freely without hazard or obstruction when the fire alarm is activated in accordance with current safety code standards. Maintenance Supervisor has removed from use the rubber door wedge from the self closing to the beauty shop as well as the Social Service office door. Strike plate to the door of Room 20 has been repaired and is now currently functioning correctly. Facility Maintenance Supervisor will immediately check all facility corridor doors to ensure that they close safely and function properly in the event of fire at the facility.	3/19/14

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K 029 SS=D	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 observation, the facility failed to ensure hazardous areas resisted the passage of smoke. This was evidenced by one ceiling penetration and two doors that were obstructed from closing or latching. This affected two of three smoke compartments and could result in a delay in containing smoke or fire to a hazardous area. NFPA 101, 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	K 029	The Facility Maintenance Supervisor on a monthly basis will inspect the facility corridor doors for any flaws that may cause them to not close properly when the fire alarm is activated. A log of his repairs will be kept and the Administrator will be notified of any negative findings. On a monthly basis the Maintenance Supervisor will report findings to the Continuous Quality Improvement Committee regarding the safety status of the facilities corridor doors for review and any possible recommendations. K 029 The facility will ensure that all hazardous areas have no wall penetrations in the future. Maintenance Supervisor will immediately repair the ½ inch penetration around the 6 inch diameter exhaust vent in the	3/19/14

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K 029	Continued From page 3 (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 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. Findings: During a tour of the facility and interview with Staff 2 on 2/19/14, the hazardous area enclosures were observed. 1. At 11:35 a.m., there was an unsealed 1/2 inch penetration around a 6 inch diameter exhaust vent in the ceiling of the hot water heater room. The hot water heater room was located across the hallway from the laundry room. 2. At 5:15 p.m., the door to the soiled utility room failed to self close completely and latch. The steel door was bent out of shape around the door handle and the latching hardware was missing. 3. At 5:20 p.m., the laundry hot water heater room door failed to self close completely. The strike	K 029	ceiling of the hot water heater room located across the hallway from the laundry room. The door to the soiled utility room has been repaired allowing it to close and latch completely. New hardware has also been added to the door. Also, the strike plate to the hot water heater room door has been repaired freeing it from any obstruction and it now closes completely and safely. Maintenance Supervisor will perform monthly random checks of the facilities walls and ceilings of it hazardous area's for any unsafe penetrations and ensure the doors to those areas are functioning correctly. Negative findings will be brought forward to the facility monthly CQI committee meeting for possible recommendations for further repairs.	

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K 029	Continued From page 4 plate obstructed the door from closing.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain readily accessible exit passageways as evidenced by one set of cross corridor doors that failed to release when the panic bars were pressed. This affected two of three smoke compartments and could result in a delayed evacuation in the event of an emergency. NFPA 101 (2000 Edition) 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in	K 038	The facility will ensure all of its exit doors function safely without fault, making sure that a safe means of egress is available in the event of an emergency. Facility will enlist the services of a reputable and qualified locksmith to make the necessary adjustments or repairs to the corridor doors located near rooms 4 and 5. Maintenance Supervisor will examine all facility corridor doors for possible malfunction. Negative finding will be report immediately to the Administrator for recommendations. Monthly safety checks of all corridor doors will be made by the Maintenance Supervisor or designee. Findings will be	3/19/14

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K 038	Continued From page 5 Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made. Findings: During a facility tour and interview with Maintenance Staff 1 on 2/19/14, the exit access doors were observed. 1. At 3:30 p.m., the exit access doors located in the corridor between resident rooms 4 and 5 failed to release from the closed and latched position. The cross corridor doors were opposite swinging but failed to open in either direction when the panic bars were depressed during 3 of 5 attempts. Maintenance Staff 1 commented that the latching mechanism required adjustment.	K 038	reviewed by the facilities safety committee on a monthly basis.	
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		

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K 046	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain their emergency lighting units. This was evidenced by the facility's failure to perform a 90 minute annual test on three of three emergency lighting units during the past twelve months. This affected three of three smoke compartments and could result in limited visibility in the event of a power failure. 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 1/2 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 inspections 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: During record review and interview with Maintenance Staff 1 on 2/19/14, the emergency lighting unit test records were requested.	K 046	K 046 The facility will maintain emergency lighting units that are functional and in operating condition. Maintenance Supervisor will immediately perform the required 90 minute test to ensure all emergency lighting unit are functioning to the NFPA 101 Life Safety Code Standards. Results of the test will be kept on file for official review by the Maintenance Supervisor. Any negative findings will be immediately reported to the Administrator for possible recommendations. The facility will ensure a 90 minute test will be performed annually as required by the NFPA 101 Life Safety Code, 2000 Edition 7.9.3 Periodic Testing of Emergency Lighting	3/19/14

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K 046	Continued From page 7 1. At 11:45 a.m., the facility was observed to have three emergency lighting units. The records for the emergency lighting units indicated that the facility completed a 90 second test annually. During an interview, Maintenance Staff 1 confirmed that a 90 minute annual test had not been completed.	K 046	Equipment standards. Negative findings will be brought to the attention of the facility CQI committee by the Maintenance Supervisor or designee. Any needed functional repairs will be immediately made in order to keep the units in a safe working order.	
K 048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to educate all staff in the response to fire emergencies and alarms. This was evidenced by two staff members that did not know how to respond to fire emergencies and one staff member that did not know how to respond to a tamper alarm. This affected three of three smoke compartments and could result in a delayed staff response to a fire or disaster emergency. NFPA 101, 2000 Edition 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area	K 048	2014 MAR 11 AM 10:21 SAN FRANCISCO REGION STATE DEPT OF PUBLIC HEALTH K 048 The facility will ensure that all of its staff are aware of and have knowledge of what the various signals from the fire alarm panel represent and how to respond to various scenario's that may arise during a possible emergency. The Dietary Service Supervisor will in-service the facility dietary staff by 3/19/14 on the proper	3/19/14

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K 048	Continued From page 8 (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire Findings: During a facility tour with Maintenance Staff 1 on 2/19/14, nursing staff and kitchen staff were interviewed. 1. At 2:58 p.m., the Dietary Staff 1 was asked to describe how she would respond to a range top fire. Dietary Staff 1 failed to describe the use of the manual pull station to operate the exhaust hood fire suppression system located over the range top. Dietary Staff 1 was not able to describe when and how to operate the Class K portable fire extinguisher for grease and oil fires. 2. At 3:10 p.m., Nurse Staff 1 was asked to describe how she would respond to a scenario with smoke in a sleeping room with a resident present. Nurse Staff 1 failed to describe removing the resident and closing the door to contain the smoke. 3. At 3:49 p.m., Nurse Staff 2 was asked how to respond to a tamper alarm on the fire alarm control panel, located in the closet behind the nurse station. Nurse Staff 1 indicated that she was not familiar with the purpose of the tamper alarm and stated that she would try to figure it out herself. Nurse Staff 1 subsequently silenced the local audible tamper alarm at the fire alarm control panel before notifying anyone. The tamper alarm was indicating that the automatic fire sprinkler control valve was closed.	K 048	way to use a Class K portable fire extinguisher in the event of a kitchen grease fire. The inservice documentation will be kept on file by the Dietary manager and will be held at least annually. The Director of Staff Development will inservice the facility staff by 3/19/14 regarding facility fire safety procedures. Specifically this inservice will cover the topics of the evacuation of residents from harms way, as well as what the various signals from fire alarm panel, what they mean and how to respond to them. On a quarterly basis, the Director of Staff Development will randomly test the knowledge of facility staff regarding tamper switch notification. Findings will be reported to the CQI committee for possible recommendations.	

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K 052 K 052 SS=F	Continued From page 9 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 record review and interview, the facility failed to maintain their fire alarm system. This was evidenced by the facility's failure to conduct an annual fire alarm system test and inspection during the past twelve months. This affected three of three smoke compartments and could result in a failure of the fire alarm system in the event of a fire emergency. NFPA 72, National Fire Alarm Code, 1999 Edition. 7-3.2 Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply. Table 7-3.2 requires annual testing of building systems connected to the fire supervising station.	K 052 K 052 K 052	3/19/14 The facility will ensure that its fir alarm system is kept in a good operating condition in accordance with current NFPA standards. The facility will enlist the services of a reputable and qualified fire service company and have them perform the annual fire alarm test according to NFPA 72, National Fire Alarm Code standards on an ongoing basis. Test results of the annual test will be kept on file by the Maintenance Supervisor for official review when necessary. Maintenance Supervisor will report the results of the annual fire alarm test to the facility CQI committee for possible recommendations.	

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K 052	Continued From page 10 7-5.2 Maintenance, Inspection, and Testing Records. 7-5.2.2 A permanent record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 7-5.2.2. (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(s) tested, for example, " Tests performed in accordance with Section _____. " (8) Functional test of detectors (9) Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturers (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative (15) Disposition of problems identified during test (for example, owner notified, problem corrected/successfully retested, device abandoned in place) Findings:	K 052		

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K 052	Continued From page 11 During record review and interview with Staff 2 on 2/19/14, the fire alarm system test and inspection records were requested. 1. Between 8:15 a.m. and 11:45 a.m., there were no records that indicated the facility had completed an annual fire alarm system test and inspection during the past twelve months. Staff 2 confirmed that the most recent annual fire alarm system test and inspection had been completed on 2/3/12. The facility was approximately 12 months overdue for an annual fire alarm system test and inspection.	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide a complete automatic fire sprinkler system in accordance with National Fire Protection Association (NFPA) 101, Life Safety	K 056	Facility shall ensure all of its building overhangs and any cloth canopy's that are attached to the building have correct fire sprinkler installed according to NFPA 101 Life Safety Code Standards. The facility will submit plans to its local OSHPD office and secure approval for the installation of fire sprinklers to the building over hangs and canopy located at the front entrance.	3/19/14

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

PRINTED: 02/27/2014
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
	055249	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

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K 056	Continued From page 12 Code, 2000 Edition, and NFPA 13, 1999 Edition. This was evidenced by a cloth canopy that was attached to the main entrance, and an exterior wood frame roof overhang that were greater than four feet in width, and were not equipped with automatic fire sprinkler protection. This deficient practice affected one of three smoke compartments, and could result in the spread of smoke and fire, in the event of a fire. CMS issued S&C-09-04, Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement, dated October 3, 2008. This letter required all long term care facilities to be equipped with a supervised sprinkler system by August 13, 2013, installed in accordance with the 1999 Edition of the National Fire Protection Association's (NFPA) Standard for Installation of Sprinkler Systems (NFPA 13), and maintained in accordance with the 1998 Edition of the National Fire Protection Association's (NFPA) Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, (NFPA 25). NFPA 101, 2000 Edition 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code. Exception No. 2: NFPA 13D, Standard for the	K 056	The facility will schedule the installation of fire sprinklers for its entrance cloth canopy and over hangs that are over 4 feet in width by 3/19/14. The sprinkler installation will be performed by a reputable and qualified fire service company. Maintenance Supervisor will inspect the facility ground for any further attached canopies and over hangs that measure more than 4 feet in width. Negative findings will be reported to the Administrator and immediately scheduled them for fire sprinkler installation.	

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K 056	Continued From page 13 Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code. 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. NFPA 13, 1999 Edition 1-6 Level of Protection. 1-6.1 A building, where protected by an automatic sprinkler system installation, shall be provided with sprinklers in all areas. Exception: This requirement shall not apply where specific sections of this standard permit the omission of sprinklers. 5-13.8 Exterior Roofs and Canopies 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Findings: During a facility tour with Staff 2 on 2/19/14, the roof overhangs and the entrance canopy were observed.	K 056		

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K 056	Continued From page 14 1. At 12:30 p.m., there was no automatic fire sprinkler protection located under the roof overhang at the entrance to the facility. The exterior stucco covered wood frame roof overhang measured approximately six feet in width by seventeen feet in length. 2. At 12:32 p.m., there was no automatic fire sprinkler protection located under the canopy that was attached around the glass doors at the entrance of the facility. The canopy was greater than six feet in width and eleven feet in length, and was constructed of a dark green canvas over a steel square tubing frame. S&C-13-55-LSC dated August 16th, 2013, revised on 12/20/2013, states that CMS will engage with any facility that has a waiver, but has not yet installed sprinklers in overhangs or canopies (and therefore fall into the category of partially sprinklered) to schedule the waiver phase out as part of their plan of correction.	K 056		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	K 066 Facility will use flame resistant smoking receptacles to dispose of all ash and cigarette butts. This will reduce the risk of a fire emergency.	3/19/14

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K 066	Continued From page 15 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their designated smoking areas. This was evidenced by cigarette butts and ashes that were mixed with combustible materials in trash containers. This affected two of two designated smoking areas and could result in a cigarette ignited fire emergency. Findings: During a facility tour and interview with Maintenance Staff 1 on 2/19/14, the smoking areas were observed. 1. At 3:21 p.m., in the resident smoking courtyard, there was a plastic lined metal trash can that was 3/4 full of combustible trash and topped with cigarette butts and ashes. 2. At 5:10 p.m., in the staff smoking courtyard there was a plastic trash container 1/3 full of combustible trash and mixed with several cigarette butts.	K 066	Housekeeping Supervisor will remove the plastic lined metal trash cans from both the resident and staff smoking courtyards in order to reduce the risk of a fire emergency. Housekeeping Supervisor or designee will make daily rounds of smoking areas to ensure smoking urns or ashtray's are properly disposed of in a safe metal container reducing the risk of fire. Negative find will be reported to the facility administrator for possible recommendations. Director of Staff Development will inservice the facility staff on fire safety as it relates to the proper disposal of smoking urns and cigarette butts.	

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K 067 K 067 SS=F	Continued From page 16 NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain their fire/smoke dampers. This was evidenced fire/smoke dampers that had not been tested, inspected, cleaned, or lubricated during the past four years. This affected three of three smoke compartments and could result in the spread of smoke or fire to other locations of the facility due to a malfunctioning fire/smoke damper. NFPA 90A, 1999 edition 3-4.7 At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Findings: During a facility tour, record review, and interview with Facility Staff 2 on 2/19/14, the fire/smoke damper test and maintenance records were requested. 1. Between 10:36 a.m. and 11:18 a.m., fusible link fire/smoke dampers were observed throughout the facility. Maintenance Staff 1	K 067 K 067 K 067	Facility will make certain that its heating, ventilating, and air conditioning system is in compliance with NFPA standards. Maintenance Supervisor will schedule the services of a qualified reputable company to service the facilities HVAC fire dampers throughout the facility. Any negative findings discovered during the servicing of the fire dampers will be repaired and reported to the Administrator for possible recommendations. Records will be kept for future reference and be available to agencies who have the authority to review. The facility Maintenance Supervisor will ensure that its fire dampers are serviced every	3/19/14

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K 067	Continued From page 17 confirmed the fire/smoke dampers. At 11:50 a.m., there were no records available that indicated the facility had tested, cleaned, lubricated, or inspected their fire/smoke dampers during the past four years. At 4:05 p.m., Facility Staff 2 confirmed that he was not able to locate any documents for fire/smoke damper maintenance.	K 067	four years by a qualified reputable company in accordance with NFPA regulations. Records will be kept for future reference and made available to agencies who have the authority to review the documents.	
K 073 SS=E	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 observation and interview, the facility failed to limit the use of combustible decorations. This was evidenced by six resident room doors that were completely covered in decorative paper wrapping. This affected two of three smoke compartments and could result in the expedited spread of smoke or fire in the event of a fire emergency. NFPA 101, 2000 edition 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. 10.3.5* Furnishings or decorations of an explosive or highly flammable character shall not be used. 10.3.6 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under	K 073	The facility will ensure that its doors are free from decorations that do not meet NFPA 101 Life Safety Code standards. Only flame retardant decorations that are approved by the facility Administrator will only be used for future facility decorations. Administrator made rounds and had all Valentine's Day door decorations removed from room doors 3,4,17,18,20,22. No other	3/19/14

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K 073	Continued From page 18 service conditions encountered in actual use. Findings: During a facility tour and interview with Maintenance Staff 2 on 2/19/14, the corridors and doors were observed. 1. At 10:23 a.m., the door to Room 17 was completely covered with a decorative paper. 2. At 10:25 a.m., the door to Room 22 was completely covered with a decorative paper. 3. At 4:40 p.m., the door to Room 3 was completely covered with a decorative paper. Maintenance Staff 2 explained that the doors were wrapped for a holiday decoration contest. 4. At 4:41 p.m., the door to Room 4 was completely covered with a decorative paper. 5. At 4:45 p.m., the door to Room 20 was completely covered with a decorative paper. 6. At 4:48 a.m., the door to Room 18 was completely covered with a decorative paper. There was no documentation that indicated the decorative paper items were flame resistant or had been treated with fire retardant substances.	K 073	door decorations were found throughout the facility. During monthly safety rounds the facility Administrator or designee will inspect the facility corridors for potentially hazardous decorations, debris or wall penetrations. Negative finding will be reported to the facility Safety Committee for possible recommendations.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	Facility will inspect its generator monthly and under load for 30	3/19/14

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K 144	Continued From page 19 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain their emergency generator. This was evidenced by the facility's failure to test their generator at a minimum of 30 percent of the nameplate rating during the monthly 30 minute load tests and by no record of an annual two hour load bank test to supplement their generator testing. This affected three of three smoke compartments and could result in an emergency generator malfunction in the event of a power failure. NFPA 99, Standard for Health Care Facilities, 1999 Edition 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. 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 a minimum of 30 minutes, using one of the	K 144	minutes per month in accordance with NFPA standards. Maintenance Supervisor will test the facility generator at 30% load of the nameplate rating or at a specified exhaust temperature and record the results of this testing on a monthly basis. Negative finding will be reported to the Administrator. Maintenance Supervisor will immediately schedule a load bank generator test with a qualified reputable generator servicing company and record the findings of the test results. Negative findings will be reported to the Administrator. Annual generator load bank test will be scheduled within the next twelve months by the Maintenance Supervisor and on an ongoing continuous annual basis from a qualified reputable company. Results will be recorded and kept for future	

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K 144	Continued From page 20 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 record review and interview with Maintenance Staff 2 on 2/19/14, the emergency generator maintenance, inspection, and testing records were requested. 1. At 11:15 a.m., the document labeled "Report of Emergency Power Test" indicated that the diesel fueled generator was tested under load for 30 minutes each month. There was no documentation that indicated if the generator was operating at a minimum of 30 percent of the generator nameplate rating or at the recommended exhaust temperature. Maintenance Staff 2 had not confirmed what load was drawn from the generator during the load tests. At 1:40 p.m., Maintenance Staff 2 explained that there was no annual two hour load bank test performed for the diesel fueled generator during the past 12 months.	K 144	reference and reported to the Administrator.	

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K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their electrical equipment and wiring connections. This was evidenced by the use of extension cords and surge protectors as a substitute for fixed wiring, a damaged electrical outlet, frayed power cords, and a wiring connection made outside of a junction box. This affected three of three smoke compartments and could result in electrical shock or an electrical fire. NFPA 70 National Electrical Code 1999 Edition 110-12(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasive, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 240-4, Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent. A. Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified. 331-13. Splices and Taps. Splices and taps shall be made only in junction boxes, outlet boxes,	K 147 K 147	The Facility will ensure that all electrical wiring and equipment are in accordance with current NFPA 70 and NFPA 99 standards. Maintenance Supervisor performed immediate safety round in search of any further electrical hazards. No further negative findings were noted. The following repairs were all completed by and or supervised under the direction of the Maintenance Supervisor: 1. Maintenance Supervisor removed all surge protectors and extension cords from the facilities beauty shop. 2. Maintenance Supervisor removed surge protector and power cord from the attic above the water heater.	3/19/14

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K 147	Continued From page 22 device boxes, or conduit bodies. See Article 370 for rules on the installation and use of boxes and conduit bodies. 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. (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. Findings: During a facility tour with Maintenance Staff 2 on 2/19/14, the electrical equipment and wiring connections were observed. 1. At 11:18 a.m., in the beauty shop, there was a table top hair dryer and a curling iron plugged into an extension cord which was plugged into wall outlet. A hand held hair dryer was plugged into a surge protector which was plugged into the same wall outlet. 2. At 11:30 a.m., in the attic above the hot water	K 147	3. The two blue wire nut connections will be secured inside of a fire safety appropriate junction box by the Maintenance Supervisor. 4. Surge protector has been removed from room 23A. 5. Surge protector has been removed from room 6A. 6. Surge protector has been removed from room 12C. Bed power cord has been replaced. 7. Power cords to room 11 beds A and B have been repaired by the Maintenance Supervisor. 8. Power cord for room 14 bed A has been repaired. 9. Electrical cover for the outlet located in the dry goods area has been replaced securing exposed wires. 10. Hot water #2 has had the extension cord removed from service. Maintenance Supervisor inspect the facility during his monthly	

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COUNTRY VILLA MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(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 23 heater room, there was a power cord plugged into a surge protector. The flexible power cord passed through the roof next to an exhaust duct. 3. At 11:40 a.m., there were two blue wire nut connections that were not contained within a junction box in the attic above the hopper room. 4. At 4:29 p.m., in room 23A there was a bed plugged into a surge protector. 5. At 4:49 p.m., in room 6A there was a bed and an oxygen concentrator plugged into a surge protector. 6. At 4:54 p.m., in room 12C there was a bed and oxygen concentrator plugged into a surge protector. The bed power cord was frayed at the plug. 7. At 4:55 p.m., in room 11 beds A and B power cords were frayed at the plug connection. 8. At 4:58 p.m., in room 14 the power cord for bed A was frayed at the plug connection. 9. At 5:04 p.m., there was a copy machine in the dry goods storage area that was plugged into a damaged electrical outlet. The metal cover plate was bent down exposing the electrical connections. 10. At 5:22 p.m., the #2 hot water heater was plugged into a black extension cord that was plugged into an electrical wall outlet.	K 147	safety rounds for possible electrical safety issues and report his findings to the CQI committee for review and possible recommendations.	