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

PRINTED: 09/23/2011
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
	055079	A. BUILDING 01 B. WING _____	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION VIEW HEALTH CENTER	1425 WOODSIDE DR SAN LUIS OBISPO, CA 93401

(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: 1958 K7 Survey Under: 2000 Existing STRUCTURE TYPE: TYPE V, ONE STORY, 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 the NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition (existing). The facility was surveyed in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) for Long Term Care Facilities. Census: 149 Representing the California Department of Public Health: 29665 The facility is not in compliance with 42 CFR 483.70 (a).	K 000	**This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.**	
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	K 029	K 029 One hour fire rated construction with ¾ hour fire rated doors protects hazardous areas. Doors are self-closing.	10-1-11

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

ADMINISTRATOR 10-1-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 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 are separated from other spaces by smoke resisting partitions and self-closing doors. This was evidenced by one hazardous area with no self-closing door. This affected one of four smoke compartments and could result in the spread of fire from a hazardous area to other areas of the facility. Findings: During the facility tour on 9/21/11, the hazardous areas were observed. Combustible storage rooms greater than 50 square feet in size are considered hazardous areas. At 9:59 a.m., Room 502 was approximately 300 square feet in size and contained 3 shelves of diapers, one shelf of pillows, and more than 10 cardboard boxes of supplies. The door to Room 502 was not equipped with a self-closing device.	K 029	1.The deficient practice was immediately corrected by installing a self-closing device on the door to room 502. 2. The Director of Environmental services installed the self-closing device on the door to room 502. 3. The Director of Environmental Services will audit the entire building for self-closing devices to ensure compliance. Any non-compliance will be brought to the quality assurance committee for review and possible change to the policy and procedure.	10-1-11
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.	K 076		

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K 076	Continued From page 2 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that combustible materials are not stored near oxygen tanks. This was evidenced by a rack of oxygen cylinders that was stored against cardboard boxes with combustibles. This affected one of four smoke compartments and could result in an increased risk of a fire. NFPA 99, Standard for Health Care Facilities, 1999 Edition. 8-3.1.11.2(c)(2) Storage for nonflammable gases less than 3000 cubic feet. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 feet (6.1 meters), or 2. A minimum distance of 5 feet (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Findings: During a facility tour on 9/21/11, medical gas storage areas were observed. At 10:27 a.m., there were 12 full oxygen E-tanks	K 076	K 076 Medical gas storage and administration areas are protected. 1.The 11 oxygen E tanks were immediately removed from the Station 2 utility room. 2. The Director of Environmental Services relocated the 11 E tanks to the oxygen storage room. 3. The Director of Environmental Services or designee will inservice all Licensed nursing staff regarding proper location of oxygen E tanks. The Director of Environmental Services will audit for compliance and report any non-compliance to the quality assurance committee for review .	10-1-11

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K 076	Continued From page 3 stored in the utility room near Nurses Station 2. One E-tank was stored on a crash-cart and eleven E-tanks were stored in a rack in the left corner of the room. The rack was stored against three cardboard boxes containing supplies wrapped in plastic. During an interview at 10:30 a.m., nursing staff stated that oxygen tanks are usually stored in the oxygen storage room and not in the utility room.	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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their electrical wiring in accordance with NFPA 70. This was evidenced by one surge protector that was plugged into an extension cord. This affected one of four smoke compartments and could result in an increased risk of an electrical fire. NFPA 70, National Electrical Code, 1999 Edition. 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	K 147	K 147 Electrical wiring and equipment is in accordance with NFPA 70 National Electrical Code. 1.The extension cord was immediately removed from the housekeeping office. 2. The Director of Environmental Services removed the extension cord 3.The Director of Environmental Services will audit the entire building for compliance with electrical extension cord . Any non-compliance will be brought to the quality assurance committee for review and possible change to the policy and procedure.	10-1-11

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K 147	Continued From page 4 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 on 9/21/11, the electrical wiring was observed. At 10:11 a.m., there was a surge protector plugged into an extension cord in the head of housekeeping office.	K 147		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	K 211 Where Alcohol Based Hand Rub dispensers are installed in a corridor, Dispensers are not installed over or adjacent to an ignition source. 1. The ABHR dispenser was immediately removed from the hospice electrical room.	10-1-11

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K 211	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that ABHR, Alcohol Based Hand Rub, dispensers were not installed over ignition sources. This was evidenced by one ABHR dispenser that was installed directly over an ignition source. This affected one of four smoke compartments, and could result in the increased risk of a fire. Findings: During the facility tour on 9/23/11, the ABHR dispensers were observed. At 10:07 a.m., the ABHR dispenser, in the hospice electrical room, was installed approximately 10 inches directly above a light switch.	K 211	2. The Director of Environmental Services removed the ABHR dispenser from the hospice electrical room. 3. The Director of Environmental Services will audit the entire building for ABHR dispenser location compliance. Any non-compliance will be brought to the quality assurance committee for review and possible change to the policy and procedure.	