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

PRINTED: 02/05/2015
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
	555118	A. BUILDING 01 - EVERGREEN REHABILITATION CARE CENTER B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN NURSING & REHABILITATION CARE CENTER	2030 EVERGREEN AVENUE MODESTO, CA 95350

(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: 1/1/69 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION 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. The Entity Reported Incident, CA00429118, was investigated during the re-certification survey and 4 deficiencies were written as a result of the survey. K0051 K0054 K0061 K0062 Representing the California Department of Public Health: 26602 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 165	K 000	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq. This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted. Corrected POC 2/23/15	
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	K 012	K012 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the integrity of the building construction.	

LA[redacted] DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director of Nurses 2/23/15

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.

POC accepted 2/26/15 per Jared Okimoto

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K 012	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of their building construction. This was evidenced by unsealed penetrations in the walls and ceilings. This affected two of eight smoke compartments and could result in the spread of smoke or fire to other locations in the facility. Findings: During the facility tour with staff, from 1/28/15 to 1/29/15, the ceilings and walls were observed. 1/29/15 1. At 9:54 a.m., there was an approximately one and a half inch penetration in the ceiling of the closet inside Office 1. There was an approximately one inch penetration in the east wall around two tan cables. 2. At 10:34 a.m., there was an approximately one inch by four inch ceiling penetration in Room 120. The penetration was in the ceiling around a four inch by four inch electrical box above the drop down ceiling. 3. At 12:13 p.m., there was an approximately half inch by three inch wall penetration in Dining Room 2. The penetration was in the west wall, adjacent to a two plug receptacle wall outlet.	K 012	1. The 1 ½ inch penetration in the ceiling of the closet inside office 1 and the 1 inch penetration in the east wall around two tan cables was repaired using Fire Block (FB136). It was applied to the penetration to seal it on 1/29/15 by Maintenance 2. The 1 inch by 4 inch ceiling penetration around the electrical box above the drop down ceiling in room 120 was repaired using double thickness sheet rock, joint compound and Fire Block (FB136) sealant on 1/29/15 by maintenance 3. The half inch by three inch wall penetration in dining room 2, on the west wall, adjacent to a two plug receptacle wall outlet was repaired using double thickness sheet rock, joint compound and Fire Block (FB136) on 1/29/15 by maintenance The Director of Maintenance or designee will monitor 5 areas monthly to ensure there are no penetrations A copy of this audit will be given to CQI quarterly for review.	2/27/15
K 018 SSaE	NFPA 101 LIFE SAFETY CODE STANDARD	K 018	K018 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 018	Continued From page 2 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 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 seven self-closing doors that failed to close and latch. This affected six of eight smoke compartments and could result in the spread of smoke or fire to other locations in the facility. NFPA 101 Life Safety Code 2000 Edition 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	K 018	It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the corridor doors. 1. The self closing corridor door to room 119 was repaired on 1/28/15 by maintenance 2. The self closing corridor door to dining room 2 was repaired on 1/28/15 by maintenance 3. The self closing corridor door to room 204 was repaired on 1/28/15 by maintenance. 4. The self closing doors to rooms 217 & 218 were repaired on 1/28/15 by maintenance. 5. The self closing corridor door to Social Services was repaired on 1/29/15 by maintenance. 6. The self closing corridor door to the Med Room, at Stetion 2 was repaired on 1/29/15 by maintenance 7. The self closing corridor door to the exercise pool was repaired on 1/29/15 by maintenance. An outside company was contacted, Jim Miller Construction, and will inspect and test self closing corridor doors and self closing resident doors on 2/13/15.	

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K 018	Continued From page 3 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. 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 7.2.1.8.1 A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Findings: During a facility tour with staff, from 1/28/15 to 1/29/15, the corridor doors were observed. 1/28/15 1. At 3:24 p.m., the self-closing corridor door to Room 119 failed to close and latch after activation of the fire alarm system. The door was equipped with a magnetic door hold and a self-closing	K 018	The Director of Maintenance or designee will monitor 2 self closing corridor doors weekly to ensure they close and latch properly The Director of Maintenance or designee will monitor 5 self closing room doors weekly to ensure they close and latch properly A copy of this audit will be given to CQI quarterly for review	2/27/15

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K 018	Continued From page 4 device. 2. At 4:00 p.m., the self-closing corridor door to Dining Room C failed to close and latch after activation of the fire alarm system. The door was equipped with a magnetic door hold and a self-closing device. 3. At 4:06 p.m., the self-closing corridor door to Room 204 failed to close and latch. The door did not release from the magnetic door hold. 4. At 4:23 p.m., the self-closing doors to Rooms 217 and 218 failed to fully close and latch after activation of the fire alarm system. The doors were equipped with magnetic door holds and self-closing devices. 1/29/15 5. At 12:47 p.m., the self-closing corridor door to Social Services failed to close and latch. The door was tested three times. 6. At 1:10 p.m., the self-closing corridor door to the Med Room, at Station 2, failed to close and latch. The door was tested three times. 7. At 1:14 p.m., the self-closing corridor door to the exercise pool failed to close and latch. The door was tested three times.	K 018		
K 027 SS=E	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.	K 027	K027 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the smoke barrier doors.	

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K 027	Continued From page 5 Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. 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 and interview, the facility failed to maintain their smoke barrier doors. This was evidenced by two of nine smoke barrier doors that failed to close and latch during testing of the fire alarm system. This affected four of eight smoke compartments and could result in the spread of smoke or fire from one smoke compartment to another, in the event of a fire. Findings: During a facility tour with staff, from 1/28/15 to 1/29/15, the smoke barrier doors were observed. 1/28/15 1. At 3:25 p.m., the north smoke barrier door by Room 216, failed to fully close and latch after activation of the fire alarm system. 2. At 4:05 p.m., the south smoke barrier door by Family Lounge A, remained opened to the fullest extent after activation of the fire alarm system. At 4:06 p.m., Housekeeping Staff 1 reported that the door had released from the magnetic hold, but the door was stuck on the carpet.	K 027	1. The smoke barrier door by room 216 was repaired on 1/28/15 by maintenance and now closes and latches 2. The smoke barrier door by Family Lounge A was repaired on 1/28/15 by maintenance and now closes and latches An outside company was contacted, Jim Miller Construction, and will inspect and test smoke barrier doors on 2/13/15 to confirm they are working properly. The Director of Maintenance or designee will monitor 5 smoke barrier doors weekly to ensure they close and latch properly. A copy of this audit will be given to CQI quarterly for review.	2/27/15
K 040	NFPA 101 LIFE SAFETY CODE STANDARD	K 040	K040 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 040 SS=D	Continued From page 6 Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their exit access doors. This was evidenced by one of nine exit access doors that failed to open. This affected one of eight smoke compartments and could result in a delayed evacuation, in the event of a fire emergency. Findings: During a facility tour with staff on 1/28/15, the exit doors were observed. 1. At 3:54 p.m., the north smoke barrier door by Room 216 failed to open when the push bar was tested. The door was used as exit access. The door was tested four times. The door could not be opened to achieve 32 inches in clear width.	K 040	It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the exit access doors. 1. The north smoke barrier door by room 216 was repaired on 1/28/15 by maintenance and now opens An outside company was contacted, Jim Miller Construction, and will inspect and test smoke barrier doors on 2/13/15 to confirm they are working properly. The Director of Maintenance or designee will monitor 5 smoke barrier doors weekly to ensure they are in working order. A copy of this audit will be given to CQI quarterly for review.	2/27/15
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the	K 051	K051 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the fire alarm system. The facility immediately started a Fire Watch on 1/28/15, for station 1 north hall as per facility policy until the alarm system repairs were complete on 1/30/15 by R.G.E.	

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K 051	Continued From page 7 path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire alarm system. This was evidenced by the fire alarm panel indicating trouble and failure of a manual fire alarm pull station that failed to activate the fire alarm system. This affected two of eight smoke compartments and could result in a delayed notification of a fire alarm system activation. NFPA 101 Life Safety Code, 2000 Edition 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems. Exception No. 1: Manual fire alarm boxes in	K 051	1. The smoke detector in room 205 was repaired on 1/28/15 by maintenance 2 The fire alarm system was repaired and tested on 1/30/15 by R.G.E. The Director of Maintenance or designee will test the fire alarm system monthly to ensure it is in working order. A copy of this audit will be given to CQI quarterly for review.	2/27/15

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K 051	Continued From page 8 patient sleeping areas shall not be required at exits if located at all nurses ' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded. Exception No. 2: Fixed extinguishing systems protecting commercial cooking equipment in kitchens that are protected by a complete automatic sprinkler system shall not be required to initiate the fire alarm system. Exception No. 3: Detectors required by the exceptions to 19.7.5.2 and 19.7.5.3. 19.3.4.3 Notification. 19.3.4.3.1 Occupant Notification. Occupant notification shall be accomplished automatically in accordance with 9.6.3. Exception No. 1:* In lieu of audible alarm signals, visible alarm indicating appliances shall be permitted to be used in critical care areas. Exception No. 2: Where visual devices have been installed in patient sleeping areas in place of the audible alarm, they shall be permitted where accepted by the authority having jurisdiction. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 9.6.2 Signal Initiation. 9.6.2.1 Where required by other sections of this Code, actuation of the complete fire alarm system shall occur by any or all of the following means of	K 051	Continues from page 8	

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K 051	Continued From page 9 initiation, but shall not be limited to such means: (1) Manual fire alarm initiation (2) Automatic detection (3) Extinguishing system operation Findings: During a facility tour with staff, from 1/28/15 to 1/29/15, the fire alarm system was observed. 1/28/15 1. At 3:18 p.m., the fire alarm panel indicated "trouble" and "trouble silence" under warning indicator lights. At 3:19 p.m., during an interview, Maintenance Staff 1 reported that the smoke detector in Room 205 had to be disabled because the room was painted. He indicted that the trouble indicators had been activated two days ago (1/26/15), but that the fire alarm system was still working throughout the facility. 2. At 3:43 p.m., the manual fire alarm pull station between Rooms 107 and 109 was tested by staff. The manual fire alarm pull station failed to activate an alarm at the fire alarm panel and the chime failed to emit an audible alarm after activation of the fire alarm system. At 3:44 p.m., during an interview, Maintenance Staff 1 reported that 29 troubles showed up in the printout for the fire alarm panel. He stated that the troubles were all in the North Hall Station 1, from Room 101 to Room 112 and Physical Therapy. At 3:46 p.m., Maintenance Staff 2 reported that	K 051	Continued from page 9	

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K 051	Continued From page 10 there was an issue with the magnetic door holds in December 2014 and believed that wing may have been disconnected when the issue took place. Maintenance Staff 1 stated that the annual fire alarm system test and inspection took place on 12/9/14, and the issue with the magnetic door holds occurred after. Maintenance Staff 1 reported that the vendor would be called out to the facility as soon as possible and that the facility would be on a fire watch until the system was working in the North Hall Station 1.	K 051		
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 and interview, the facility failed to maintain their smoke detectors. This was evidenced by four smoke detectors that failed to activate the fire alarm system when tested. This affected two of eight smoke compartments and could result in a delayed notification of smoke, in the event of a fire. NFPA 101, 2000 edition 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 continued in use, subject to the approval of the authority having jurisdiction.	K 054	K054 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the facility smoke detectors. The facility immediately started a Fire Watch on 1/28/15, for station 1 north hall as per facility policy until the alarm system was repaired on 1/30/15 by R.G E. 1. The smoke detector in the corridor by Physical Therapy is now working. 2. The smoke detector inside Physical Therapy is now working 3. The smoke detector inside room 110 is now working. 4. The smoke detector inside room 113 is now working.	

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	555118	A. BUILDING 01 - EVERGREEN REHABILITATION CARE CENTER B. WING _____	01/29/2015

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EVERGREEN NURSING & REHABILITATION CARE CENTER	2030 EVERGREEN AVENUE MODESTO, CA 95350

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K 054	Continued From page 11 NFPA 72 National Fire Alarm Code 1999 Edition 7.2.2. Fire alarm systems and other systems and equipment that are associated with fire alarm systems and accessory equipment shall be tested according to Table 7-2.2, 13. Initiating Devices (g) Smoke Detectors - The detectors shall be tested in place to ensure smoke entry into the sensing chamber and an alarm response. Testing with smoke or listed aerosol approved by the manufacturer shall be permitted as acceptable test methods. Other methods approved by the manufacturer that ensure smoke entry into the sensing chamber shall be permitted. Findings: During a facility tour with staff, from 1/28/15 to 1/29/15, the smoke detectors were observed. 1/28/15 1. At 3:32 p.m., the smoke detector in the corridor by Physical Therapy failed to activate the fire alarm system when tested. The smoke detector was tested four times with artificial canned smoke. 2. At 3:37 p.m., the smoke detector inside the Physical Therapy room failed to activate the fire alarm system when tested. The smoke detector was tested three times with artificial canned smoke. 3. At 3:39 p.m., the smoke detector inside Room 110 failed to activate the fire alarm system when tested. The smoke detector was tested three	K 054	The Director of Maintenance or designee will test the fire alarm system monthly to ensure it is in working order. A copy of this audit will be given to CQI quarterly for review.	2/27/15

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K 054	Continued From page 12 times with artificial canned smoke. 4. At 3:42 p.m., the smoke detector inside Room 113 failed to activate the fire alarm system when tested. The smoke detector was tested three times with artificial canned smoke. At 3:43 p.m., during an interview, Maintenance Staff 1 reported that there were 29 troubles showing up on the fire alarm panel report printout he generated. He stated that the troubles were all in Station 1, from Room 101 to Room 112 and Physical Therapy.	K 054		
K 056 SS=E	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 sprinkler system in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2000 Edition, and NFPA 13, 1999 Edition. This was	K 056	K056 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to provide a complete automatic sprinkler system in accordance with Nation Fire Protection Association (NFPA)101, Life Safety Code, 2000 Edition, and NFPA 13, 1999 Edition. On 2/2/15 the architect was contacted and Jorgenson & Co. were contacted on 2/9/15 to draw up plans. Jorgenson will be out on 2/13/15 to inspect and measure to develop plans. The plans will be sent to the architect for review and then to OSHPD. A message was left on 2/10/15 with the Inspector of Record at OSHPD regarding this matter.	

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K 056	Continued From page 13 evidenced by non-sprinklered combustible wood framed roof overhangs that exceeded four feet in width. This deficient practice affected three of eight 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 Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters	K 056	1. Automatic sprinkler heads will be installed under the approximately seven foot eight inch wide roof overhang on the west side of the facility. 2. Automatic sprinkler heads will be installed under the approximately seven foot eight inch wide roof overhang on the west side of the facility, on the south side entry of the facility 3. Automatic sprinkler heads will be installed under the approximately seven foot four inch wide roof overhang on the west side of the facility, on the south west side of facility 4. Automatic sprinkler heads will be installed under the approximately five foot two inch wide roof overhang on the south side of the facility. The Co-Administrator or designee will monitor quarterly for any new regulations affecting the physical plant through bulletins & annual New Laws Seminars A copy of this audit will be given to CQI annually for review.	4/29/15

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K 056	Continued From page 14 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 the facility tour with staff, from 1/28/15 to 1/29/15, the exterior of the facility was observed. 1/29/15 1. At 9:37 a.m., there were no automatic sprinkler	K 056	Continued from page 14	

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K 056	Continued From page 15 heads installed under an approximately seven foot eight inch wide roof overhang on the west side of the facility. The combustible wood framed roof overhang, on the north side entry of the facility, spanned between the lobby and the restrooms. The length between the lobby and the restrooms was approximately 12 feet. 2. At 9:40 a.m., there were no automatic sprinkler heads installed under an approximately seven foot eight inch wide roof overhang on the west side of the facility. The combustible wood framed roof overhang, on the south side entry of the facility, spanned between the Business Office and the Administrator's Office. The length between the Business Office and the Administrator's Office was approximately 17 feet. 3. At 9:45 a.m., there were no automatic sprinkler heads installed under an approximately seven foot four inch wide roof overhang on the west side of the facility. The combustible wood framed roof overhang, in the south west side of the facility, spanned between Dining Room 1 and the Co-Administrator's Office. The length between the Dining Room 1 and the Co-Administrator's Office was approximately seven and a half feet. 4. At 10:20 a.m., there were no automatic sprinkler heads installed under an approximately five feet two inch wide roof overhang on the south side of the facility. The combustible wood framed roof overhang, at the kitchen entry, spanned between the kitchen and dry food storage room. The length between the kitchen and dry food storage room was approximately 14 feet. S&C-13-55-LSC dated August 16th, 2013, revised on 12-20-13, states that CMS will engage	K 056	Continued from page 15	

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K 056	Continued From page 16 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 061 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their automatic sprinkler system control valves. This was evidenced by one of two automatic sprinkler system control valves that failed to activate a trouble or supervisory alarm at the fire alarm panel when the valve was closed. This affected two of eight smoke compartments and could result in a delayed notification and restoration of a suspension in water supplied to the automatic sprinkler system. NFPA 101, 2000 edition 9.7.2 Supervision. 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the	K 061	K061 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the automatic sprinkler system control valves. The facility immediately started a Fire Watch on 1/28/15, for station 1 north hall as per facility policy until the alarm system was repaired on 1/30/15 by R.G.E. 1. The automatic sprinkler system control valve, located on the side of the building behind the medical records office now activates a trouble alarm at the fire alarm control panel and monitoring station. The Director of Maintenance or designee will test the fire alarm / tamper alarm monthly to ensure it is in working order A copy of this audit will be given to CQI quarterly for review.	2/27/15

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K 061	Continued From page 17 sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. Findings: During a facility tour with staff, from 1/28/15 to 1/29/15, two of two automatic sprinkler system control valves were tested. 1/29/15 1. At 9:02 a.m., the automatic sprinkler system control valve, located on the side of the building behind the medical records office and by the street, failed to activate a trouble alarm at the fire alarm control panel and monitoring station when the valve was closed. Maintenance Staff 1 was interviewed at that time. Maintenance Staff 1 reported that the tamper alarm for Station 1 was part of the troubles reported yesterday on the fire alarm panel printout.	K 061		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K062 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the automatic sprinkler system	

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K 062	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their automatic sprinkler system. This was evidenced by sprinklers that did not have 18 inches of clearance, one corroded sprinkler head, sprinkler escutcheon rings that were dislodged, and an Inspector's Test Valve that failed to activate the fire alarm system within 90 seconds. This affected five of eight smoke compartments and could result in a delayed response of the automatic sprinkler system, in the event of a fire. NFPA 101 Life Safety Code 2000 Edition 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. 9.6.1.7* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system	K 062	The facility immediately started a Fire Watch on 1/26/15, for station 1 north hall as per facility policy until the alarm system was repaired on 1/30/15 by R.G.E. 1. The test valves now activate the fire alarm system within 90 seconds. 2 The gap between the escutcheon ring and ceiling in the Dietary Directors office was repaired by the maintenance department on 1/29/15 3. The boxes in the emergency food storage room were immediately moved by the Director of Dietary. 4. The penetration around the escutcheon ring at the ceiling in the personal storage room was repaired by the maintenance department on 1/29/15. 5. Jorgenson & Co was contacted on 2/23/15 to change automatic sprinkler head in the shower room of station 3 they will be out on 2/25/15 to complete work. 6. The dish pans inside the janitor's closet across from room 228 were immediately removed by the Janitorial Staff.	

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K 062	Continued From page 19 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 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. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Where supervision of automatic sprinkler systems is provided in accordance with another provision of this Code, waterflow alarms shall be transmitted to an approved, proprietary alarm receiving facility, a remote station, a central station, or the fire department. Such connection shall be in accordance with 9.6.1.4. NFPA 13 Standard for Installation of Sprinkler Systems, 1999 Edition 5-5.6* Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Exception No. 1: Where other standards specify greater minimums, they shall be followed. Exception No. 2: A minimum clearance of 36 in.	K 062	All residents have the potential to be effected by this regulation, therefore the dietary & Janitorial staff were in serviced by their supervisors on 2/4/15 which included not storing anything within 14 inches from bottom of sprinklers or 18 inches from ceiling. The Director of maintenance or designee will monitor both test valves quarterly to ensure they activate the fire alarm system within 90 seconds. The Director of maintenance or designee will monitor 10 escutcheon rings / sprinkler pipes per month to ensure there are no penetrations. The Director of maintenance or designee will monitor 1 storage room per week to ensure nothing is within 14 inches from bottom of sprinklers or 18 inches from ceiling. Copies of these audits will be given to CQI quarterly for review.	2/27/15

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K 062	Continued From page 20 (0.91 m) shall be permitted for special sprinklers. Exception No. 3: A minimum clearance of less than 18 in. (457 mm) between the top of storage and ceiling sprinkler deflectors shall be permitted where proven by successful large-scale fire tests for the particular hazard. Exception No. 4: The clearance from the top of storage to sprinkler deflectors shall be not less than 3 ft (0.9 m) where rubber tires are stored. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 2-2 Inspection. 2.2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended	K 062	Continued from page 20	

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	555118	A. BUILDING 01 - EVERGREEN REHABILITATION CARE CENTER B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN NURSING & REHABILITATION CARE CENTER	2030 EVERGREEN AVENUE MODESTO, CA 95350

(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 062	Continued From page 21 ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. NFPA 72, National Fire Alarm Code 1999 Edition 2-6 Sprinkler Waterflow Alarm-Initiating Devices. 2-6.2* Initiation of the alarm signal shall occur within 90 seconds of waterflow at the alarm-initiating device when flow occurs that is equal to or greater than that from a single sprinkler of the smallest orifice size installed in the system. Movement of water due to waste, surges, or variable pressure shall not be indicated. Findings: During the facility tour with staff, from 1/28/15 to 1/29/15, the automatic sprinkler system was observed. 1/29/15 1. At 8:58 a.m., one of two Inspector's Test Valves failed to activate the fire alarm system within 90 seconds. The exterior bell activated but interior notification devices did not. At 8:59 a.m., during an interview, Maintenance Staff 1 reported that the Inspector's Test Valve was on the North Hall 1 and was part of the troubles reported on the fire alarm panel printout. 2. At 10:19 a.m., there was an approximately one inch gap between the escutcheon ring and the ceiling exposing an approximately half inch penetration around the sprinkler pipe in the	K 062	Continued from page 21	

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K 062	Continued From page 22 Dietary Director's Office. 3. At 12:10 p.m., there were boxes stored within approximately 14 inches of the sprinkler deflector, in the emergency food storage room. 4. At 12:48 p.m., there was an approximately half inch by one inch penetration in the personal storage room. The penetration was around the escutcheon ring at the ceiling. 5. At 1:19 p.m., the automatic sprinkler-head in the shower room of Station 3, across from Room 222, was corroded. The sprinkler was green in color. 6. At 1:20 p.m., there were dish pans stored within approximately 14 inches of the automatic sprinkler head inside the janitor's closet, across from Room 228.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguishers. This was evidenced by one portable fire extinguisher that was missing five monthly visual inspections. This affected the one of eight smoke compartments and could result in a delayed notification of a malfunctioning portable fire	K 064	K064 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the portable fire extinguishers. 1. The portable fire extinguisher was removed from the Chief Executive Officer's office on 2/10/15 by Maintenance Personnel The Director of Maintenance or designee will monitor 3 portable fire extinguishers monthly to ensure that monthly visual inspections are current.	

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K 064	Continued From page 23 extinguisher. NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition 4.3.1 *Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 4.3.4.1. Personnel making inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. 4.3.4.2. At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. Findings: During the facility tour with staff, from 1/28/15 to 1/29/15, the portable fire extinguishers were observed. 1/29/15 1. At 1:30 p.m., the portable fire extinguisher located inside the Chief Executive Officer's office was missing five of ten monthly inspections. The annual service and inspection was completed on 2/24/14. The portable fire extinguisher service tag did not have initials verifying completed monthly visual inspections for March, April, October, November and December 2014.	K 064	A copy of this audit will be given to CQI quarterly for review.	2/27/15
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.	K 076	K076 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to secure the medical gas cylinders.	

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K 076	Continued From page 24 (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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to secure their medical gas cylinders. This was evidenced by 12 unsecured oxygen cylinders. This affected one of eight smoke compartments and could result in damage to a compressed medical gas cylinder. NFPA 101, 2000 Edition 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, 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 4 4-3.5.2.2 Storage of Cylinders and Containers. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid	K 076	1. The 8 E sized medical gas cylinders were immediately secured using double chains by Maintenance Personnel 2. The 4 H sized medical gas cylinders were immediately secured using double chains by Maintenance Personnel All residents have the potential to be effected by this regulation, therefore on 2/10/15; the nursing staff received in-service training by the Director of Staff Development, which included securing oxygen tanks properly using double chains The clinical support staff member or designee will monitor the oxygen room daily to ensure the cylinders are secured properly. A copy of this audit will be given to CQI quarterly for review.	2/27/15

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K 076	Continued From page 25 confusion and delay if a full cylinder is needed hurriedly. 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 NFPA 99, Health Care Facilities 1999 Edition 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). 3. Provisions shall be made for racks of fastenings to protect cylinders from accidental damage or dislocation Findings: During a tour of the facility with staff, from 1/28/15 to 1/29/15, the medical gas storage room was observed. 1/29/15	K 076	Continued from page 25	

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K 076	Continued From page 26 1. At 12:36 p.m., the oxygen storage room had eight E sized cylinders loosely draped with chains. The eight cylinders were not secured from falling. 2. At 12:37 p.m., the oxygen storage room had four H sized tank loosely draped with chains. The four tanks were not secured from falling.	K 076		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke barrier walls. This was evidenced by smoke barrier walls that had unsealed penetrations. This affected eight of eight smoke compartments and could result in the spread of smoke or fire to other smoke compartments. NFPA 101, Life Safety Code, 2000 edition. 8.3.6.1., Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tube and ducts, and similar building services equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.	K 104	K104 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the smoke barrier walls. 1. The 1 3/8 in wall penetration by room 202, on the lower left side of the smoke barrier wall, at the attic access was repaired on 1/28/15 by maintenance using joint compound and Fire Block (FB136) sealant 2. The ½ inch unsealed penetration surrounding the 18 inch by 36 inch piece of sheetrock in the smoke barrier wall by room 201 was repaired on 1/28/15 by maintenance using Fire Block (FB 136)sealant 3. The ½ inch unsealed conduit penetrating the smoke barrier wall between rooms 308 and 310 was repaired on 1/28/15 by maintenance using Fire Block (FB136) sealant.	

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K 104	Continued From page 27 b. It shall be protected by an approved device that is designed of the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke 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 smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings: During a facility tour with staff, on 1/28/15, the smoke barrier walls were observed. 1. At 1:48 p.m., there was an approximately one and three eighth inch wall penetration by Room 202. The penetration was located on the lower left side of the smoke barrier wall, at the attic access. 2. At 1:55 p.m., there was a half inch unsealed penetration surrounding an approximately 18 inch by 36 inch piece of sheetrock, in the smoke barrier wall by Room 201. 3. At 2:11 p.m., there was an approximately half inch unsealed conduit penetrating the smoke barrier wall between Rooms 308 and 310. The	K 104	4 The two foot by three foot penetration in the smoke barrier wall between rooms 220 and 221 was repaired on 1/28/15 by Maintenance, using double sheet rock with joint compound and Fire Block (FB136) sealant. 5. The 18 inch by 24 inch penetration in the smoke barrier wall across from the therapy office was repaired on 1/28/15 by maintenance using double sheet rock with joint compound and Fire Block (FB136) sealant. 6. The 2 ½ in round penetration in the smoke barrier wall between rooms 126 and 128 was repaired on 1/28/15 by maintenance using double sheet rock with joint compound and Fire Block (FB136) sealant. The Director of Maintenance or designee will monitor 2 smoke barrier walls quarterly to ensure there are no penetrations. A copy of this audit will be given to CQI quarterly for review.	2/27/15

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K 104	Continued From page 28 conduit was on the lower left side of the wall, at the attic access near Room 220. 4. At 2:25 p.m., there was an approximately two foot by three foot penetration in the smoke barrier wall between Rooms 220 and 221. The sheet rock was torn out and was leaning against a wood beam. 5. At 2:35 p.m., there was an approximately 16 inch by 24 inch penetration in the smoke barrier wall across from the Therapy Office. The penetration was in front of the attic access, on the upper side of the wall. 6. At 2:48 p.m., there was an approximately two and a half inch round penetration in the smoke barrier wall between Rooms 126 and 128. The penetration was around blue, orange and white cables penetrating the wall.	K 104		
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 electrical receptacle outlets with broken ground ports, by the use of adapters, and surge protected multi-outlet extension cords connected to other surge other extension cords. This affected seven of eight smoke compartments and could result in an increased risk of electrical fire or shock.	K 147	K147 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain electrical equipment and wiring connections. 1. The 3 plug adapter in the Administrator's office was removed on 1/29/15 by maintenance. 2. The 2 plug receptacle wall outlet in the hallway by the office area will be repaired on 2/13/15 by Jim Miller Construction.	

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K 147	Continued From page 29 NFPA 70, National Electrical Code, 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (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, abrasives, 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. 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,	K 147	3. A cover was placed on the 8 inch by 8 inch electrical box at station 1 on 1/29/15 by maintenance. 4. The surge protectors were removed from the Dietary Managers office on 1/29/15 by maintenance. 5. The 2 two plug receptacles in room 321 will be repaired on 2/13/15 by Jim Miller Construction. 6. The two plug receptacle wall outlet in room 323 will be repaired on 2/13/15 by Jim Miller Construction. 7. The two plug receptacle wall outlet in room 325 will be repaired on 2/13/15 by Jim Miller Construction 8. The two plug receptacle wall outlet in room 324 will be repaired on 2/13/15 by Jim Miller Construction. 9. The two plug receptacle wall outlet in room 320 will be repaired on 2/13/15 by Jim Miller Construction. 10. The two plug receptacle wall outlet in room 316 will be repaired on 2/13/15 by Jim Miller Construction.	

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K 147	Continued From page 30 structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. Findings: During the facility tour with staff, from 1/28/15 to 1/29/15, the electrical equipment and wiring connections were observed. 1/29/15 1. At 9:52 a.m., there was a three plug adapter connecting the surveillance system in the Administrator's Office. The adapter was located on the east wall. 2. At 9:56 a.m., there was a two plug receptacle wall outlet with a broken ground port in the hallway in the office area. The receptacle was located outside the File Room/Admissions Room. 3. At 9:59 a.m., there was an approximately eight inch by eight inch electrical box without a cover plate at Nurse Station 1. The receptacle was underneath the counter. 4. At 10:40 a.m., there was a six plug surge protector connected to another eight plug surge protector in the Dietician's Office. The surge protectors were connecting computer equipment. 5. At 12:18 p.m., there were 2 two plug receptacle wall outlets with broken ground ports in Room 321. The receptacles were located on the north and south walls. 6. At 12:20 p.m., there was a two plug receptacle	K 147	11. The two plug receptacle wall outlet in room 217 will be repaired on 2/13/15 by Jim Miller Construction. 12. The two plug receptacle wall outlet in room 215 will be repaired on 2/13/15 by Jim Miller Construction. 13. The two plug receptacle wall outlet in room 214 will be repaired on 2/13/15 by Jim Miller Construction. 14. The two plug receptacle wall outlet in room 203 will be repaired on 2/13/15 by Jim Miller Construction. 15. The two plug receptacle wall outlet in the staff dining room, station 2 will be repaired on 2/13/15 by Jim Miller Construction 16. The two plug receptacle wall outlet in bath 1 will be repaired on 2/13/15 by Jim Miller Construction. 17 The two plug receptacle wall outlet at nurses station 2 will be repaired on 2/13/15 by Jim Miller Construction 18. The red two plug receptacle wall outlet in the corridor between 312 and 314 will be repaired on 2/13/15 by Jim Miller Construction	

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K 147	Continued From page 31 wall outlet with broken ground ports in Room 323. The receptacle was located on the south wall. 7. At 12:23 p.m., there was a two plug receptacle wall outlet with broken ground ports in Room 325. The receptacle was located on the north wall. 8. At 12:24 p.m., there was a two plug recaptacle wall outlet with broken ground ports in Room 324. The receptacle was located on the north wall. 9. At 12:25 p.m., there was a two plug receptacle wall outlet with a broken ground port in Room 320. The receptacle was located on the north wall. 10. At 12:31 p.m., there was a two plug receptacle wall outlet with a broken ground port in Room 316. The receptacle was located on the north wall. 11. At 12:41 p.m., there was a two plug receptacle wall outlet with a broken ground port in Room 217. The receptacle was located on the west wall. 12. At 12:45 p.m., there was a two plug receptacle wall outlet with a broken ground port in Room 215. The receptacle was located on the north wall. 13. At 12:50 p.m., there was a two plug receptacle wall outlet with a broken ground port in Room 214. The receptacle was located on the south wall, between the beds. 14. At 12:52 p.m., there were 2 two plug receptacle wall outlets with broken ground ports in Room 203. The receptacles were located on	K 147	The Director of Maintenance or designee will monitor 5 wall receptacles per month to ensure they are in good working condition A copy of this audit will be given to CQI quarterly for review.	2/27/15

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(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 32 the north wall. 15. At 12:56 p.m., there was a two plug receptacle wall outlet with a broken ground port in Staff Dining Room, Station 2. The receptacle was located on the north wall. 16. At 1:04 p.m., there was a two plug receptacle wall outlet with a broken ground port in Bath I. The receptacle was located on the south wall. 17. At 1:12 p.m., there was a two plug receptacle wall outlet with a broken ground port at Nurse Station 2. The receptacle was located on the east wall. 18. At 1:47 p.m., there was a red, two plug receptacle wall outlet with a broken ground port in the corridor between Rooms 312 and 314. The receptacle was located on the east wall.	K 147		
K 211 SS=E	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	K211 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Evergreen Nursing & Rehabilitation Care Center to maintain the alcohol based hand rub dispensers. 1. The ABHR dispenser in the men's restroom across from maintenance was moved on 1/30/15 by janitorial staff. 2. The ABHR dispenser in the women's restroom across from maintenance was moved 1/30/15 by janitorial staff.	

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

PRINTED: 02/05/2015
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
	555118	A. BUILDING 01 - EVERGREEN REHABILITATION CARE CENTER B. WING	01/29/2015

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K 211	Continued From page 33 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their alcohol based hand rub (ABHR) dispensers. This was evidenced by six ABHR dispensers mounted above or adjacent to ignition sources. This affected three of eight smoke compartments and could result in an ABHR ignited fire emergency. Findings: During the facility tour with staff, from 1/26/15 to 1/29/15, the ABHR dispensers were observed. 1/29/15 1. At 10:27 a.m., the men's restroom, across the hall from the maintenance office, had an ABHR dispenser mounted five inches adjacent to a two plug receptacle wall outlet. The hand rub was 70 percent ethyl alcohol by volume. 2. At 10:29 a.m., the women's restroom, across the hall from maintenance office, had an ABHR dispenser mounted three inches adjacent to a light switch. The hand rub was 70 percent ethyl alcohol by volume. 3. At 10:44 a.m., Room 112 had an ABHR dispenser mounted five inches adjacent to a light switch. 4. At 10:53 a.m., Physical Therapy had an ABHR dispenser mounted directly above a microwave.	K 211	3. The ABHR dispenser in room 112 was moved 1/30/15 by janitorial staff. 4. The ABHR dispenser in physical therapy was moved 1/30/15 by janitorial staff. 5. The ABHR dispenser in the women's visitor's restroom at station 2 was moved 1/30/15 by janitorial staff. 6. The ABHR dispenser in bath 1 was moved 1/30/15 by janitorial staff. The Director of Housekeeping in serviced her staff on 2/4/15, it included not installing ABHR dispensers within 6 inches of any electrical outlets or switches. The Director of Housekeeping will check 5 rooms per month to ensure the ABHR dispensers are placed appropriately A copy of this audit will be given to CQI quarterly for review.	2/27/15

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K 211	Continued From page 34 5. At 1:02 p.m., there was an ABHR dispenser mounted directly over a light switch in the women's visitors restroom located at Station 2. 6. At 1:05 p.m., Bath I had an ABHR dispenser mounted within four inches of a light switch, near the sink.	K 211	Continued from page 34	