

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

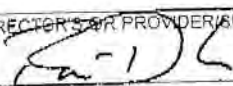
PRINTED: 07/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2013
NAME OF PROVIDER OR SUPPLIER VILLA RANCHO BERNARDO CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15720 BERNARDO CENTER DRIVE SAN DIEGO, CA 92127	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: K7 SURVEY UNDER: STRUCTURE TYPE: TYPE (1) (111), Two Story, Fully 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: Census: 265 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities, NFPA 101 LIFE SAFETY CODE STANDARD	K 000	This plan of correction constitutes my credible allegation of compliance for the deficiencies noted. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R.405.1907.	8/18/2013
K 050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	On 7/19/2013, the Administrator contacted the Fire Services Consultant (Fire Prevention Training Specialist) and instructed him on the requirement to vary the times of the Fire Drills. Fire Drills will be conducted quarterly for each shift and the time of the drills will be varied by at least 1 hour from the time of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

8-2-2013

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 8/5/13 Joel Galang

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K 050	Continued From page 1 This STANDARD is not met as evidenced by: Based on document review, the facility failed to conduct fire drills at unexpected times. This could result in delayed response by staff during fire. This affected 5 of 5 smoke compartments of the 1st floor and 5 of 5 smoke compartments on the 2nd floor. Findings: On 7/17/13, at 11:23 a.m., during document review, the facility fire drills were reviewed. The fire drills were held as follows; A.M. Shift 3 of 4 drills were held between 10:03 a.m. and 11:01 a.m. P.M. Shift 3 of 4 drills were held between 3:00 p.m. and 3:46 p.m. Night Shift 4 of 4 drills were held between 11:25 p.m. and 12:15 a.m. The facility failed to vary the time of their fire drills.	K 050	the prior shift drill. * The Administrator will audit future Fire Drill reports to ensure the times are varied by at least 1 hour for each shift drill. * Results of this audit will be presented to the facility's CQI Committee by the Administrator monthly for three months, then annually there- after. The Committee will evaluate the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated timeframes.	8/18/2013	
K 052 SS=E	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	K 052	* On 7/18/2013, JJJ Enterprise, the facility's alarm contractor counted and tested all the audible/visual alarm devices in the facility. The total count was 49 devices and all functioned properly. The alarm technician updated the Certifi- cate of Inspection with the above information. * The Administrator will audit the future annual Certificate of Inspection reports from the alarm contractor to ensure that		

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on document review, and interview, the facility failed to ensure that all devices were tested in accordance with NFPA 72, National Fire Alarm Code. This was evidenced by no current testing of the audible/visual devices. This affected 5 of 5 smoke compartments on the 1st and 2nd floor, and could result in devices not functioning in the event of a fire. Findings: On 7/17/13, at 2:59 p.m., the annual certification of the fire alarm system was reviewed. There was no documented testing of the chimes/strobes. The last testing of the chimes/strobes was on 6/8/11, at this time the vendor documented he tested 100% but gave no indication of how many devices were in the facility. NFPA 70 National Fire Alarm Code 1999 Edition Table 7-3.2 shows the devices have to be tested annually.	K 052	all devices listed on the certificate are counted and tested. • Results of this audit will be presented to the facility's CQI Committee by the Administrator after the annual alarm inspection is completed. The Committee will evaluate the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated time-frames.	8/18/2013
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 document review, the facility failed to ensure that all fire alarm devices were tested. This was evidenced by failure to test all smoke detectors annually in accordance with NFPA 72, National Fire Alarm Code. This could result in the smoke detectors not functioning in the event of a fire.	K 054	• On 6/26/2013, JJJ Enterprise, the facility's alarm contractor completed testing of the smoke detectors in the facility. The alarm technician used the facility's smoke detector listing as a worksheet. All 188 smoke detectors listed on the worksheet were tested. The technician incorrectly documented 175 smoke detectors on the Certificate of Inspection. On 7/18/2013, the technician corrected the Certificate of Inspection by noting 188 smoke	

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K 054	Continued From page 3	K 054		8/18/2013
K 064 SS=D	<p>Findings: On 7/17/13, during document review, the annual certification of the fire alarm system was reviewed. The certification indicated that 176 smoke detectors were tested. The facility has 188 smoke detectors according to the smoke detector test log. On 8/30/12, 176 smoke detectors were tested and on 6/8/11, 176 smoke detectors were tested.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire extinguishers. This was evidenced by one monthly inspection missing from one fire extinguisher. This could result in the fire extinguisher not working in the event of a fire. This affects 1 of 5 smoke compartments on the 1st floor.</p> <p>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.</p> <p>4-3.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on</p>	<p>K 064</p> <ul style="list-style-type: none"> detectors tested. The Administrator will audit the future annual Certificate of Inspection reports from the alarm contractor to ensure that the certificate list the correct number of devices tested. Results of this audit will be presented to the facility's CQI Committee by the Administrator after the annual inspection is completed. The Committee will evaluate the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated timeframes. <p>K 064</p> <ul style="list-style-type: none"> The fire extinguisher in the elevator control room was inspected, dated and initialed on the attached tag by the Maintenance Supervisor. The location of all fire extinguishers will be designated on the facility's floor plan. The Maintenance staff will utilize the floor plan to ensure fire extinguishers in 		

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K 064	Continued From page 4 file, or in an electronic system (e.g., bar coding) that provides a permanent record.	K 064	all locations are checked monthly.	8/18/2013	
K 067 SS=D	Findings: On 7/18/13, during a tour of the facility with the Maintenance Staff, the fire extinguishers were observed. At 9:13 a.m., there was no monthly inspection of the fire extinguisher for June 2013 in the elevator room. 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, the facility failed to maintain the heating, ventilating and air conditioning system. This was evidenced by equipment not being maintained. This could result in injury to residents or staff, and affects 1 of 5 smoke compartments on the 1st floor. NFPA 101, Life Safety Code, 2000 Edition 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 provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature	K 067	<ul style="list-style-type: none"> The monthly fire extinguisher inspections and documentation will be included in the monthly safety inspection checklist. Results of these inspections will be reported by the Environmental Services Manager to the facility's CQI Committee monthly for three months, then quarterly thereafter. The Committee will evaluate the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated timeframes. The thermostat in the 1st floor Therapy Office was reattached to the wall by the Maintenance staff. The Maintenance staff will check all thermostats in the facility to ensure they are securely mounted to the walls. Inspections of the facility's thermostats will be included in the monthly safety inspection checklist. Results of these 		

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K 067	Continued From page 5 shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. Findings: On a tour of the facility on 7/17/13 to 7/18/13, the HVAC system was observed. On 7/17/13, at 3:05 p.m., the thermostat in physical therapy on the 1st floor was not attached to the wall, and exposing wires, that could potentially cause injury to staff and residents.	K 067	inspections will be reported by the Environmental Services Manager to the facility's CQI Committee monthly for three months, then quarterly there- after. The Committee will eva- luate the effectiveness of the plan of correction for poten- tial modifications and or conti- nuation beyond the stated time- frames.	8/18/2013	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that staff were aware that fire extinguishers in the kitchen were used second to the hood extinguishing system. This was evidenced by no signs posted above the fire extinguishers in the kitchen. This affects 1 of 5 smoke compartments on the 1st floor, and could result in the spread of fire. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition 7-2.1.1 A placard identifying the use of the extinguishers as secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area. Findings:	K 069	<ul style="list-style-type: none"> Placards identifying the two "K" fire extinguishers in the kitchen as secondary fire suppression equipment have been ordered through Simplex Grinnell the facility's fire suppression contractor. Once received, the placards will be installed above the kitchen fire exting- uishers by the Maintenance staff. Inspections of the facility's kitchen fire extinguishers placards will be included in the monthly safety inspection checklist. Results of these inspections will be reported by the Environmental Services Manager to the facility's CQI Committee quarterly for one year, then annually thereafter. The Committee will evaluate 		

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K 069	Continued From page 6 On 7/18/13, at 9:06 a.m., during a tour of the facility kitchen with the Maintenance Staff, the fire extinguishers were observed. Two of Two fire extinguishers did not have placards posted above them identifying that the extinguishers were secondary backup means to the suppression system.	K 069	the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated timeframes.	8/18/2013	
K 144 SS=C	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	<ul style="list-style-type: none"> The Maintenance Staff will be reeducated by the Environmental Services Manager regarding the testing and inspection requirements for the facility's emergency generator. Copies of the weekly test and or inspection will be submitted to the facility's Administrator. 		
K 147 SS=C	<p>This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the emergency generator. This was evidenced by missing weekly visual inspection. This affects the entire facility and could result in the emergency generator malfunctioning in the event of an emergency.</p> <p>Findings: On 7/17/13, during document review, the emergency generator logs were reviewed. At 11:44 a.m., during review of the Generator Test Log, no documentation was provided for a weekly inspection for the week of 10/22/12.</p>	K 147	<ul style="list-style-type: none"> Inspections of the facility's emergency generator log will be included in the monthly safety inspection checklist. Results of these inspections will be reported by the Environmental Services Manager to the facility's CQI Committee monthly for three months, then quarterly thereafter. The Committee will evaluate the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated timeframes. 		

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K 147	<p>Continued From page 7</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the electrical wiring and equipment. This was evidenced by appliances and medical devices being plugged into surge protectors. This affects 1 of 5 smoke compartments on the 1st floor and 1 of 5 smoke compartments on the 2nd floor. This could result in a fire.</p> <p>NEC 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:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <p>(5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(6) Where installed in raceways, except as otherwise permitted in this Code.</p> <p>Findings: On a tour of the facility on 7/17/13 to 7/18/13, with</p>	K 147	<ul style="list-style-type: none"> • 1. In the Medical Records Office, the microwave oven was removed. • 2. In Room 421 bed B, the surge protector was removed and the air mattress is connected directly into an electrical wall outlet. • The Maintenance Staff and the Department Managers will be reeducated by the Environmental Services Area Manager regarding the prohibition of improper electrical connections and ensuring the electrical appliances in the facility for proper connections to a power source. • The Department Managers will be responsible for monitoring proper power source connections for appliances and equipment in their areas through monthly safety inspections. • Proper electrical connections of appliances or patient care equipment will be included in 	8/18/2013	

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K 147	Continued From page 8 the Maintenance Staff, the electrical wiring and equipment was observed. 1. On 7/17/13 at 3:52 p.m., in the medical records office on the 1st floor the microwave oven was plugged into a surge protector and not directly into a wall. 2. On 7/18/13 at 9:21 a.m., the air mattress on bed B in room 421 was plugged into a surge protector and not directly into a wall.	K 147	the monthly safety inspection checklist. Results of these inspections will be reported by the Department Managers to the facility's CQI Committee monthly for three months, then quarterly thereafter. The Committee will evaluate the effectiveness of the plan of correction for potential modifications and or continuation beyond the stated timeframes.	8/18/2013	