STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555870	A. BUILDING 01 B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA HEALTH CENTER	7922 PALM STREET LEMON GROVE, CA 91945

(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: 2011 K7 SURVEY UNDER: 2000 New Code STRUCTURE TYPE: TYPE (11), protected, ONE STORY WITH A BASEMENT, 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, New codes. Representing the California Department of Public Health: 29566. Census: 94	K 000	This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted. The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility to comply with the requirements of participation and to continue to provide high quality resident care. **K052** *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:* A heat detector will be installed in the generator room for the protection of the fire alarm panel. The heat detector is UL certified and approved by the Office of the State of California Fire Marshal. The heat detector alarms at both nursing stations to notify staff and occupants when the fire alarm panel may be in-danger.	7/12/13
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to protect	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-5-13

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 acceptable per Joel Yalung, HFE II-S, 07/08/2013

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K 052	Continued From page 1 the fire alarm panel. This was evidenced by the room which housed the fire alarm panel was not equipped with a smoke or heat detector. The smoke or heat detector acts as a early warning system to notify occupants when the panel would be in-danger from fire and unable to function. This could result in staff unaware of the fire alarm panel in danger, delay notification to occupants and possible harm to residents and staff, in the event of a fire. This affected 9 of 9 smoke compartments. Findings: National Fire Protection Association 72 National Fire Alarm Code, 1999 Edition 1-5.6* Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit (s) to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. During tour of facility with the Administrator on 6/19/13, the fire alarm panel was observed. At 3:11 p.m., the fire alarm panel was mounted on the wall in the locked generator room located at the back of the facility, ground level. The generator room was not equipped with a smoke or heat detector for the protection of the fire alarm panel. The above finding was acknowledged by the	K 052	*How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken:* No other residents affected *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:* Maintenance staff will test the heat detectors monthly to ensure proper notification is received at each nursing station. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrective is achieved and sustained:* Administrator will monitor compliance by supervising monthly fire alarm heat detector testing to assure proper activation occurs. *Date when corrective action will be completed:* July 12th, 2013	7/12/13

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K 052	Continued From page 2 Administrator at the time and during exit conference on 6/20/13.	K 052	K062 *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:* 1. An escutcheon plate was installed on the walk-in freezer sprinkler head in the basement kitchen. 2. The shelves in the basement emergency supply room were altered to maintain 18" between the sprinkler head and the storage items. *How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken:* No other residents affected *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:* Maintenance staff shall receive inservice training regarding proper maintenance of our automatic sprinkler system including but not limited to the placement of escutcheon rings and always maintaining at least an 18" clearance.	7/12/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic sprinkler system. This was evidenced by sprinkler head missing escutcheon ring and failure to maintain 18 inches clearance space between sprinkler deflector and top of storage shelves. An 18" clearance is required to be maintained between the sprinkler heads and the storage items. If this clearance is not maintained, water dispersion from an activated sprinkler head would be compromised and thereby rendering sprinkler ineffective. The escutcheon plate is used to cover the penetration around the sprinkler head. This affected 2 of 2 smoke compartments of the basement. This could result in the disruption of the sprinkler spray pattern, a delay in extinguishing a fire and potential harm to residents and staff, in the event of a fire. Findings: During tour of the facility with the Administration on 6/20/13, the sprinkler heads were observed.	K 062		

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K 062	Continued From page 3 1. At 10:05 a.m., in the basement kitchen, the walk-in freezer sprinkler head was not equipped with an escutcheon plate. A foam like-material was installed in and around the penetration of the sprinkler head. 2. At 10:25 a.m., the basement emergency supplies, storage room had boxes of supplies stored on top shelves approximately 13 inches from the sprinkler deflectors obstructed the water flow pattern of the deflector. The above findings were acknowledged by the Administrator at the time and during the exit conference on 6/20/13.	K 062	*How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrective is achieved and sustained:* All sprinkler heads will be inspected as part of the monthly fire safety inspections. Verification of 18" clearance verified by daily maintenance room rounds. *Date when corrective actions were completed:* June 20, 3013 **K072**	7/12/13
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the access to a primary means of escape. This was evidenced by industrial copier blocked egress corridor path. This affected 1 of 9 smoke compartments. This could result delay the evacuation of residents and staff and the increased risk of injury to the residents and staff, in the event of a fire.	K 072	*How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:* The industrial copier was moved out of the corridor by the Administrator office and into an office where is no longer blocks the corridor egress path. *How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken:* No other residents affected *What measures will be put into place or what systemic changes the facility*	

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K 072	Continued From page 4 Findings: During the facility tour with Administrator on 6/20/13, the egress corridor path was observed. At 9:28 a.m., an industrial copier(equipped with a fax, scanner and attached computer) blocked the corridor egress path by the Administrator office. The copier was plugged into the corridor wall outlet. The above finding was acknowledged by the Administrator at the time and during exit conference on 6/20/13.	K 072	*will make to ensure that the deficient practice does not recur:* Maintenance staff shall receive inservice training regarding keeping means of egress continuously free of all obstruction or impediment to full instant use in case of fire or other emergency. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrective is achieved and sustained:* Maintenance will monitor the means of egress during their daily rounds. Administrator will monitor compliance through making weekly facility rounds. *Date when corrective action was completed:* July 6th, 2013 **K147** *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* The lamp in the Occupation Therapy Room is now plugged directly into a wall outlet. *How the facility will identify other resident having the potential to be affected by the same deficient practice*	7/12/13
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 electrical safety. This was evidenced by electrical appliances plugged into multi-plug, surged protector power strip and not into wall outlets . This affected 1 of 9 smoke compartments. This could potentially cause a fire and potential harm to residents and staff in the event of a fire emergency. NFPA 70 Section 400-8 1999 Ed. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following:	K 147		

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K 147	Continued From page 5 (1) As a substitute for a 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 (5) Where concealed behind building walls, structural ceilings, suspended ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this code Findings: During a tour of the facility with the Administrator on 6/20/13, the corridor rooms were observed. At 9:09 a.m., the Occupation Therapy Room had a lamp plugged into a multi-plug surge protector power strip instead of a wall outlet. The above finding was acknowledged by the Administrator at the time and during the exit conference on 6/20/13.	K 147	*and what corrective action will be taken:* No other residents affected *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:* Maintenance staff shall receive inservice training regarding electrical safety including appliances not being plugged into multi-plug surged protected power strips and into wall outlets. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrective is achieved and sustained:* Maintenance will monitor the use of power strips as part of monthly facility safety inspections. Administrator will monitor compliance through review of Maintenance inspection logs and by making monthly facility rounds. *Date when corrective action was completed:* June 20, 2013	7/12/13