STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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: 3/31/1974 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY PLUS BASEMENT, CONSTRUCTION TYPE (V) (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification 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: 27254	K 000	DISCLAIMER STATEMENT This Plan of Correction constitutes a written credible allegation of compliance for the deficiencies noted. Preparation and/or execution of this Plan of Correction does not constitute admission in agreement or by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and / or executed solely because required by provisions of Federal and State law. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JAN 16 2014 L & C DIVISION SAN JOSE	2-10-15
K 018 SS=E	The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018	1. The door wedge that is holding the door to the employee break room by Station 4 West Wing was removed. 2. The Medical Records Storage door across room 301 was repaired and is now positively latching. 3. The bed that was obstructing the door of room 216 was moved and is now closing properly with no obstruction.	2-10-15

LABORATORY DI[redacted]

Any deficiency s[redacted]titution 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2055 FOREST AVENUE SAN JOSE, CA 95128

(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 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain corridor doors to resist the passage of smoke, as evidenced by corridor doors that did not latch when closed, and by corridor doors that were impeded from closing. This condition affected five of nine smoke compartments, and could result in the migration of smoke in the event of a fire. NFPA 101 Life Safety Code, 2000 Edition 4.5.7 Maintenance. 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 maintained unless the Code exempts such maintenance. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable	K 018	4. The door to resident room 210 was freed from the stool and is now closing properly. 5. The bed obstructing the door in resident room 110 was moved and now properly closing. 6. The hardware to resident room 405 door is completed and is now properly working with a positive latch. 7. The resident room 614 door was fixed by the Maintenance Man and is now properly working. Maintenance Director completed an inspection on all the room and the doors to ensure proper closing. No other issues noted. Maintenance Director will conduct rounds daily to ensure that doors are not obstructed and are properly latching. Department Managers and the Nursing Management Team will continue to conduct ambassador rounds daily with a focus of ensuring doors are not obstructed and are latching properly. Findings in the Ambassador rounds will be discussed in the daily morning meeting.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 018	Continued From page 2 with not more than one releasing operation. Exception No. 1:* Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. Findings: During a tour of the facility with staff members between 12/30/13, and 12/31/13, the corridor doors were observed. 1. On 12/30/13, at 3:58 p.m., in the West Wing Station 4, the door to the employee break room was held open by a door wedge. The door was equipped a self closing mechanism. 2. On 12/31/13, at 11:04 a.m., the Medical Records Storage Room across from resident room 301, failed to fully close and positively latch. 3. On 12/31/13, at 11:05 a.m., the door to resident room 216 was obstructed by the resident bed.	K 018	Findings and issues identified during the ambassador rounds and Maintenance Director rounds will be reviewed in the QA and A committee monthly with follow up till sustained.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 018	Continued From page 3 4. On 12/31/13, at 11:08 a.m., the door to resident room 210, was obstructed by a stool. 5. On 12/31/13, at 11:16 a.m., the door to resident room 110 was obstructed by the resident bed. 6. On 12/31/13, at 11:21 a.m., the door to resident room 405 did not positively latch due to hardware on the door frame that was missing. 7. On 12/31/13, at 11:31 a.m., the door to resident room 614 did not positively latch when closed.	K 018	BLANK PAGE	
K 027 SS=F	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. 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 the fire doors as evidenced by fire doors that did not fully close and latch, and by fire doors that were obstructed from closing. These deficient conditions affected five of nine smoke compartments, and could result in the	K 027	1. The two carts obstructing the right hand fire door by room 605 was removed and fire door is now closing properly. 2. The Fire door by room 501 was adjusted and repaired. Is now fully closing and latching and so as the 1 inch penetration repaired. 3. The right hand fire door by resident room 219 was adjusted and is now fully closing and latching. 4. The left hand fire door by resident room 216 was adjusted and is now fully closing and latching. 5. The left hand fire door by resident room 310 was adjusted and is now fully closing and latching.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 027	Continued From page 4 spread of smoke in the event of a fire. NFPA 101 Life Safety Code, 2000 Edition 8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) *Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. NFPA 80 Standard for Fire Doors and Fire Windows 2-4.1.2* A closing device shall be installed on every fire door. Exception: With approval by the authority having jurisdiction, where pairs of doors are provided for mechanical equipment rooms to allow the movement of equipment, the device shall be permitted to be omitted on the inactive leaf. 2-4.1.3 All components of closing devices used shall be attached securely to doors and frames by steel screws or through-bolts. 2-4.1.4* All closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation.	K 027	6. The left hand fire door by resident room 103 was adjusted and is now fully closing and latching. 7. The right hand fire door by resident room 414 was adjusted and is now fully closing and latching. 8. The right hand fire door by resident room 604 was adjusted and is now fully closing and latching. 9. The right hand fire door by resident room 617 was adjusted and is now fully closing and latching. 10. The left hand fire door on the east side of the breezeway was adjusted and is now fully closing and latching. 11. The right hand fire door by on the west side of the breezeway was adjusted and is now fully closing and latching.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2066 FOREST AVENUE SAN JOSE, CA 95128

(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 027	Continued From page 5 Findings: During a tour of the facility with a staff member between 12/30/13, and 12/31/13, the facility's fire doors were observed. 1. On 12/30/13, at 4:05 p.m., the right hand fire door by resident room 605 was obstructed by two carts. 2. On 12/31/13, at 11:50 a.m., the right hand fire door by resident room 501, released upon activation of the fire alarm system. The door failed to fully close and positively latch. There was a one inch penetration in the door near the door handle where a screw was missing. 3. On 12/31/13, at 11:53 a.m., the right hand fire door by resident room 219, released upon activation of the fire alarm system. The door failed to fully close and positively latch. 4. On 12/31/13, at 11:54 a.m., the left hand fire door by resident room 216, released upon activation of the fire alarm system. The door failed to positively latch when closed. 5. On 12/31/13, at 12 p.m., the left hand fire door by resident room 310, failed to release from the door magnet upon activation of the fire alarm system. When closed, the door failed to positively latch. 6. On 12/31/13, at 12:03 p.m., the left hand fire door by resident room 103, released upon activation of the fire alarm system. The door failed to positively latch when closed.	K 027	Maintenance Director completed rounds to inspect all fire doors to ensure that they are all working closing and latching. No other issues were found. Maintenance Director will conduct facility rounds every month to ensure that all fire doors are adjusted to close freely and are latching properly. Follow up as indicated. Administrator will provide in-service education to Maintenance Director regarding the fire doors to properly close and latching properly. Findings and issues identified during the Maintenance rounds will be reviewed by the QA and A committee monthly until sustained.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 027	Continued From page 6 7. On 12/31/13, at 12:08 p.m., the right hand fire door by resident room 414, released upon activation of the fire alarm system. The door failed to positively latch when closed. 8. On 12/31/13, at 12:13 p.m., the right hand fire door by resident room 604, released upon activation of the fire alarm system. The door failed to positively latch when closed. 9. On 12/31/13, at 12:15 p.m., the right hand fire door by resident room 617, released upon activation of the fire alarm system. The door failed to fully close and positively latch. 10. On 12/31/13, at 12:20 p.m., the left hand fire door on the East side of the Breezeway, released upon activation of the fire alarm system. The door failed to positively latch when closed. 11. On 12/31/13, at 12:23 p.m., the right hand fire door on the West side of the Breezeway, released upon activation of the fire alarm system. The door failed to positively latch when closed.	K 027	BLANK PAGE	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	The facility will conduct a fire drill for all shift by January 15, 2014 to fill in for the missing drills of the first and second quarter of 2013. All other fire drills were checked and were conducted timely. No other issues noted. The Maintenance Supervisor and The Director of Staff Development will make sure that all Fire Drills are conducted timely for all three shifts.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 050	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review, the facility failed to conduct quarterly fire drills. This deficient was evidenced by missing four of twelve fire drills. This could slow and or delay an actual fire emergency evacuation and staff response and affects all staff and residents in the facility. NFPA 101 Life Safety Code, 2000 Edition 19.7.1.2* Fire drills in health care occupancies shall include the transmission of fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours)and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. NFPA 99 Standard for Health Care Facilities, 1999 Edition 11-5.3.9* Drills. Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both. Findings: During document review with a staff member on	K 050	The Administrator will give in-service education to the Maintenance Supervisor and Director of Staff Development to ensure that the Fire Drills are done timely for all three shifts. Issues or concerns from the Fire Drills will be reported to the Daily Morning Meeting as needed. Findings and trends reported in the daily morning meeting will be brought to the QA and A monthly until sustained.	2-10-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055316	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 050	Continued From page 8 12/31/13, the documents for the fire drills were requested. At 9:36 a.m., the fire drill records reviewed were missing 2 NOC shift, 1 PM shift, and 1 AM shift drill. There were no records for the first quarter AM or NOC shift drills, and the second quarter PM shift drill.	K 050	**BLANK PAGE**	
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 interview and record review, the facility failed to ensure the maintenance, inspection and testing of smoke detectors, as evidenced by not conducting the required smoke detector sensitivity testing. This deficient practice affected nine of nine smoke compartments, and could result in the failure of the smoke detectors in the event of a fire. NFPA 101, Life Safety Code, 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. NFPA 72, National Fire Alarm Code, 1999 Edition	K 054	The Testing of the Smoke Detectors is scheduled with CINTAS, the fire alarm company doing the testing of the Fire Alarms of the building. Smoke Detector sensitivity testing was done in 2012 with no issues noted and was done by EEMS- Electrical Energy Management System, Tom Gaffy. Maintenance Director will continue to monitor and file reports from the Fire Alarm companies specific to Smoke Detectors. Administrator will give In-service education to Maintenance Director to ensure the timely testing of smoke detectors for sensitivity. Any issues with the testing will be discussed in the morning meeting. Any findings and trends identified during the morning meeting will be reported in the QA and A meeting monthly until sustained.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 054	Continued From page 9 5-4.7 Record Keeping and Reporting. 5-4.7.1 A permanent record of the time, date, and location of all signals and restorations received and the action taken shall be maintained for at least 1 year and shall be able to be provided to the authority having jurisdiction. These records shall be permitted to be created by manual means. 5-4.7.2 Testing and maintenance records shall be retained as required in 7-5.3. These records shall be permitted to be created by manual means. 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range	K 054	BLANK PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 054	Continued From page 10 (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. 7-5.2 Maintenance, Inspection, and Testing Records. 7-5.2.1 Records shall be retained until the next test and for 1 year thereafter. 7-5.2.2 A permanent record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 7-5.2.2. (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(s) tested, for example, " Tests performed in accordance with Section _____."	K 054	BLANK PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 054	Continued From page 11 (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturers (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative (15)Disposition of problems identified during test (for example, owner notified, problem corrected/successfully retested, device abandoned in place) Findings: During document review with a staff member on 12/31/13, the documents for the smoke detector sensitivity testing were requested. At 10:10 a.m., no documents were provided to show that the facility had conducted the sensitivity testing of the smoke detectors. There was no report for the sensitivity testing, including a complete list of smoke detectors, results of the sensitivity testing, or the name of the person conducting the tests.	K 054	BLANK PAGE	
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	K 064	CINTAS company in charge of all the facility Fire Extinguishers was scheduled to evaluate and re-charge the K-type portable fire extinguisher in the Kitchen indicating any over charge or under charge.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 064	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and document review, the facility failed to maintain the portable fire extinguishers, as evidenced by a K-type portable fire extinguisher that was overcharged. This condition affected one of nine smoke compartments, and could result in the failure of the portable fire extinguisher in the event of a fire. NFPA 101 Life Safety Code, 2000 Edition 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers, 1998 edition 4-3.2 Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place	K 064	Maintenance Director checked all fire extinguishers for overcharge or undercharge, no other issues noted. Maintenance Director will continue to monitor K-type portable fire extinguisher located in the kitchen for any over charge or under charge in the unit. Administrator will give in-service education to the Director of Maintenance to ensure the timely monitoring of the K-type portable fire extinguisher located in the kitchen for any over or under charge of the unit. Any issues or negative finding from the monitoring will be reported and discuss in the morning meeting. Any findings and trends identified during the morning meeting will be reported in the QA and A meeting monthly until sustained.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2066 FOREST AVENUE SAN JOSE, CA 95128

(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 064	Continued From page 13 Findings: During a tour of the facility with staff members on 12/30/13, the portable fire extinguishers were observed. At 3:53 p.m., the gauge on the K-type portable fire extinguisher in the kitchen indicated the fire extinguisher was overcharged.	K 064	**BLANK PAGE**	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (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 maintain the storage of oxygen cylinders, as evidenced by empty and full e-cylinder oxygen cylinders that were stored together within the same rack. This deficient practice affected two of nine smoke compartments, and could result in the delay of delivering oxygen in the event of an emergency. NFPA 101, 2000 Edition	K 076	1. The two empty oxygen cylinders and the two full oxygen cylinders located in the west wing station 4 are now separated in two different racks. 2. The six empty oxygen cylinders and the 15 full oxygen cylinders located in the East wing station 1 are now separated in two different racks. The Maintenance Director and the Central Supply Personnel look into the other oxygen closet and the full tanks are separated from the empty tanks. No other issues noted. The Central supply personnel requested from the oxygen company another rack for empty oxygen cylinders for the two oxygen closets.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 076	Continued From page 14 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, Health Care Facilities, 1999 Edition 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. NFPA 99, 1999 Edition 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. NFPA 99, 1999 Edition 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) shall comply with 4-3.1.1.2 and 4-3.5.2.2. NFPA 99, 1999 Edition. 4-3.5.2.2 (2) If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. Findings:	K 076	The Administrator gave in-service education to both the Central supply personnel and the Maintenance Director to ensure that the empty cylinders are segregated from the full cylinders at all times. The Director of Staff Development will give in-service education to the License Nurses and the Nursing Assistants to make sure that empty oxygen cylinders are separated from the Full oxygen cylinders. Ambassador rounds are than daily to include the oxygen room being monitored for proper storage. Any findings from the rounds will be discussed in the morning meeting. Any trends from the ambassador rounds will be brought to the AQ and A meeting monthly until sustained.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 076	Continued From page 15 During a tour of the facility with a staff member between 12/30/13 and 12/31/13, the oxygen storage areas were observed. 1. On 12/30/13, at 4 p.m., in the West Wing Station 4 Oxygen Storage room, there were 2 empty and 2 full oxygen cylinders stored within the same rack without being segregated. 2. On 12/31/13, at 10:53 a.m., in the East Wing Station 1 Oxygen Storage Area, there were 6 empty and 15 full oxygen cylinders were stored within the same rack without being segregated.	K 076	**BLANK PAGE**	
K 144 SS=F	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. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to maintain the generators, as evidenced by not conducting the required monthly full load tests of the two facility generators for eight of twelve months. This condition affected nine of nine smoke compartments, and could result in the failure of the generators in the event of a power outage.	K 144	A full load testing was conducted immediately on January 2 2014 with the two generators by the Maintenance Director. No issues or problems noted. Maintenance Director documented on his monthly calendar regarding the operation of the two generators. The two generators are working properly in normal operating condition with no issues. The Administrator gave in-service education to the Maintenance Director on testing of the two generators at full load every month according to the regulation to ensure proper functioning of the system in case of power outage.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 144	Continued From page 16 NFPA 101, Life Safety Code, 2000 Edition 7.9.2.3 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems. 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 99, Health Care Facilities, 1999 Edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1.* Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test conditions. The scheduled test under load conditions shall include a complete simulated	K 144	Any issues or problems during the monthly testing of the two generators will be reported to the Administrator during the morning stand up meeting for immediate resolution. Trends discussed in the morning meeting regarding the generator will be brought to the QA and A meeting monthly until sustained.	2-10-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 144	Continued From page 17 cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 1999 Edition 6-3 Maintenance and Operational Testing. 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 6-3.4 A written record for the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer. 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the	K 144	BLANK PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 144	Continued From page 18 generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.1 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. 6-4.3 Load tests of generator sets shall include complete cold starts. Findings: During document review with a staff member, on 12/30/13, the generator maintenance records were reviewed. At 3:40 p.m., eight of twelve monthly full load tests had not been conducted for two of two generators. No records were provided for full load	K 144	BLANK PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 144	Continued From page 19 tests from May, 2013, to December, 2013. During an interview, staff stated no full load tests had been conducted for either of the facility's two generators.	K 144	**BLANK PAGE**	
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 interview and observation, the facility failed to maintain the electrical panels, as evidenced by an electrical panel that was obstructed. This deficient practice affected one of nine smoke compartments, and could result in the ignition of an electrical fire. NFPA 101 Life Safety Code, 2000 Edition SECTION 9.1 UTILITIES 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (b) Clear Spaces. Working space required by	K 147	The Refrigerator obstructing the access to the Electrical Panel in the East Wing Station 1 Medicine Room 2 was removed to have a clear access to the Electrical Panel whenever needed. The Maintenance Director made rounds to ensure that all other Electrical Panels are not obstructed and that there is a free access. No other Issues noted at this time. The Administrator gave in-service education to the Maintenance Director regarding the electrical panels being free from any obstructions for easier access. Ambassador rounds and the Nursing Management Team does rounds daily to ensure that part of the inspection is to make sure that the Electrical Panels are free from any obstructions. Findings will be brought to the daily morning meeting. Findings and trends from the daily morning meeting will be brought to the monthly QA and A meeting until sustained.	2-10-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(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 20 this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space shall be suitably guarded. 800-5. Access to Electrical Equipment Behind Panels Designed to Allow Access. Access to equipment shall not be denied by an accumulation of wires and cables that prevents removal of panels, including suspended ceiling panels. Findings: During a tour of the facility with staff members on 12/31/13, the electrical panels were observed. At 10:51 a.m., in the East Wing Station 1 Med Room 2, a refrigerator obstructed access to an electrical panel.	K 147	BLANK PAGE	