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FORM APPROVED
OMB NO. 0938-0391

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
	556143	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAND HOUSE	100 BARNET SEGAL LANE MONTEREY, CA 93940

(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: 05/01/1992 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, PROTECTED WOOD FRAME, 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) 488.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR 488.70 (a) for Long Term Care Facilities. Census: 25	K 000		
K 018 SS=D	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 19.3.6.2.6	K 018		

LABO [redacted]

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

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K 018	Continued From page 1 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 its corridor doors. This was evidenced by a corridor door that failed to close and positively latch. This could result in the passage of smoke in the event of a fire, and affected one of four smoke compartments. 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. Findings: During a tour of the facility with staff members on 10/30/13, the corridor doors were observed. At 10:38 a.m., the corridor door to the McCone Family Dining Room was equipped with a	K 018	• WO #91045 completed 31OCT13 – repaired, adjusted door to latch properly. • Check all doors monthly. – increase inspections to weekly if 5% of doors fail; then back to monthly if no failures in 4 weeks. • Monitor doors during fire drills	

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K 018	Continued From page 2 self-closing device and a magnetic hold-open device. The double door was released from its hold-open device and allowed to close. The right door failed to latch.	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. 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, the facility failed to maintain the doors in smoke barriers to continuously serve as a barrier to prevent the spread of smoke and/or fire. This was evidenced by smoke barrier doors equipped with latching hardware that failed to latch when tested. This affected two of four smoke compartments, and could result in the spread of smoke and/or fire from one smoke compartment to another. NFPA 101, 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 the provisions of this Code, such	K 027		

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K 027	Continued From page 3 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. NFPA 80, 1999 Edition 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 overpome the resistance of the latch mechanism so that positive latching is achieved on each door operation. Findings: During a facility tour with staff members on 10/30/13, the smoke barrier doors were observed. 1. At 2:10 p.m., the right leaf of the smoke barrier door located by the Play Room did not latch during the fire alarm testing. Smoke barrier door was held open with the magnetic device and released upon activation of the fire alarm system, but the right leaf failed to positively latch. 2. At 2:21 p.m., the left leaf of the smoke barrier door located by the Supply Room did not latch during the smoke detector fire alarm testing.	K 027	K 027-1 • WO #91093 completed 06NOV13 – Repaired top latch and adjusted bottom latch as much as possible; door latches. • Check all doors monthly. – increase inspections to weekly if 5% of doors fail; then back to monthly if no failures in 4 weeks. • Monitor doors during fire drills K 027-2 • WO #91076 completed 01NOV13 – Cleaned and adjusted latches; latch engages. • Check all doors monthly. – increase inspections to weekly if 5% of doors fail; then back to monthly if no failures in 4 weeks. • Monitor doors during fire drills	

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K 027	Continued From page 4 Smoke barrier door was held open with the magnetic device and released upon activation of the fire alarm system, but the left leaf failed to positively latch. 3. At 2:24 p.m., the right leaf of the smoke barrier door located by the Supply Room did not latch during the manual pull fire alarm testing. Smoke barrier door was held open with the magnetic device and released upon activation of the fire alarm system, but the right leaf failed to positively latch.	K 027	K 027-3 • WO #91076 completed 01NOV13 – Filed down frame stop; latch engages. • Check all doors monthly. -- increase inspections to weekly if 5% of doors fail; then back to monthly if no failures in 4 weeks. • Monitor doors during fire drills	
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 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their automatic sprinkler system. This was evidenced by an escutcheon ring that had shifted, foreign material on sprinkler heads, and by the failure to correct deficiencies on the five year sprinkler riser inspection report. This affected four of four smoke compartments, and could result in a delayed activation of the automatic fire sprinkler system. NFPA 101 Life Safety Code, 2000 edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained	K 062		

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K 062	Continued From page 5 . In accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 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. 9-4.2.1 Inspection. Valves shall be inspected internally every 5 years to verify that all components operate properly, move freely, and are in good condition. During a facility tour, and record review with staff members on 10/30/13, the automatic sprinkler system was observed. 1. At 10:55 a.m., the escutcheon ring had shifted to one side and exposed an approximately 1/8 inch penetration in the ceiling, in Room 20. 2. At 11:09 a.m., there was foreign material on	K 062	K 062-1 • WO #91049 completed 01NOV13 –Repaired, patched opening; ring was placed tight to ceiling. • Check all escutcheon rings quarterly. • Monitor escutcheon rings during fire drills – increase inspections to monthly if 5% of rings fall; then back to quarterly if no failures in 3 months. K 062-2 • WO #91048 completed 31OCT13 – Cleared debris from sprinkler head. • Check all sprinkler heads quarterly. • Monitor sprinkler heads during fire drills – increase inspections to monthly if 5% of sprinkler heads are found with foreign material; then back to quarterly if no failures in 3 months.	

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K 062	Continued From page 6 the sprinkler head, in the Oxygen Room. 3. At 11:25 a.m., there was foreign material on the sprinkler head, in the Activities Office. 4. At 11:27 a.m., there was foreign material on 9 of 8 sprinkler heads, in the Rehabilitation Gym. 5. At 2:00 p.m., the Inspection, Testing, and Maintenance Fire Sprinkler System report for the automatic sprinkler system dated 4/15/13, showed the automatic sprinkler system did not pass inspection. The five year inspection was marked "failed". The section on the report for deficiencies and comments indicated the following: "One sprinkler head at the entrance was far from ceiling; Need to add one sprinkler head in the kitchen area next to burner; 7 loaded sprinkler heads in the kitchen area; Paint on the sprinkler head near the entrance to engineering and near the director of Nursing office; One sprinkler head blocked by the exit sign in front of Room 2, No sprinkler heads under the building in storage area; Boiler Room needs six sprinkler heads changed to 212 degree and 13 locations outside where there is not any protection under the wood balconies". During interview with the Assistant Director at 2:05 p.m., staff stated that item #3, "7 loaded sprinkler heads in the kitchen area", was the item from the list of deficiencies on the 5 year sprinkler report that had been corrected. They are currently working on correcting the remaining deficiencies.	K 062	K 062-3 • WO #91047 completed 31OCT13 – Cleared debris from sprinkler head. • Check all sprinkler heads quarterly. • Monitor sprinkler heads during fire drills – increase inspections to monthly if 5% of sprinkler heads are found with foreign material; then back to quarterly if no failures in 3 months. K 062-4 • WO #91046 completed 31OCT13 – Cleared debris from 8 sprinkler heads. • Check all sprinkler heads quarterly. • Monitor sprinkler heads during fire drills – increase inspections to monthly if 5% of sprinkler heads are found with foreign material; then back to quarterly if no failures in 3 months. K 062-5 (see attached grid)	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147		

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K 147	Continued From page 7 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 wiring and equipment. This was evidenced by a cracked electrical faceplate. This deficient practice affected one of four smoke compartments, and could result in the ignition of an electrical fire. NFPA 101, 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 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. NFPA 70, 1999 edition 410-56(a) After Installation, receptacle faces shall be flush with or project from faceplates of insulating material and shall project a minimum of 0.015 in. (0.381 mm) from metal faceplates. Faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Findings: During a tour of the facility with staff members on 10/30/13, the electrical wiring and equipment were observed.	K 147		

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K 147	Continued From page 8 At 10:35 a.m., there was a cracked electrical faceplate by the exit door, in Room 2.	K 147	K 147 • WO #91044 completed 31OCT13 – Replace outlet faceplate.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 416.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the Alcohol Based Hand Rub (ABHR) dispensers from being installed over or adjacent to ignition sources. This was evidenced by an ABHR dispenser that was installed adjacent to a light switch. This could lead to an increased risk for an electrical fire, and affected one of four smoke compartments. NFPA 101 Life Safety Code, 2000 Edition 18.3.2.7* Alcohol-based Hand-rub Solutions. Alcohol-based hand-rub dispensers shall be	K 211	• Check all faceplates quarterly. • Monitor faceplates during fire drills – increase inspections to monthly if 5% of faceplates fail; then back to quarterly if no failures in 3 months.	

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K 211	Continued From page 9 protected in accordance with 8.4.3 unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8 m). (2) The maximum individual dispenser fluid capacity shall be: (a) 0.3 gallons 91.2 liters) for dispensers in rooms, corridors, and areas open to corridors. (b) 0.5 gallons (2.0 liters) for dispensers in suites of rooms (3) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2 m) form each other. (4) Not more than a aggregate 10 gallons (37.8 liters) of alcohol-based hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet. (5) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (6) The dispensers shall not be installed over or directly adjacent to an ignition source. (7) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments. Findings: During a tour of the facility with staff members on 10/30/13, the Alcohol Based Hand Rub dispensers were observed. At 11:05 a.m., in the Staff Only Room, the Alcohol Based Hand Rub dispenser was installed approximately 2 1/2 inches adjacent to the electrical light switch. A staff member confirmed the finding.	K 211	K 211 • WO #91046 completed 31OCT13 – relocated dispenser minimum 6" away from switch and patched wall. • Check all dispensers quarterly. • Monitor dispensers during fire drills – increase inspections to monthly if 5% of dispensers fail; then back to quarterly if no failures in 3 months.	

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