DEPARTMENT OF HEALTH AND HUMAN SERVICES

SANLEANDROHEALTHCARE

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PRINTED:	01/02/2014
FORM/	APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING DT 056345 B. WING 12/30/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **268 JUANA AVENUE** SAN LEANDRO HEALTHCARE CENTER SAN LEANDRO, CA 94577 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) K 000 i INITIAL COMMENTS K 000 K3 BUILDING: 01 CALFORNIA DEPARTMENT K6 PLAN APPHOVAL: 9/1/1972 OF PUBLIC HEALTH K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TWO STORY & BASEMENT, PROTECTED WOOD FRAME AND BRICK, CONSTRUCTION TYPE (V) (III), 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 Life Safety Code Unit: Surveyor: 31070 The facility is not in compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 52 K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 SS=E Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% 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 ABORATORY DIRE ny deficiency state stitution may be excused from correcting providing it is determined that of for nursing homes, the findings stated above are disclosable 90 days ther safeguards or

allowing the date of

ays following the d

rogram participatio

g homes, the above findings and plans of correction are disclosable 14

es are cited, an approved plan of correction is requisite to continued

, DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	NT OF DEFICIENCIÉS OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		056345	B. WING		· · · · · · · · · · · · · · · · · · ·	1 4:	2/30/2013
SAN LE	PROVIDER OF SUPPLIER			368	EST ADDRESS, CITY, STATE, ZIP CODE JUANA AVENUE N LEANDRO, CA 94577		2/30/2013
(X4) ID PREFIX TAG	I (ÉACH DEFICIÉNCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ΠRE	(XS) COMPLETION DATE
	are provided with a the door closed. Duare permitted. 19 Roller latches are prin all health care faction all health care faction all health care factions that were obstructed and fire in the affected 3 of 4 smoke and fire in the affected 3 of 4 smoke findings: During the facility tou on 12/30/13, the door that first floor was obstructed at the first floor was obstructed at the when the door wextent and released.	means suitable for keeping rich doors meeting 19.3.6.3.6.3 rohibited by CMS regulations illities. Interpolation of the series o	KO			thing thy ing ay erly al pree e or ili gnee all as ns	1/20/14
Į v	Veigh room located o	eff-closing door to the in the first floor failed to		ļ,	decide if any actions should be take		1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FOR	M APPROVI	
STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION OG 01 - MAIN BUILDING 01	(X3) D/	O. 0938-03 ATE SURVEY OMPLETED	
	056345 B, WING					•:	
	F PROVIDER OR SUPPLIER EANDRO HEALTHCAR!	CENTER		STREET ADDRESS, CITY, STATE, ZIP 368 JUANA AVENUE SAN LEANDRO, CA 94577	, CODE	12/30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X6) COMPLETION DATE	
	latch when the door extent and released 4. At 3:46 p.m., the in the Basement failt were made. 5. At 3:55 p.m., the Stairway in the Base door was held open released. 6. At 3:59 p.m., the seconds office locate to latch when the doc fullest extent and released NFPA 101 LiFE SAFI Any door in an exit particular enclosure, horizontal hazardous area enclosure, horizontal hazardous area enclosure of throactivation of: a) the required manual b) local smoke detection systemake detection systemake	was held open to the fullest. Three attempts were made. door to the Restroom located ed to latch. Three attempts self-closing door to the ment failed to latch when the to the fullest extent and self-closing door to Medical of on the second floor failed or was held open to the eased. ETY CODE STANDARD assageway, stairway exit, smoke barrier or usure is held open only by automatically close all such ughout the facility upon all fire alarm system; ors designed to detect the the opening or a required.	K 021	3			

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

5103573014

PRINTED: 01/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:			ile Construction 3 01 - Main Building 01	COMPLETED			
		056 345	B. WING _		12/30/2013		
NAME OF PROVIDER OR SUPPLIER SAN LEANDRO HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 368 JUANA AVENUE SAN LEANDRO, CA 94577			
(X4) ID PREFIX TAG	FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY PULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEPICIENCY)	LD BE COMPLETION		
K 021	Based on observer failed to maintain hold-open devices that failed to auto magnetic hold-op alarm testing. This in the spread of signs. This affected Findings: During the facility on 12/30/13, the devices were observed to be deviced with a magnetic release during were tested twice with the manual planspector's Test vinspection on 1/7, checked, and passible to release during tested twice with the manual pull signs of	is not met as evidenced by: atlon and interview, the facility their doors on magnetic s. This was evidenced by doors matically release from the en devices and close during fire is deficient practice could result moke and fire in the event of a 12 of 4 smoke compartments. It could be doors to the Pation of the first floor were held netic hold-open device, but failed fire alarm testing. The doors with the smoke detector, twice with station, and once with the seed inspection. The door to the Rehabilitation and on the first floor was held netic hold-open device, but failed fire alarm testing. The doors were seed inspection. The door to the Rehabilitation and on the first floor was held netic hold-open device, but failed fire alarm testing. The door was the smoke detector, twice with the failed. The annual fire alarm failed indicated the door was		1. Specific Action and/or measures correct the deficiency The patio dining room doors and rehab room doors now properly release from the magnetic hold-ordevice and now close during fire alarm testing 2. Who will be directly responsible the corrective action Maintenance supervisor or his designate will be put in play systematic changes the facility make to ensure that the deficient practice does not recur The maintenance supervisor or his designee will do monthly rounds to check all doors properly release and close during testing 4. How the facility plans to monito performance to make sure solutions are sustained The maintenance supervisor will go his inspection report to the QA tean decide if any actions should be taged.	the pen for ignee ace or will it		
SS-E				•			

		A MEDICAID SERVICES			OMB N	O. 0938-03	
AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			IPLE CONSTRUCTION IQ 01 - MAIN BUILDING 01	(X3) D	(X3) DATE SURVEY COMPLETED	
		056345	B. WING _		_	2/30/2013	
	ANDRO HEALTHCARI SUMMARY STA	E CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 368 JUANA AVENUE SAN LEANDRO, CA 94577 PROVIDER'S PLAN OF CORRECT	CTION		
TAG	REGULATORY OR L	C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFIDIENCY)	ገጠ ስ ል።	COMPLETIO DATE	
K 027	Door openings in an 20-minute fire prote 1%-inch thick solid is protective plates that from the bottom of the Horizontal sliding do Doors are self-closin accordance with 19. not required to swind	ge 4 noke barriers have at least a ction rating or are at least conded wood core. Non-rated to not exceed 48 inches he door are permitted, ors comply with 7.2.1.14. Ing or automatic closing in 2.2.2.6. Swinging doors are in with egress and positive ed. 19.3.7.5, 19.3.7.6,	K 02	7 1. Specific Action and/or measures correct the deficiency The smoke barrier door located o the first floor now positively latch. 2. Who will be directly responsible the corrective action Maintenance supervisor or his des	n es for	1/20/19	
t i r c	Based on observation maintain their door of as evidenced by 1 of falled to positively lat could result in the spother smoke comparathis affected 2 of 4 s. Findings: During fire alarm testions for 12/30/13, the observed. At 1:10 p.m., 1 of 1 sriche first floor was held nold-open device. The eleased from the maintaining fire alarm testinatch. The smoke barvith the smoke detect	not met as evidenced by: on, the facility failed to penings in smoke barriers, 1 smoke barrier doors that ch. This deficient practice read of smoke and fire into tments in the event of a fire moke compartments. Ing with the Maintenance smoke barrier doors were noke barrier door located on lopen with a magnetic e smoke barrier door gnetic hold-open device ig, but failed to positively rier door was tested twice or, twice with the manual with the Inspector's Test		 3. What measures will be put in playstematic changes the facility make to ensure that the deficient practice does not recur. The maintenance supervisor or his designee will do monthly rounds to ensure all smoke barrier doors properly release and latch. 4. How the facility plans to monitor performance to make sure solution are sustained. The maintenance supervisor will glinks inspection report to the QA team decide if any actions should be tail. 	lace or will nt its ions		

01/17/2014 05:31 5103573014 SANLEANDROHEALTHCARE DEMAH I MENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/02/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED. STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 056345 B. WING NAME OF PROVIDER OR SUPPLIER 12/30/2013 STREET ADDRESS, CITY, STATE, ZIP CODE SAN LEANDRO HEALTHCARE CENTER 368 JUANA AVENUE SAN LEANDRO, CA 94577 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG **BEFICIENCY**) K 029 Continued From page 5 K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 K 029 K029 \$\$≈D 120/14 One hour fire rated construction (with 1/4 hour Specific Action and/or measures to fire-rated doors) or an approved automatic fire correct the deficiency extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazerdous areas. When The door to the hazardous areas now the approved automatic fire extinguishing system latches and also nothing obstructs the option is used, the areas are separated from door other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or 2. Who will be directly responsible for field-applied protective plates that do not exceed the corrective action 48 inches from the bottom of the door are permitted. 19.3.2.1 Maintenance supervisor or his designee What measures will be put in place or systematic changes the facility will make to ensure that the deficient This STANDARD is not met as evidenced by: practice does not recur Based on observation, the facility failed to maintain their hazardous areas, as evidenced by The maintenance supervisor or his one door to a hazardous area that failed to latch, designee will conduct monthly rounds and by one door to a hazardous area that was to ensure the door to the hazardous obstructed. This deficient practice could result in area latches and nothing is obstructing the spread of smoke and fire in the event of a fire. it. This affected 1 of 4 smoke compartments. Findings: 4. How the facility plans to monitor its performance to make sure solutions During the facility tour with the Maintenance Staff are sustained on 12/30/13, the hazardous areas were observed. The maintenance supervisor will give

At 3:48 p.m., the door to the Pantry in the

room was over fifty square feet in size.

Kitchen failed to latch when pulled closed. The

2. At 3:49 p.m., the interior door located in the Pantry in the Kitchen was obstructed by a plastic crate. The room was over fifty square feet in size. his inspection report to the QA team

on a monthly basis. The QA team will

decide if any actions should be taken.

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

PRINTED: 01/02/2014 FORM APPROVED OMB NO. 0938-0891

STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SÜRVEY APLETED
	PROVIDER OR SUPPLIER	056345 E CENTER	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 368 JUANA AVENUE		/30/2013
(X4) ID PREFIX TAG K 046 K 046 SS=E	Continued From pa NFPA 101 LIFE SA Emergency lighting provided in accords This STANDARD I Based on docume facility failed to mai as evidenced by the	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFD TAG K 0	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) K046	es to al test on ing system duct this han 30	COMPLETION DATE
	maintenance of the deficient practice of provide backup light failure, and a delay of 4 smoke comparation. NFPA 101, 2000 Etc. 7.9.3 Periodic Testit Equipment. A function every required etc. 30-day intervals for annual test shall be battery-powered en not less than 1 1/2 fully operational for Written records of whall be kept by the authority having jur Exception: Self-test battery-operated en that automatically put than 30 seconds at than once every 30 a status indicator si 30-day functional testing.	emergency lighting. This puld result in the failure to ating in the event of a power in evacuation. This affected 4 atments. dition and of Emergency Lighting tional test shall be conducted emergency lighting system at not less than 30 seconds. An acconducted on every required nergency lighting system for hours. Equipment shall be the duration of the test.		3. What measures will be put in or systematic changes the fact make to ensure that the deficing practice does not recur. The maintenance supervisor or will conduct this test on a month and address any issues. This to documented and filed. 4. How the facility plans to more performance to make sure sure sustained. The maintenance supervisor whis inspection report to the QA on a monthly basis. The QA to decide if any actions should be	place hithy will lent designee hity basis test will be hitor ite olutions iteam eam will	

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

PRINTED, 01/02/2014 FORM APPROVED QMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. SUILDING 01 - MAIN BUILDING 01			
		056345	B. WING			12	/30/2013	
	NAME OF PROVIDER OR SUPPLIER SAN LEANDRO HEALTHCARE CENTER				REET ADDRESS, CITY, STATE, ZIP CODE 8 JUANA AVENUE AN LEANDRO, CA 94577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(XS) COMPLETION DATE	
K 046	Continued From p	age 7	K)46	•			
	on 12/30/13, the d	tour with the Maintenance Staff locumentation for the testing of the emergency lighting quested						
	At 3:06 p.m., there was no documentation regarding the monthly or annual testing and maintenance of the facility's emergency light located in the generator area.			,		•		
	given to a staff me	Staff stated the form had been ember, but there were no that the testing was						
K 062	tested by the Mair	ghting worked properly when tenance Staff. AFETY CODE STANDARD	K	062				
\$S#D	continuously main condition and are	ic sprinkler systems are nained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,						
	Based on observe maintain their auto evidenced by one inches of clearant result in an obstru	is not met as evidenced by: ation, the facility falled to omatic sprinkler system, as sprinkler that did not have 18 be. This deficient practice could action to the sprinkler's spray ent of a fire. This affected 1 of 4 ents.				,		

PRINTED: 01/02/2014 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION 12/30/2013 058345 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 368 JUANA AVENUE SAN LEANDRO, CA 94577 SAN LEANDRO HEALTHCARE CENTER PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE . (705) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC (DENTIFYING INFORMATION) DATE PHEFIX TAG PRÉFIX DEFICIENCY) TAG K 062 Continued From page 8 K062 K 062 1/20/14 Specific Action and/or measures to NFPA 101, 2000 Edition correct the deficiency 19,7.6 Maintenance and Testing. The card board boxes on the top shelf were NFPA 101, 2000 Edition removed and now nothing is under the 4.6.12 Maintenance and Testing sprinkler. It now meets the 18 inch 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level compliance. of protection, or any other feature is required for 2. Who will be directly responsible for compliance with the provisions of this Code, such the corrective action device, equipment, system, condition, arrangement, level of protection, or other feature Maintenance supervisor or his designee shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 3. What measures will be put in place or systematic changes the facility will make to ensure that the deficient NFPA 13, 1999 Edition practice does not recur 5-5.6* Clearance to Storage. The clearance between the deflector and the top of storage shall The maintenance supervisor will conduct be 18 inch (457 mm) or greater. rounds to ensure that there are no items within 1B inches of the sprinklers. These NFPA 25, 1998 Edition 2-2,1.2 Unacceptable obstructions to spray rounds will be documented. patterns shall be corrected. 4. How the facility plans to monitor its performance to make sure solutions Findings: are sustained During the facility tour with the Maintenance Staff on 12/30/13, the automatic sprinkler system was The maintenance supervisor will give his inspection report to the QA team observed. on a monthly basis. The QA team will At 4:05 p.m., the sprinkler clearance was decide if any actions should be taken. approximately 5 inches in the Nurse's Storage room located on the second floor. There were cardboard boxes stacked on the top shelf approximately 5 inches directly under the

K 064

sprinkler deflector.

NFPA 101 LIFE SAFETY CODE STANDARD

K 064

PRINTED: 01/02/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X8) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING Of - MAIN BUILDING OF B. WING 056345 12/30/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 368 JUANA AVENUE SAN LEANDRO HEALTHCARE CENTER SAN LEANDRO, CA 94577 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION (X4) ID PREFIX PAEFIX DATE REQULATORY OF LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY K 064 064 K 064 Continued From page 9 \$\$*D 1. Specific Action and/or measures to Portable fire extinguishers are provided in all correct the deficiency health care occupancies in accordance with 19.3.5.6, NFPA 10 9.7.4.1. The portable fire extinguisher that was undercharged has now been replaced with a new one. The k-fire extinguisher is now less than 60 inches above the floor. 2. Who will be directly responsible for This STANDARD is not met as evidenced by: the corrective action Based on observation and interview, the facility failed to maintain their fire extinguisher's, as Maintenance supervisor or his designee evidenced by one portable fire extinguisher that was undercharged, and by a K-fire extinguisher 3. What measures will be put in place that was mounted higher than 60 inches above or systematic changes the facility will the floor. This deficient practice could result in make to ensure that the deficient the fire extinguisher's inability to extinguish a fire. practice does not recur and in a delay in access to the fire extinguisher in the event of a fire. This affected 2 of 4 smoke The maintenance supervisor will conduct compartments. monthly rounds to ensure AV fire extinguishers are properly charged and in NFPA 101, 2000 Edition the proper position. 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of 4. How the facility plans to monitor its another section of this Code, portable fire performance to make sure solutions extinguishers shall be installed, inspected, and are sustained maintained in accordance with NFPA 10. Standard for Portable Fire Extinguishers. The maintenance supervisor will give his inspection report to the QA team NFPA 10, 1998 Edition on a monthly basis. The QA team will 1-6.2 Portable fire extinguishers shall be decide if any actions should be taken. maintained in a fully charged and operable condition, and kept in their designated places at all time when they are not being use.

1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more

than 5 ft (1.53 m) above the floor. Fire

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CENTERS FOR MEDICARE & MEDICAID SERVICES							M APPROVE O. 0938- 039	
STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346				CONSTRUCTION - MAIN BUILDING 01	(K2) D	O. 0636-035 ATE SURVEY OMPLETED	
			B, WING		<u> </u>	1.	7/20/0040	
	NAME OF PROVIDER OR SUPPLIER SAN LEANDRO HEALTHCARE CENTER			368	LEET ADDRESS, CITY, STATE, ZIP CODE JUANA AVENUE N LEANDRO, CA 94577		12/30/2013	
(X4) ID Prefix Tag	X (GACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PAEFII TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDAE	COMPLETION DATE	
	40 lb (18.14 kg) (ex so installed that the not more than 3 ½ 1 no case shall the clip of the fire extinguist 4 in. (10.2 cm). 4-3.1 Frequency. Finspected when inition thereafter at approximation extinguishers shall intervals when circularly extinguishers shall infollowing items: (a) Location in design (b) No obstruction to (c) Operating instruction of facing outward (d) *Safety seals and oroken or missing (e) Fullness determing (e) Fullness determing (f) Examination for observable range or ponozzle (g) Pressure gauge reperable range or ponozzle checked (for v) HMIS label in place indings:	g a gross weight greater than cept wheeled types) shall be top of the fire extinguisher is it (1.07 m) above the floor. In earance between the bottom her and the floor be less than her and the floor be less than her extinguishers shall be ally placed in service and imately 30-day intervals. Fire the inspected at more frequent metances require. Periodic inspection of fire include a check of a least the include a check of a least the intervals or visibility tions on nameplate legible. I tamper indicators not intervals physical damage, or clogged eading or indicator in the sition wheels, carriage, hose, and wheeled units)	ко	64				
- OI	uring the facility tour 1 12/30/13, the fire e pserved.	with the Maintenance Staff extinguishers were						

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•		AND HUMAN SERVICES & MEDICAID SERVICES				FORI	D: 01/02/20 M APPROVI	ΕD
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
L		056345	a. WING	·		1 12	2/30/2013	
NAME OF PROVIDER OR SUPPLIER SAN LEANDRO HEALTHCARE CENTER				368	REET ADDRESS, CITY, STATE, ZIP CODE JUANA AVENUE N LEANDRO, CA 94577	1 52	<u> 230/2013</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BG IDENTIFYING INFORMATION)	IĎ PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRICIENCY)	DRF	(X5) COMPLETIO DATE	N
K 064	At 3:29 p.m., the extinguisher located undercharged. The zone marked rechar indicated the last ins The Maintenance St extinguisher was une pointed to the red zone.		K	264	· -	-	-	
	the Kitchen was mou	inted approximately 67 to the operable handle.	,				1	