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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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: 9/1/1972 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 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JAN 21 2014 L & C DIVISION SAN JOSE	1/24/14
K 018 SS=E	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	K 018		

ABORATORY DIRE [redacted]

[redacted]

ny deficiency state[redacted] stitution may be excused from correcting providing it is determined that
ther safeguards pr[redacted] pt for nursing homes, the findings stated above are disclosable 90 days
llowing the date o[redacted] g homes, the above findings and plans of correction are disclosable 14
ays following the d[redacted] cies are cited, an approved plan of correction is requisite to continued
rogram participatic[redacted]

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their doors as evidenced by self-closing doors that failed to latch, and by doors that were obstructed from closing. This deficient practice could result in the spread of smoke and fire in the event of a fire. This affected 3 of 4 smoke compartments. Findings: During the facility tour with the Maintenance Staff on 12/30/13, the doors were observed. 1. At 3:16 p.m., the door to Room 8 located on the first floor was obstructed by a cart. 2. At 3:19 p.m., the self-closing door to the Social Services office located on the first floor failed to latch when the door was held open to the fullest extent and released. Three attempts were made. 3. At 3:38 p.m., the self-closing door to the Weigh room located on the first floor failed to	K 018	K018 **1. Specific Action and/or measures to correct the deficiency** a. The cart was removed and now nothing is obstructing room 8. b. The self closing door to the social services office now latches properly c. The self closing door to the weighing room now latches properly d. The door to the rest room in the basement now latches properly e. The self closing door to the stairway in the basement now closes properly f. The self closing door to the medical records office is now latched **2. Who will be directly responsible for the corrective action** Maintenance supervisor or his designee **3. What measures will be put in place or systematic changes the facility will make to ensure that the deficient practice does not recur** The maintenance supervisor or designee will do monthly inspection to ensure all self closing doors properly latch **4. How the facility plans to monitor its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	1/20/14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 latch when the door was held open to the fullest extent and released. Three attempts were made. 4. At 3:46 p.m., the door to the Restroom located in the Basement failed to latch. Three attempts were made. 5. At 3:55 p.m., the self-closing door to the Stairway in the Basement failed to latch when the door was held open to the fullest extent and released. 6. At 3:59 p.m., the self-closing door to Medical Records office located on the second floor failed to latch when the door was held open to the fullest extent and released.	K 018		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021		

PRINTED: 01/02/2014
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
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 021	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their doors on magnetic hold-open devices. This was evidenced by doors that failed to automatically release from the magnetic hold-open devices and close during fire alarm testing. This deficient practice could result in the spread of smoke and fire in the event of a fire. This affected 2 of 4 smoke compartments. Findings: During the facility tour with the Maintenance Staff on 12/30/13, the doors on magnetic hold-open devices were observed during fire alarm testing. 1. At 1:11 p.m., the double doors to the Patio Dining room located on the first floor were held open with a magnetic hold-open device, but failed to release during fire alarm testing. The doors were tested twice with the smoke detector, twice with the manual pull station, and once with the Inspector's Test Valve. The annual fire alarm inspection on 1/7/13, indicated the doors were checked, and passed inspection. 2. At 1:12 p.m., the door to the Rehabilitation Department located on the first floor was held open with a magnetic hold-open device, but failed to release during fire alarm testing. The door was tested twice with the smoke detector, twice with the manual pull station, and once with the Inspector's Test Valve. The annual fire alarm inspection on 1/7/13, indicated the door was checked and passed inspection.	K 021	K021 1. . **Specific Action and/or measures to correct the deficiency** The patio dining room doors and the rehab room doors now properly release from the magnetic hold-open device and now close during fire alarm testing 2. **Who will be directly responsible for the corrective action** Maintenance supervisor or his designee 3. **What measures will be put in place or systematic changes the facility will 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 monitor its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	1/20/14
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 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 their door openings in smoke barriers, as evidenced by 1 of 1 smoke barrier doors that failed to positively latch. This deficient practice could result in the spread of smoke and fire into other smoke compartments in the event of a fire. This affected 2 of 4 smoke compartments. Findings: During fire alarm testing with the Maintenance Staff on 12/30/13, the smoke barrier doors were observed. At 1:10 p.m., 1 of 1 smoke barrier door located on the first floor was held open with a magnetic hold-open device. The smoke barrier door released from the magnetic hold-open device during fire alarm testing, but failed to positively latch. The smoke barrier door was tested twice with the smoke detector, twice with the manual pull station, and once with the Inspector's Test Valve.	K 027	K027 **1. Specific Action and/or measures to correct the deficiency** The smoke barrier door located on the first floor now positively latches **2. Who will be directly responsible for the corrective action** Maintenance supervisor or his designee **3. What measures will be put in place or systematic changes the facility will 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 its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	1/20/14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 029 K 029 SS=D	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their hazardous areas, as evidenced by one door to a hazardous area that failed to latch, and by one door to a hazardous area that was obstructed. This deficient practice could result in the spread of smoke and fire in the event of a fire. This affected 1 of 4 smoke compartments. Findings: During the facility tour with the Maintenance Staff on 12/30/13, the hazardous areas were observed. 1. At 3:48 p.m., the door to the Pantry in the Kitchen failed to latch when pulled closed. The room was over fifty square feet in size. 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.	K 029 K 029	K029 1. **Specific Action and/or measures to correct the deficiency** The door to the hazardous areas now latches and also nothing obstructs the door 2. **Who will be directly responsible for the corrective action** Maintenance supervisor or his designee 3. **What measures will be put in place or systematic changes the facility will make to ensure that the deficient practice does not recur** The maintenance supervisor or his designee will conduct monthly rounds to ensure the door to the hazardous area latches and nothing is obstructing it. 4. **How the facility plans to monitor its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	1/20/14

PRINTED: 01/02/2014
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
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	388 JUANA AVENUE SAN LEANDRO, CA 94577

(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 046 K 046 SS=E	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency lighting, as evidenced by the lack of documentation regarding the monthly and annual testing and maintenance of the emergency lighting. This deficient practice could result in the failure to provide backup lighting in the event of a power failure, and a delay in evacuation. This affected 4 of 4 smoke compartments. NFPA 101, 2000 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046 K 046	K046 **1. Specific Action and/or measures to correct the deficiency** The facility performed a functional test on every required emergency lighting system in the facility. We will also conduct this test every 30 days for not less than 30 seconds. **2. Who will be directly responsible for the corrective action** Maintenance supervisor or his designee **3. What measures will be put in place or systematic changes the facility will make to ensure that the deficient practice does not recur** The maintenance supervisor or designee will conduct this test on a monthly basis and address any issues. This test will be documented and filed. **4. How the facility plans to monitor its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	1/20/14

PRINTED. 01/02/2014
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
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 046	Continued From page 7 Findings: During the facility tour with the Maintenance Staff on 12/30/13, the documentation for the testing and maintenance of the emergency lighting equipment was requested 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. The Maintenance Staff stated the form had been given to a staff member, but there were no records to indicate that the testing was conducted. The emergency lighting worked properly when tested by the Maintenance Staff.	K 046		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic sprinkler system, as evidenced by one sprinkler that did not have 18 inches of clearance. This deficient practice could result in an obstruction to the sprinkler's spray patterns in the event of a fire. This affected 1 of 4 smoke compartments.	K 062		

PRINTED: 01/02/2014
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
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 062	Continued From page 8 NFPA 101, 2000 Edition 19.7.6 Maintenance and Testing. 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 13, 1999 Edition 5-5.6* Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 inch (457 mm) or greater. NFPA 25, 1998 Edition 2-2.1.2 Unacceptable obstructions to spray patterns shall be corrected. Findings: During the facility tour with the Maintenance Staff on 12/30/13, the automatic sprinkler system was observed. At 4:05 p.m., the sprinkler clearance was 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 sprinkler deflector.	K 062	K062 **1. Specific Action and/or measures to correct the deficiency** The card board boxes on the top shelf were removed and now nothing is under the sprinkler. It now meets the 18 inch compliance. **2. Who will be directly responsible for the corrective action** Maintenance supervisor or his designee **3. What measures will be put in place or systematic changes the facility will make to ensure that the deficient practice does not recur** The maintenance supervisor will conduct rounds to ensure that there are no items within 18 inches of the sprinklers. These rounds will be documented. **4. How the facility plans to monitor its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	1/20/14
K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064		

PRINTED: 01/02/2014
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
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 SS=D	Continued From page 9 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire extinguisher's, as evidenced by one portable fire extinguisher that was undercharged, and by a K-fire extinguisher that was mounted higher than 60 inches above the floor. This deficient practice could result in the fire extinguisher's inability to extinguish a fire, and in a delay in access to the fire extinguisher in the event of a fire. This affected 2 of 4 smoke compartments. NFPA 101, 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, 1998 Edition 1-6.2 Portable fire extinguishers shall be 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	K 064	K064 **1. Specific Action and/or measures to correct the deficiency** 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 the corrective action** Maintenance supervisor or his designee **3. What measures will be put in place or systematic changes the facility will make to ensure that the deficient practice does not recur** The maintenance supervisor will conduct monthly rounds to ensure AV fire extinguishers are properly charged and in the proper position. **4. How the facility plans to monitor its performance to make sure solutions are sustained** The maintenance supervisor will give his inspection report to the QA team on a monthly basis. The QA team will decide if any actions should be taken.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 10 extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 ½ ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). 4-3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of a 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 Findings: During the facility tour with the Maintenance Staff on 12/30/13, the fire extinguishers were observed.	K 064		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056346	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 11 1. At 3:29 p.m., the portable ABC fire extinguisher located near Nurse's Station 2 was undercharged. The needle pointed to the red zone marked recharge. The certification tag indicated the last inspection was on 12/3/13. The Maintenance Staff confirmed the fire extinguisher was undercharged, and the needle pointed to the red zone marked recharge. 2. At 3:50 p.m., the K-fire extinguisher located the Kitchen was mounted approximately 67 inches from the floor to the operable handle.	K 064		