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
	055292	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIELDS RICHMOND NURSING CTR	1919 CUTTING BLVD RICHMOND, CA 94804

(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: 1965 K7 Survey Under: 2000 Existing K12 Structure Type: One Story, Type V, 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. The facility is not in compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Representing the Department of Public Health: 29753, HFE-I Census: 73	K 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH NOV 30 2011 L & C DIVISION SAN JOSE **K018** It is the facility's policy to maintain the corridor doors within regulations. **Findings:** 1. The server room door has been replaced with a fire rated solid core door by the Maint. Director 2. The Wheelchair has been removed 3. The door jam has been repaired on the CS door by the Maint. Dir. and latches properly	11-28-11
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 19.3.6.3.6 are permitted. 19.3.6.3	K 018		

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 11-30-11

A[redacted]on 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.

[redacted]

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K 018	Continued From page 1 Rolier 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, as evidenced by a door that had two areas of ventilation to the corridor, and by doors whose closure was obstructed or that failed to latch. This could result in the passage of smoke and flames in the event of a fire, and affected one of three smoke compartments. Findings: During a tour of the facility with the Maintenance Director on 10/28/11, the corridor doors were observed. 1. At 11:40 a.m., the door to the Server Room had two vented areas (one at the top of the door and one at the bottom) that were covered with a heavy fabric-like material taped to the vents. The tape did not secure the materia to the door. The top vent measured 26 inches by 16 inches; the bottom vent measured 16 inches by 8 inches. 2. At 2:35 p.m., a wheelchair obstructed closure of the door to Room 15.	K 018	**Systemic Changes:** A. All staff will be re-in-serviced by the Maint. Dir and the DSD on "Proper Fire Prevention". B. All corridor doors will be checked monthly by the Maint Dir/ Maint. Department for preventive reviews. Any deficiencies noted will be corrected promptly. **Monitor for Compliance:** The DSD and Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm., Maint. Dir. And DSD are responsible for compliance of this regulation ongoing.	

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K 018	Continued From page 2 3. At 2:53 p.m., the self-closing door to the Central Supply Room at Nurses Station 1 failed to latch when tested. The door was held open to its fullest extent, but closure was obstructed by the door jamb.	K 018	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH DEC 1 2011 L & C DIVISION SAN JOSE	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain its fire alarm system, as evidenced by an obstructed pull station. This could result in delayed activation of the fire alarm system, and affected one of three smoke compartments. Findings: During a tour of the facility with the Maintenance Director on 10/28/11, the pull stations were observed. At 2:44 p.m., an artificial plant approximately six feet in height obstructed clear access to the pull	K 052	**K 052** It is the facility's policy to maintain its fire alarm system. **Findings:** 1. The artificial plant has been removed by the Maint Dir. **Systemic Changes:** A. All staff will be re-in-serviced by the Maint. Dir and the DSD on "Proper Fire Prevention". B. All corridor doors will be checked monthly by the Maint Dir/ Maint. Department for preventive reviews. Any deficiencies noted will be corrected promptly. **Monitor for Compliance:** The DSD and Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm., Maint. Dir. And DSD are responsible for compliance of this regulation ongoing.	11/28/11

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K 052	Continued From page 3 station by Room 10.	K 052		
K 054 SS=D	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 observation, the facility failed to maintain its smoke detectors, as evidenced by two smoke detectors that were not flush with the ceiling. This could result in the smoke detectors malfunctioning in the event of a fire, and affected one of three smoke compartments. Findings: During a tour of the facility with the Maintenance Director on 10/28/11, the smoke detectors were observed. At 11:40 a.m., Smoke Detector 27 and Smoke Detector 29 were not flush with the ceiling, both hanging approximately 1/2 inch below the ceiling tile.	K 054	**K 054** It is the facility's policy to maintain its smoke detectors per regulations. **Findings:** A professional company has been hired to appropriately repair Smoke Detectors 27 & 29. **Systemic Changes:** The Maint. Dir will make Preventative Maintenance Rounds monthly to observe for and repair any deficiencies noted in this regulation. **Monitor for Compliance:** The Maint. Dir will present a documented QA Preventative Safety review at least quarterly. The QA committee will monitor for compliance in this regulation ongoing. The Adm and Maint Dir are responsible to ensure compliance.	11-28-11
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	K 062	**K 062** It is the facility's policy to maintain its sprinkler system according to regulations.	11-28-11

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K 062	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain its sprinkler system, as evidenced by items stored less than 18 inches from a sprinkler's deflector, by the presence of paint on the deflectors of two sprinklers in the rooms of two residents, and by a missing sprinkler escutcheon plate. Paint on a sprinkler's deflector could result in the disturbance of the sprinklers' water spray pattern, and a missing escutcheon plate could result in the sprinkler to malfunction in the event of a fire. This affected one of three smoke compartments. Findings: During a tour of the facility with the Maintenance Director on 10/28/11, the sprinklers were observed. 1. At 11:49 a.m. in Supply Closet 3 there were four empty 14-inch by 10-inch boxes stored in a manner which proviced no clearance beneath the sprinkler's deflector. 2. At 2:03 p.m., there was paint on the sprinkler's deflector in Room 1. 3. At 2:07 p.m., there was paint on the sprinkler's deflector in Room 20. 4. At 2:36 p.m., there was a missing sprinkler escutcheon plate above Bed 14 B.	K 062	1. All boxes were removed by the Maint. Director. 2 & 3-All paint has been removed by the Maint. Director 4. The escutcheon plate was repaired by the fire alarm company. **Systemic Changes:** The Maint. Dir will make Preventative Maintenance Rounds monthly to observe for and repair any deficiencies noted in this regulation. **Monitor for Compliance:** The Maint. Dir will present a documented QA Preventative Safety review at least quarterly. The QA committee will monitor for compliance in this regulation ongoing. The Adm and Maint Dir are responsible to ensure compliance.	
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	K 064 It is the facility's policy to maintain its fire extinguishers according to regulations.	11/28/11

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K 064	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its fire extinguishers, as evidenced by a fire extinguisher that was mounted higher than the required height. This could result in staff not being able to properly access the fire extinguisher in the event of a fire, and affected one of three smoke compartments. NFPA 10, 1-6.10, 1998 Edition 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 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). Findings: During a tour of the facility with the Maintenance Director on 10/28/11, the fire extinguishers were observed. At 2:21 p.m., the ABC-type fire extinguisher in the kitchen was mounted at 66 inches.	K 064	**Findings:** 1. The fire extinguisher in dietary has been set to the proper height with the handle at 55 inches by the Maint. Director **Systemic Changes:** All fire extinguishers will be inspected monthly with the fire alarm testing and the Preventive Maintenance Rounds. **Monitor for compliance:** The Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm. and Maint. Dir. is responsible for compliance of this regulation ongoing.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 066	**K 066** It is the facility's policy to enforce its smoking policy.	11-28-11

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K 066	Continued From page 6 Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to enforce its smoking policy, as evidenced by the presence of trash in the noncombustible safety-type ashtray and cigarette butts on the ground. This could result in a fire, and affected three of three smoke compartments. Findings: During a tour of the facility with the Maintenance	K 066	**Findings:** 1. A ½ inch mesh wire has been installed over opening in ash tray to prevent objects other than cigarettes to be placed in ash tray by the Maint Director. **Systemic Changes:** The Maint Staff will continue to empty all ashtrays daily, with a focus on keeping all combustible materials out of the ashtrays. The Maint Director will monitor for compliance daily with the Preventable Maintenance Rounds. **Monitor for compliance:** The Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm. and Maint. Dir. is responsible for compliance of this regulation ongoing.	

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K 066	Continued From page 7 Director on 10/28/11, the smoking policy was reviewed and the designated smoking area was observed. At 3:00 p.m., there was a juice box, napkins, wrappers, and other trash in the noncombustible safety-type ashtray in the designated smoking area. There were also greater than 10 cigarette butts on the ground surrounding the ashtray.	K 066		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to continuously maintain a means of egress free of all obstructions or impediments, as evidenced by a cart that remained in the corridor at the same location for more than 30 minutes.. This could result in delayed evacuation in the event of a fire, and affected 73 of 73 residents. Findings: During a tour of the facility with the Maintenance Director on 10/28/11, the corridors and egress paths were observed. 1. At 9:15 a.m. during the cursory tour of the facility, there were five Geri Chairs in the corridor	K 072	**K 072** It is the facility's policy to continuously maintain a means of egress free of all obstructions or impediments according to regulations. **Findings:** 1. Facility is evaluating a place for safe storage of chairs when they are not in use and will remove chairs as appropriate. 2. The snack cart has been removed by the Dietary Service Assistant **Systemic Changes:** A. All staff will be re-in-serviced by the Maint. Dir and the DSD on "Proper Fire Prevention". B. All corridors will be checked daily by the Maint Dir/ Maint. Department for preventive reviews. Any deficiencies noted will be corrected promptly.	11-28-11

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K 072	Continued From page 8 outside the Back Dining Room. During the formal tour, the five Geri Chairs were in the same location in the corridor outside the Back Dining Room at 11:52 a.m. 2. At 9:10 a.m. during the cursory tour of the facility, a multi-tiered snack cart was situated in the corridor along the wall across from the kitchen. During the formal tour, the multi-tiered snack cart was in the same location in the corridor at 2:30 p.m.	K 072	**Monitor for Compliance:** The DSD and Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm., Maint. Dir. And DSD are responsible for compliance of this regulation ongoing.	
K 076 SS=D	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 provide proper storage for medical gas in accordance with NFPA 99, as evidenced by the storage of full oxygen cylinders with empty oxygen cylinders in the same rack. This could result in staff not accessing the proper cylinder in the event of an emergency, and affected 73 of 73 residents.	K 076	**K 076** It is the facility's policy to provide proper storage for medical gas in accordance with NFPA 99. **Findings:** 1. The empty oxygen cylinders have been stored separately from the full containers by the Maint. Dir. **Systemic Changes:** All lic staff will be in serviced on ensuring that empty and full containers are stored separately by the DON and DSD. New racks have been purchased to allow for separate storage by the SS Assistant.	11-28-11

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K 076	Continued From page 9 NFPA 99, 1999 Edition 4-5.5.2.2 Storage of Cylinders and Containers Level 3. (b) Nonflammable Gases. 1. Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 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: During a tour of the facility with the Maintenance Director on 10/28/11, the Oxygen Storage Room was observed. At 12:19 p.m., there were three empty oxygen cylinders stored with 11 full oxygen cylinders in the same rack.	K 076	**Monitor for Compliance:** The DSD, DON, SS Assistant and Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm., DON and SS Assistant are responsible for compliance of this regulation ongoing.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain its electrical wiring and equipment, as evidenced by an unauthorized use of surge protectors and unapproved adapters, by missing or broken electrical outlet receptacles and faceplates, and by items stored in front of the electrical panel. This deficient practice could	K 147	**K 147** It is the facility's policy to maintain its electrical wiring and equipment per regulations. **Findings:** 1. The surge protector has been removed and replaced by the Maint Director	11-28-11

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K 147	Continued From page 10 result in the increased risk of fire, and could result in authorized staff's inability to clearly access the electrical panel for inspection and maintenance. This affected three of three smoke compartments. Findings: During a tour of the facility with Maintenance Director on 10/28/11, the electrical wiring and equipment were observed. 1. At 11:10 a.m., a 16-inch by 14-inch safe rested atop the cord to the surge protector in the Business Office. Computer equipment and two chargers were plugged into the surge protector. 2. At 11:15 a.m., there was a missing faceplate on the right wall beneath the windows in the Rehab Room. 3. At 11:35 a.m., there was an unapproved six-plug adapter in use at Bed 8 B. 4. At 11:44 a.m., there were three non-computer items plugged into the surge protector at Bed 6 A. 5. At 12:05 p.m., there was an unapproved three-plug extension cord in use at Bed 24 C. 6. At 12:13 p.m., the refrigerator and an ice maker in the Staff Lounge were plugged into a surge protector that was suspended 48 inches above the floor. 7. At 12:16 p.m., a 42-inch fan was stored in front of the electrical panel in the Staff Lounge.	K 147	2. The face plate has been replaced by the Maint Director 3. The six plug adapter has been removed by Maint Dir 4. All medical equipment has been removed from surge protectors by the Maint Dir 5. Extension cord has been removed by the Maint Dir 6. The surge protector has been removed. 7. The fan has been removed by the Maint Dir 8. The surge protector and six plug adaptor has been removed by the Maint Dir 9. All medical equipment has been removed from surge protectors by the Maint Dir 10 & 11 The six plug adapters have been removed by the Maint Dir. 12. All medical equipment has been removed from surge protectors by the Maint Dir 13. The surge protector and six plug adaptor has been removed by the Maint Dir 14 & 15. The surge protector has been removed by the Maint Dir	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIELDS RICHMOND NURSING CTR	1919 CUTTING BLVD RICHMOND, CA 94804

(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 11 8. At 12:35 p.m., hospital equipment was plugged into a circular surge protector in Room 31. Hospital equipment was plugged into an unapproved six-plug adapter between Beds 31 B and 31 C. 9. At 12:44 p.m., three non-computer items were plugged into a surge protector at Bed 30 B. 10. At 1:58 p.m., there was an unapproved six-plug adapter between Beds 4 A and 4 B. 11. At 2:06 p.m., there was an unapproved six-plug adapter between Beds 20 A and 20 B. 12. At 2:10 p.m., three non-computer items were plugged into a surge protector to the front of Bed 18 B. 13. At 2:12 p.m., there was an unapproved six-plug adapter at Bed 16 D, and a surge protector under the television at Bed 16 D was mounted to the wall with three non-computer items plugged into it. 14. At 2:38 p.m., a fan and personal size refrigerator were plugged into a surge protector in the Maintenance Office. 15. At 2:40 p.m., a surge protector in the Director of Nurses Office with computer equipment was connected to a surge protector with a pluggec charger.	K 147	**Systemic Changes:** Maintenance department and facility staff has been re-in serviced by the Maint Director and DSD regarding proper use of surge protector. The facility is conferring with an electrician to determine how to increase the electrical supply to rooms as needed without surge protectors. Correction will be completed according to the appropriate guidelines by the electrician. **Monitor for Compliance:** The DSD and Maint Director will make rounds daily to observe for areas of non-compliance. Any deficiencies will be corrected promptly. The Adm., Maint. Dir. And DSD are responsible for compliance of this regulation ongoing.	