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

PRINTED: 04/07/2015
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
	555323	A. BUILDING 01 B. WING	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	944 REGAL ROAD ENCINITAS, CA 92024

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1988 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V(111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 29751 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census 109	K 000	**Preparation and/or execution of this Plan of Correction (POC) does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings, we submit the following POC which shall constitute the facility's credible allegation of compliance.**	
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	K 018	**K 018** The hole where the key mechanism was missing on Room 100 was replaced and is now sealed. The maintenance staff will make monthly rounds during fire alarm system check to ensure doors do not have penetrations.	4/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4/20/15

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.

accepted 5/8/15 per S. Yahung

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K 018	Continued From page 1 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, the facility failed to maintain corridor doors as evidenced by a door with missing components causing a hole in the door. This failure affected 1 of 4 smoke compartments and had the potential to harm residents and staff by allowing the spread of smoke in the event of fire. Findings: During a tour of the facility with Maintenance Staff 1 on 4/2/15, the corridor doors were observed. At 1:55 p.m., There was a one and one half inch hole in the door to Resident Room 100 were the missing plate cover for a locking mechanism was removed.	K 018	The Maintenance Director will report the outcomes of the rounds to the QA Committee Quarterly and the Administrator will oversee.	
K 027 SS=D	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	K 027		

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K 027	Continued From page 2 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 ensure that doors were capable to resist the passage of smoke and provided with a means suitable for keeping the door closed. This was evidenced by a door that failed to close and positive latch. This could result is spread of fire and smoke and potential injury to residents. NFPA 101, 2000 Edition. Life Safety Code. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device,	K 027	K 027 The clean linen closet door adjacent to the Arcadia Nursing Station has been replaced and now positively latches. The maintenance staff will make monthly rounds during fire alarm system check to ensure all closers latch properly. The Maintenance Director will report the outcomes of the rounds to the QA Committee Quarterly and the Administrator will oversee.	4/16/15

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K 027	Continued From page 3 the holdopen mechanism is released and the door becomes selfclosing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair. Findings: During a tour of the facility with Maintenance Staff 1 on 4/2/15, the doors with self closing devices were observed. At 2:30 p.m., the door to the clean linen closet adjacent to the Arcadia Nurses Station had a self closing device and failed to positive latch when tested.	K 027		
K 051 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	K051 The fire alarm system has been brought up to current code per architect and the OSHPD inspector is scheduled to review and sign off by 5/15/15. In the event of an unusual occurrence of the fire alarm system the facility will follow the fire watch policy and procedures until deemed working properly. The event will be presented to our QA Committee to address corrective actions. Administrator will monitor to ensure compliance and completion of project and submit approved documentation to Life Safety office and CMS once received.	5/15/15

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K 051	Continued From page 4	K 051		

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility to get a final approval for the installation of their fire alarm system to ensure compliance to all applicable codes. There was not final approval from OSHPD. This affected 4 of 4 smoke compartments and could result in malfunction of the fire alarm system.

NFPA 101 Life Safety Code, 2000 Edition.
9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.

NFPA 72 National Electrical Code, 1999 Edition.
7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer ' s recommendations, and shall verify correct operation of the fire alarm system.

Findings:

During a tour of the facility with Maintenance Staff 1 on 4/2/15, the records for the fire alarm system project were requested.

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K 051	Continued From page 5 At 1:00 p.m., documents indicated a fire alarm system was installed 4/2008 by previous owner without OSHPD final approval. The facility Administrator provided copies of the request for waiver and fire alarm system project dated 3/25/15. The Administrator stated the project was completed 10/15/14 but with a change in the OSHPD Fire Life Safety Officer, there has been a delay in the final OSHPD approval.	K 051		
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 maintain the storage of their oxygen cylinders. This was evidenced by E cylinders stored without a rack or cart. This failure affected 1 of 4 smoke compartments and had the potential to fall over either injuring someone or damaging the tank and leaking oxygen into the atmosphere increase the combustibility of the patients room. NFPA 99 Health Care Facilities, 1999 Edition.	K 076	K 076 The oxygen room has been re-done and now has additional rack space available and each side is clearly labeled full and empty. The nurses, central supply and rehab team have all been in serviced on the requirement that all oxygen tanks must be in a stand or secured. Central Supply will check the oxygen room weekly and on deliveries to make sure all tanks are secured or in stands. She will report her findings to QA quarterly and Administrator will oversee.	4/16/15

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K 076	Continued From page 6 4-3.3.1.1. Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. Findings: During a tour of the facility with Maintenance Staff 1 on 4/2/15, the oxygen storage closet was observed. At 3:03 p.m., there were 2 of 27 oxygen E cylinders that were stored upright on the ground, , outside of a rack, crate or chain.	K 076		
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke barrier walls. This was evidenced by unsealed penetrations in the smoke barrier walls. This affected two of four smoke compartments, and could result in the spread of smoke and fire to other compartments in the event of a fire. NFPA 101 Life Safety Code, 2000 edition 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:	K 104	**K 104** The penetrations in the smoke barrier wall located between Resident Rooms 100 and 101 were sealed with "Fire Barrier Sealant CP 25WB+". The maintenance staff will make monthly rounds during fire alarm system check to ensure fire barriers and walls are sealed properly. The Maintenance Director will report the outcomes of the rounds to the QA Committee Quarterly and the Administrator will oversee.	4/14/15

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K 104	Continued From page 7 (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings: During a tour of the facility with Maintenance Staff 1 on 4/2/15, there were two penetrations in the smoke barrier in the 100 corridor. At 3:20 p.m., there were two, one and a half inch penetrations around conduits pulled through the smoke barrier wall located between Resident Rooms 100 and 101.	K 104		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147	Continued From page 8 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 their electrical equipment in accordance with NFPA 70. This was evidenced by the use of extension cords. This affected 1 of 4 smoke compartments and had the potential to increase the risk of electrical fire causing harm to residents and staff. NFPA 101 Life Safety Code, 2000 Edition. 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electric Code 1999 Edition. Section 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as	K 147	K 147 Maintenance Director removed the identified extension cord in Room 401 Bed B on 4/2/15. Maintenance Department then conducted a facility sweep on 4/3/15 to ensure no other extension cords were used in the facility. On 04/09/2015 the Maintenance Director, DSD, DON, and ADON initiated/conducted in-services for the maintenance, facility and nursing staff related to not using extension cords in the facility. Monthly sweeps for all rooms to monitor for extension cords and room round observations by department managers for monitoring for extension cords in resident rooms. Any extension cords identified will be removed and reported in our daily QA committee for action. The Director of Maintenance and/or Designee will monitor this process though monthly sweep during fire alarm system check and will report trends to the Quality Assurance Committee quarterly. Administrator will oversee.	4/24/15

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K 147	Continued From page 9 otherwise permitted in this Code. Findings: During a tour of the facility with Maintenance Staff 1 on 4/2/15, the electrical equipment was observed. At 2:58 p.m., there was an extension cord used in Resident Room 401 Bed B.	K 147		
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, 418.100, 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 install a Alcohol Based Hand Rub dispenser (ABHR) in a location away from an ignition source. This was evidenced by an ABHR's installed adjacent to a	K 211	K 211 The Alcohol Based Hand Rub Dispensers (ABHR) in 204,501 and 506 were all moved at least 12 inches from the light switches (ignition source) on 4/3/15. A facility sweep was conducted on 4/3/15 to ensure no other ABHR were adjacent to or over ignition sources. The Maintenance Director will make monthly rounds during fire alarm systems check to make sure no ABHR are adjacent or above an ignition source. The Maintenance Director will report the outcomes of the rounds to the QA Committee Quarterly and the Administrator will oversee.	4/16/15

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K 211	Continued From page 10 light switches. This failure affected 2 of 4 smoke compartments and had the potential to increase the risk of an electrical shock. Findings: During a tour of the facility with Maintenance Staff 1 on 4/2/15, the ABHR's were observed. 1. At 2:15 p.m., there was an ABHR in Resident Room 204 that was mounted on the wall adjacent to a light switch. 2. At 2:16 p.m., there was an ABHR in Resident Room 204 that was mounted on the wall adjacent to a light switch. 3. At 2:43 p.m., there was an ABHR in Resident Room 601 that was mounted on the wall adjacent to a light switch. 4. At 2:48 p.m., there was an ABHR in Resident Room 506 that was mounted on the wall adjacent to a light switch.	K 211		