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

PRINTED: 11/09/2012
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
	555771	A. BUILDING 1a B. WING	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD GARDENS SNF	350 CALLOWAY DRIVE, BUILDING C BAKERSFIELD, CA 93312

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 4/10/01 K7 SURVEY UNDER: 2000 Existing STRUCTURE TYPE: TYPE (V) (111) FULLY SPRINKLERED The following represents the findings of the California Department of Public Health, during a 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 Department of Public Health, Life Safety Code Unit: 29752 Census: 111	K 000	California Health and Safety Code, Section 1280 requires a plan of Correction for all deficiencies. The following is a Plan of Correction for Glenwood Gardens Skilled Care Center for Statement of Deficiencies dated October 29, 2012. This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted.	
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	**K018** **A. The pneumatic closure device for the dining room door (1) leading to the corridor was adjusted by the Maintenance Supervisor on 10/30/12 to allow the door to close flush with the door frame so that no gaps are present. A stronger closure device has been ordered & will be installed by the Maintenance Supervisor on the kitchen door leading to the corridor. The kitchen door will be pinned to ensure that it also will be flush with the door frame.** **B. The facility maintenance supervisor will conduct weekly tests of the fire alarm system x 4 weeks then monthly x 2 months per company preventative maintenance schedules to verify that the identified doors close properly.** **C. The Administrator will verify weekly then monthly checks of the doors are being completed by the Maintenance Supervisor. Report of findings will be forwarded to the QAPI committee x 3 months for ongoing compliance monitoring.**	11/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William Harlow — TITLE: Administrator — (X6) DATE: 11/19/12

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.

11/26/12 POC Acceptable per Zeina Nasr, HFEI

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K 018	Continued From page 1 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 corridor doors. This was evidenced by corridor doors that failed to self close completely and latch, during fire alarm testing. This could result in the spread of fire and smoke, in the event of a fire. This affected one of nine smoke compartments. Findings: During fire alarm testing with Staff 1, Staff 2 and Staff 3, on 10/30/12, the corridor doors were observed. At 3:05 p.m., the kitchen corridor door failed to close completely and latch when released from the open position. The door remained open approximately three inches. At 3:10 p.m., dining room door 1 failed to close completely and latch when released from the open position. The door remained open approximately three inches. During an interview, Staff 2 explained that the corridor doors were being held open by a	K 018		

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K 018	Continued From page 2 "difference in air pressure" when the kitchen exhaust ventilation shutdown during fire alarm testing. He explained that the kitchen air pressure held the doors open.	K 018		
K 029 SS=D	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 hazardous areas. This was evidenced by a kitchen dry goods storage room with no automatic or self closing door. This could result in the spread of smoke and fire, in a fire emergency, affecting one of nine smoke compartments. Findings: During the facility tour with staff on 10/31/12, the hazardous areas of the facility were observed. Combustible storage rooms are considered a hazardous area and should be equipped with a self closing door.	K 029	K029 A. A self-closing device was installed on the door of the dry storage room in the kitchen by the Maintenance Supervisor on 11/1/12. B. The Maintenance Supervisor will conduct weekly checks x 4 weeks then monthly x 2 months per company preventative maintenance schedules to verify that the identified door is functioning properly. C. The Administrator will verify weekly then monthly checks of the self-closing door are being completed & documented by the Maintenance Supervisor. Report of findings will be forwarded to the QAPI committee monthly x 3 months for ongoing compliance monitoring.	11/1/12

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K 029	Continued From page 3 At 9:04 a.m., the kitchen dry goods storage room was greater than 100 square feet and contained approximately 80 cardboard boxes of supplies, 8 plastic bins, and 15 cases of plastic cups, serving ware and napkins. The door was not equipped with a self closing device.	K 029		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility to ensure the emergency generator was inspected weekly and tested for 30 minutes under load each month. This was evidenced by no documentation of monthly test results during three of the last twelve months. This could result in incomplete testing and an equipment failure in the event of a power outage. This could potentially affect all residents in the facility. Findings: During record review with Staff 1, Staff 2 and Staff 3, on 10/30/12, the emergency generator testing documents were requested. At 10:55 a.m., the generator testing log "Glenwood Gardens Skilled Care Center, Emergency Generator - 14-Day test Log" was	K 144	K144 A. Generator tests & documentation of tests has been kept current since September. As stated in the survey findings, documentation for generator tests from 4/17/12 through 8/28/12 were not able to be located due to a former Maintenance Supervisor not placing the records in the generator log book. B. The current Maintenance Supervisor will conduct and record bi-weekly generator tests per company maintenance schedules. C. The Administrator will verify bi-weekly generator tests & documentation of the tests is being completed by the Maintenance Supervisor. Report of findings will be forwarded to the QAPI committee monthly x 3 months for ongoing compliance monitoring.	11/5/12

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K 144	Continued From page 4 reviewed. One of three pages was missing for the log. During record review and interview with Staff 2 on 10/31/12 the missing emergency generator testing documents were requested. At 8:30 a.m., there was no documentation for monthly load testing between 4/17/12 and 8/28/12. Three of the last 12 months of generator testing logs were not available. At 11:20 a.m., Staff 2 confirmed that there were missing generator testing records. He explained there had been a change in staffing during this time and some records were not available.	K 144	K147 A. 1. The laundry receptacles were moved away from the electrical panel on 10/30/12. 2. A surge protector with a longer cord was ordered and switched out on 11/9/12 in the Medical Records office. 3. The extension cord was removed and the uninterruptible power supply was plugged directly into a wall power outlet in the Business Office. 4. The desk top equipment in the Business Office that was plugged into a second surge protector was removed, and a single surge protector was plugged directly into a wall power outlet. 5. The microwave, toaster, and coffee maker that were plugged into a surge protector were unplugged from the surge protector and plugged directly into wall power outlets in the Business Office. 6. The microwave that was plugged into a surge protector in the Maintenance Office has been plugged directly into a wall power outlet. 7. The second surge protector in the doctor's work area was removed and a single surge protector was plugged directly into a wall outlet. 8. The cover for the outlet behind the soda machine was installed on 11/5/12. B. The facility Maintenance Supervisor will conduct preventative checks weekly x 4 weeks then monthly x 2 months per company preventative maintenance schedules to verify that electrical devices are properly connected to appropriate power sources. C. The Administrator will verify checks of electrical devices are being completed & documented weekly then monthly by the Maintenance Supervisor. Report of findings will be forwarded to the QAPI Committee monthly x 3 months for ongoing compliance monitoring.	Items 3-7 11/1/12
K 147 SS=E	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 electrical wiring and equipment. This was evidenced by obstructions in front of electrical panels, by the use of an extension cord, by surge protectors plugged into other surge protectors, by appliances that were not plugged directly into wall outlets, and by a missing electrical cover plate. This affected three of nine smoke compartments and could increase the risk of electrical fire. NFPA 70, National Electrical Code, 1999 Edition 110-32. Work Space About Equipment. Sufficient space shall be provided and maintained about electric equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the	K 147		

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K 147	Continued From page 5 minimum clear work space shall not be less than 6 1/2 feet (1.98 m) high (measured vertically from the floor or platform), or less than 3 ft. (914 mm) wide (measured parallel to the equipment). The depth shall be as required in Section 110-34(a). In all cases, the work space shall be adequate to permit at least a 90 degree opening of doors or hinged panels. 110-26 (a)Working Space (1) Depth of Working Space. The depth of the working space in the direction of access to live parts shall not be less than indicated in Table 110-26(a). Distances shall be measured from the live parts if such are exposed or from the enclosure front or opening if such are enclosed. Table 110-26(a). Working Spaces Minimum Clear Distance (ft) Nominal Voltage to Ground Condition 1, 2 and 3 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 Findings: During the facility tour with the Staff 1, Staff 2 and Staff 3, on 10/30/12 and 10/31/12, the electrical devices and wiring connections were observed. 10/30/12 - At 2:52 p.m., the access to Electrical Panel LA, in the laundry room, was obstructed by two blue	K 147		

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K 147	Continued From page 6 laundry receptacles that were located directly against the face of the electrical panel. The panel was behind the clothes dryers. 10/31/12 - At 9:30 a.m., desk top equipment in Medical Records, was plugged into a surge protector, which was plugged into a second surge protector, which was connected to a wall outlet. At 9:34 a.m., the Business Office had an uninterruptible power supply that was plugged into a black extension cord. The extension cord was attached to the wall and plugged into an electrical outlet above the copy machine. At 9:36 a.m., desk top equipment was plugged into a surge protector, which was plugged into a second surge protector, connected to the wall outlet in the Business Office. The desk was on the left side of the office. At 9:37 a.m., a micro-wave, a toaster, and a coffee maker were plugged into a surge protector which was plugged into a wall outlet in the Business Office. At 10:21 a.m., the Maintenance area had a micro-wave plugged into a surge protector, which was plugged into a second surge protector, and was then plugged into the wall outlet. At 10:29 a.m., the doctor's work area had desk top equipment plugged into a surge protector, which was plugged into a second surge protector, and was then plugged into the wall outlet. At 10:54 a.m., the Staff Lounge had a soda	K 147		

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K 147	Continued From page 7 machine plugged into an wall outlet that was missing an electrical cover plate.	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 ensure that alcohol based hand rub dispensers were not mounted directly above an ignition source. This was evidenced by a hand dispenser located directly above a light switch. This could result in the increased risk of a fire, affecting one of nine smoke compartments. Finding: During a tour of the facility with Staff 3, on 10/31/12, the alcohol based hand rub dispensers were observed.	K 211	K211 A. The alchol based hand rub dispenser that was near the light switch was removed immediately on 10/31/12. B. The facility Maintenance Supervisor will conduct preventative checks weekly x 4 weeks to verify that no ABHR dispensers are near electrical switches. C. The Administrator will verify checks of ABHR dispensers are being completed & documented weekly X 4 weeks by the Maintenance Supervisor. Report of findings will be forwarded to the QAPI Committee for ongoing compliance monitoring.	12/14/12

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K 211	Continued From page 8 At 10:03 a.m., there was an alcohol based hand rub dispenser located directly above three light switches in the Station 1 dining/activities room. The dispenser was near the door when entering the dining room.	K 211		