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

PRINTED: 04/03/2014
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
	056189	A. BUILDING 01 - MAIN BUILDING 01 B WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(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: 1969 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY WITH BASEMENT, CONSTRUCTION TYPE V(111), PARTIALLY 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: 29665 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 104	K 000	K000 This Plan of Correction constitutes our written credible allegation of compliance for the deficiencies noted. This plan of Correction is prepared and submitted as required by law. By submitting this POC, Bella Vista Transitional Care Center does not admit that the deficiency listed on the FORM CMS-2567 exist, nor does Bella Vista admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. Bella Vista reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts, and conclusions that form the basis for these deficiencies. This plan of correction acknowledges responsibility for compliance with licensing requirements.	4-22-14
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 Corrective actions taken for this deficiency: Immediately after findings on 03/26/2014 the maintenance supervisor adjusted the two doors to ensure that they would latch properly. K018 Measures that will be put into place to ensure that this deficiency does not recur: On 3/27/2014 maintenance supervisor checked all fire barrier doors throughout the facility to ensure proper closing and	4-22-14

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

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 pr[redacted]

FO[redacted]ion sheet Page 1 of 11

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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, the facility failed to maintain their doors. This was evidenced by two doors that failed to latch. This affected the basement and could result in the faster spread of smoke and fire. Findings: During a facility tour with the Maintenance Staff 1 from 3/26/14 to 3/27/14, the doors were observed. 1. At 4:05 p.m., on 3/26/14, the corridor self-closing door to the soiled linen room failed to latch. 2. At 4:07 p.m., on 3/26/14, the corridor self-closing door to the men's locker room failed to latch.	K 018	(continued from page 1) latching. During All-Staff meeting on 4-9-2014, all staff were told of this deficiency and instructed to report any findings to the maintenance supervisor through the logs at each of the three nursing stations. K018 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Staff will close all doors during quarterly fire and disaster drills to ensure all doors latch properly. For 90 days Guardian Angels will check patient doors during their weekly rounds, while housekeeping will check all other doors weekly during their rounds. Any contrary findings will be immediately reported to the maintenance supervisor and reviewed quarterly through the QA&A process. Maintenance supervisor will also do monthly checks for the next 90 days to ensure compliance. K018 Responsible Person(s): Maintenance and Housekeeping Supervisor and Administrator or designee.	
K 021 SS=D	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	K 021	K021 Corrective actions taken for this deficiency: Immediately upon findings on 03/27/2014 the metal welcome sign blocking the fire door was removed to allow for proper closing of the door.	4-22-14

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K 021	Continued From page 2 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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that smoke barrier doors were held open by devices that will allow them to automatically close during fire. This was evidenced by one smoke barrier door that was wedged open by a metal sign. This affected two of five smoke compartments and could result in the faster spread of smoke and fire between smoke compartments. Findings: During a facility tour with Maintenance Staff 1 from 3/26/14 to 3/27/14, the smoke barrier doors were observed. At 7:43 a.m., on 3/27/14, the smoke barrier door adjacent to Nurses Station one was wedged open by a metal welcome sign.	K 021	K021 Measures that will be put into place to ensure that this deficiency does not recur: All staff were instructed not to block any fire doors. During All-Staff meeting on 4-9-2014, all staff were told of this deficiency and instructed that blocking fire doors was a safety issue. All staff expressed understanding. K021 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: During general announcements each weekday for the next 30 days all staff will be reminded to keep fire doors clear of any obstructions. Maintenance supervisor will do daily rounds for the next 30 days to ensure compliance. Any blocked doors will be immediately unblocked, and responsible staff will be counseled. Any such findings will be reported through the QA&A process. K021 Responsible Person(s): Maintenance Supervisor, Director of Staff Development and Administrator or designee.	
K 022	NFPA 101 LIFE SAFETY CODE STANDARD	K 022		

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K 022 SS=E	Continued From page 3 Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were marked with readily visible signs. This was evidenced by two doors that were not marked with exit signs. This affected two of five smoke compartments and could result in a delay in evacuation, in the event of an emergency. Findings: During a facility tour with Staff 1 from 3/26/14 to 3/17/14, the exits were observed. 1. At 9:45 a.m., on 3/27/14, there was no exit sign marking the smoke barrier door from the side of Nurses Station one leading into the front lobby. 2. At 9:47 a.m., on 3/27/14, there was no exit sign marking the smoke barrier door from the side of Room 67 leading into the front lobby. During an interview at 9:48 a.m., Staff 1 confirmed that the doors leading to the lobby area	K 022	K022 Corrective actions taken for this deficiency: Immediately after findings on 03/27/2014, phosphorescence exits signs were installed in the two areas with missing signs. K022 Measures that will be put into place to ensure that this deficiency does not recur: Maintenance supervisor has inspected the entire building to ensure that all exits are clearly marked with properly lit exit signs. There are no other locations in the facility for this deficiency to arise. K022 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: All exits are properly marked and will remain as such to ensure continued effectiveness of the corrective action. All staff were in-serviced on this deficient finding and are aware of the need for properly designated exits. K022 Responsible Person(s): Maintenance Supervisor and Administrator or designee.	4-22-14

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K 022	Continued From page 4 were part of the emergency evacuation plan.	K 022		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit paths were readily accessible at all times. This was evidenced by one exit ramp that was obstructed and by one exit pathway that was obstructed. This affected the basement and three of five smoke compartments. This could result in a delay in evacuation, in the event of a fire or other emergency. Findings: During a facility tour with the Maintenance Staff 1 from 3/26/14 to 3/27/14, the exit pathways were observed. 1. At 3:35 p.m., on 3/26/14, the entire width of the exit ramp, outside the exit door next to the kitchen, was obstructed by a parked sports utility vehicle. During an interview at 3:36 p.m., Staff 1 stated that the vehicle was parked in a no parking zone and that the exit ramp is part of the emergency exit route for the residents utilizing the basement physical therapy room. 2. At 7:30 a.m., on 3/27/14, there was yellow	K 038	K038 Corrective actions taken for this deficiency: Upon findings on 03/26/2014 the staff who parked their vehicle such that it obstructed the exit pathway was instructed to move their vehicle. Compliance was immediate. Upon second finding on 03/27/2014, the maintenance supervisor removed the tape across the stairway exit in the front of the facility. K038 Measures that will be put into place to ensure that this deficiency does not recur: All staff were immediately instructed to never park or otherwise block exit pathways from the building The maintenance team was instructed not to use caution tape or otherwise obstruct any pathways leading from the building. Pylons at the back ramp were painted red, red blocking was painted at the bottom of ramp and "No Parking" printed on the ground. K038 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The maintenance team will do daily rounds (7 times per week) for the next 90 days to ensure that no exit pathways are blocked. Any findings to the contrary will be reported in QA&A, and counseling done for any non-compliant staff.	4-22-14

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K 038	Continued From page 5 caution tape around the gate of the exit stairs outside the lobby entrance door. That door is labeled as an exit from the lobby side. During an interview at 7:36 a.m., Staff 1 stated that the caution tape was put there by the facility because it was raining the day before on 3/26/14. He stated the facility usually tapes off those stairs to discourage people from using them during the rain. Staff 1 acknowledged that the stairs were part of the emergency exit path from the front lobby.	K 038	K038 Responsible Person(s): Maintenance Supervisor and Administrator or designee.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that all areas of the facility were sprinklered in accordance with NFPA 13, Installation of Sprinkler Systems, 1999 Edition. This was evidenced by a non-sprinklered canopy that was constructed of combustible materials. This affected one of five smoke compartments and all	K 056	K056 Corrective actions taken for this deficiency: Immediately after findings on 3-27-14, the maintenance supervisor and administrator began looking into options for the awning. Sprinklering the awning was not an option, therefore the awning was completely removed on 4-22-14. K056 Measures that will be put into place to ensure that this deficiency does not recur: The facility is entirely sprinklered and the deficient awning has been completely removed in order to ensure that this deficient practice does not recur. K056 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: No further awnings will be installed to the building. Any future construction will be submitted and reviewed by OSHPD to ensure proper compliance.	4-22-14

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K 056	Continued From page 6 residents and staff who use the front entrance. This could result in a delay in extinguishing a fire, in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 9.7.1.1 Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code. Exception No. 2: NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code. NFPA 13, Installation of Sprinkler Systems, 1999 Edition. 5-13.8 Exterior Roofs and Canopies 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m)	K 056	K056 Responsible Person(s): Maintenance Supervisor and Administrator or designee.	

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K 056	Continued From page 7 in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. CMS Issued S & C-09-04, Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement, dated October 3, 2008. This letter required all long term care facilities to be equipped with a supervised sprinkler system by August 13, 2013, installed in accordance with the 1999 Edition of the National Fire Protection Association's (NFPA) Standard for Installation of Sprinkler Systems (NFPA 13), and maintained in accordance with the 1998 Edition of the National Fire Protection Association's (NFPA) Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, (NFPA 25). On August 16, 2013, and revised most recently on 12/20/13, the Center for Medicare & Medicaid Services (CMS) released a memorandum, Ref: S&C-13-55-LSC, regarding the requirement for all nursing homes to be fully sprinklered by August 13, 2013. A copy of the memorandum was provided to Staff 1 on 3/27/14. Sections of the memorandum state: A. Background In this memorandum we describe the survey and enforcement process pursuant to the August 13, 2013 deadline for installation of automatic sprinkler systems in all nursing homes that participate in Medicare or Medicaid. On August 13, 2008 the Centers for Medicare & Medicaid Services (CMS) published a final rule requiring all long term care facilities to have automatic	K 056		

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K 056	Continued From page 8 sprinkler systems installed throughout the building (73 FR 47075) no later than August 13, 2013. CMS does not have authority to allow extensions of the August 13, 2013 deadline." D. Examples and Enforcement Implications 2. Fully Sprinklered Facilities with Major Problems If the judgment of the survey agency and the CMS RO (Regional Office) is that a building with what appears to be a complete sprinkler system has many and/or significant problems with the system, that building should be considered partially sprinklered and cited under K056 at S/S D, E, or F, depending on the extent of the potential for harm. No waiver of K056 would be available. For example, a facility may be missing multiple sprinkler heads in rooms that were subdivided, such that only some of the subdivided rooms now have sprinkler heads. Or, a facility may be missing sprinklers in outside overhangs or loading dock; or required sprinkler heads are missing in the attic area. These deficiencies will be cited at S/S D, E, or F at the appropriate LSC tag. If substantial compliance is not achieved by the end of the third and/or the sixth month of the enforcement cycle, appropriate statutory remedies will go into effect." E. Canopies and Overhangs At Section 5-13.8.1, NFPA 13 requires that sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width with an exception for those with noncombustible or limited combustible construction. NFPA 13, Installation of Sprinkler Systems, 1999 Edition does not permit the omission of sprinklers under exterior roofs or canopies where the construction uses fire retardant-treated wood (FRTW) or cloth. Furthermore, FRTW cannot be assumed to be equivalent to noncombustible or limited combustible material."	K 056		

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K 056	Continued From page 9 Findings: During a facility tour with Staff 1 from 3/26/14 to 3/27/14, the sprinkler system coverage was observed. At 7:45 a.m., on 3/27/14, there was a 26 foot long by 9 foot wide cloth canopy attached to the exterior wall of the building directly above the lobby entrance door. The canopy extended approximately 26 feet from the building wall to the side walk. The canopy was not sprinklered.	K 056		
K 147 SS=D	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 safety. This was evidenced by appliances that were plugged into a multi-plug wall adaptor. This affected one of five smoke compartments and could result in the increased risk of an electrical fire. 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 Electrical Code, 1999 Edition. 400-8 Uses Not Permitted	K 147	K147 Corrective actions taken for this deficiency: Immediately upon findings on 03/27/2014 the electrical adaptor was removed from the employee breakroom. Further, the microwave was removed from the breakroom to ensure appliances are plugged directly into the wall outlets. K147 Measures that will be put into place to ensure that this deficiency does not recur: All staff were in-serviced on this finding and instructed that multi-plug adaptors are not allowed breakrooms and that all appliances must always be plugged directly into wall outlets.	03/27/14

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BELLA VISTA TRANSITIONAL CARE CENTER	3033 AUGUSTA ST SAN LUIS OBISPO, CA 93401

(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 10 Unless specifically permitted in Section 400-7, flexible cords 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. Findings: During a facility tour with Staff 1 from 3/26/14 to 3/27/14, the electrical wiring was observed. At 8:47 a.m., on 3/27/14, there was a refrigerator, a microwave, and a coffee maker plugged into a six-plug adaptor in the employee breakroom.	K 147	K147 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: Maintenance Supervisors will observe during his daily rounds (5 times per week) for the next 90 days to ensure that breakrooms remain free of multi-plug adaptors and that all appliances are plugged directly into wall outlets. Housekeepers were also instructed to do likewise. Any findings to the contrary will be immediately corrected and reported through the QA&A process. K147 Responsible Person(s): Maintenance Supervisor and Administrator or designee.	