STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. BUILDING 01 B. WING	04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HLTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

(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: 1963 & 1/1/1987 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE VWOOD FRAME CONSTRUCTION, 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: 32973 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 124	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of the building construction. This was evidenced by unsealed wall and ceiling penetrations. This affected two of seven smoke compartments, and could result in the passage of smoke to other areas in the event of a fire.	K 012	**K012** **Temporary and Permanent Correction** **It is the policy of this facility to maintain the integrity of the building construction.** **Unsealed wall and ceiling penetrations were sealed by Maintenance Supervisor.** **05/22/2016** **To ensure that all current and future residents are not affected by this deficient practice, Maintenance Supervisor will inspect facility to identify and correct any other wall or ceiling penetrations that may exist.** **Administrator will monitor compliance through weekly surveillance of the facility environment weekly for one month. If good compliance is maintained, monitoring will be reduced to maintenance monthly surveillance of facility environment which is documented and reported to Quality Improvement Committee to ensure continued compliance.**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/01/2016

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.

KPOC accepted 5/24/16 per Robert Compston

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K 012	Continued From page 1 Findings: During a tour of the facility with staff on 4/13/16, the walls and ceilings were observed. 1. At 12:10 p.m., in Dining Room Three there was an approximately two by three inch penetration in the wall behind the corridor door where the door knob strikes the wall. 2. At 12:40 p.m., in the Station Three Electrical Room Closet there was an approximately two inch diameter penetration in the ceiling with wires traveling through.	K 012	**K018** **Temporary and Permanent Correction** **It is the policy of this facility to maintain corridor doors that latch as required.** **Door Frame in Wing Twenty of Utility Room was repaired so that door would latch securely.** **05/22/2016** **Door Frame in corridor door to 2-f Oxygen Storage Room was repaired so that door would latch securely.** **Door Frame to Room 46 was repaired so that door would latch securely.** **The cubicle curtain of Bed-A was adjusted so that corridor door to Room 44 would securely latch.** **To ensure that all current and future residents are not affected by this deficient practice, the Maintenance Supervisor will inspect all doors to ensure that they are latching securely and that any repairs or adjustments are made.**	
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 shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the corridor doors. This was evidenced	K 018		

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K 018	Continued From page 2 by four doors that were obstructed and failed to latch. This affected two of seven smoke compartments, and could result in the inability to contain a fire to a room. NFPA 101, 2000 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. Findings: During a tour of the facility with staff on 4/13/16, the doors were observed. 1. At 11:48 a.m., the corridor door to Wing Twenty Utility Room was observed. The door was equipped with a self-closing device. The door was obstructed from fully closing and latching by the door frame. 2. At 11:55 a.m., the corridor door to 2-F Oxygen Storage Room was observed. The door was equipped with a self-closing device. The door was obstructed from fully closing and latching by the door frame. 3. At 12:15 p.m., the corridor door to Room 46 was observed. The door was obstructed from fully closing and latching by the door frame. 4. At 12:16 p.m., the corridor door to Room 44 was observed. The door was obstructed from fully closing and latching by the cubicle curtain of Bed-A.	K 018	**Inservice will be provided by the Staff Development Coordinator to all Direct Care and Housekeeping staff that covers not positioning cubicle curtains in a manner that blocks doors from securely latching.** **Maintenance Supervisor will monitor doors weekly for one month to ensure that they are all closing securely, if good compliance is maintained, monitoring will be reduced to monthly environmental surveillance that is completed by maintenance and reported to the Quality Improvement Committee for continued compliance.**	05/22/2016
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and	K 025		

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K 025	Continued From page 3 constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of the smoke barrier walls. This was evidenced by two walls that were not protected by sealing a penetration with a fire rated material. This affected four of seven smoke compartments, and could potentially allow the spread of smoke and/or fire to other areas of the facility, exposing residents to a smoke and/or fire environment. NFPA 101, 2000 19.3.7.3: Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 8.3.6.1: Pipes, conduits, ducts, cables, wires, air ducts, pneumatic tube and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: 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 of 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	K 025	**K026** **Temporary and Permanent Correction** **It is the policy of this facility to provide smoke barriers that provide at least a one half hour fire resistance rating and constructed in accordance with 8.3.** **The smoke barrier wall in the attic above the cross corridor doors next to Room 22 was repaired by maintenance with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier** **The smoke barrier wall in the attic above the cross corridor doors next to the Maintenance Room was repaired by maintenance with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier.** CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM MAY 23 2016 LIFE SAFETY CODE UNIT SAN BERNARDINO	05/22/2016

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K 025	Continued From page 4 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: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is made for the specific purpose. Findings: During a tour of the facility with staff on 14/13/16, the smoke barrier walls were observed. 1. At 1:25 p.m., the smoke barrier wall in the attic above the cross corridor doors next to Room 22 was observed. There was an approximately one inch diameter penetration in the lower left area of the wall. 2. At 1:35 p.m., the smoke barrier wall in the attic above the cross corridor doors next to the Maintenance Room was observed. There was an approximately one inch diameter penetration inside a metal conduit with wires traveling through it, in the lower right area of the wall.	K 025	**To ensure that all current and future residents are not affected by this deficient practice, the Maintenance Supervisor will inspect smoke corridors to ensure that no other penetrations exists and that any identified penetrations are repaired with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier.** **Maintenance Supervisor will monitor smoke barriers after anyone accesses the attic to ensure that no penetrations exist. Maintenance will also inspect the attic quarterly to ensure that there are no penetrations in the smoke barriers, or that any penetrations identified are repaired with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier.**	05/22/2016
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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	K 029		

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K 029	Continued From page 5 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, and interview, the facility failed to maintain the hazardous areas. This was evidenced by three corridor doors to hazardous areas not being equipped with self-closing devices. This affected three of seven smoke compartments, and could result in a delay in containing smoke and/or fire to a hazardous area. NFPA 101, 2000 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having	K 029	**K029** **Temporary and Permanent Correction** **It is the policy of this facility to provide self-closing doors where required.** **Administration Office will be equipped with a self-closing door.** **The corridor door to the Main Linen Room will be equipped with a self-closing door.** **The corridor door to the Maintenance Supply-Repair Shop will be equipped with a self-closing door.** **To ensure that all current and future residents are not affected by this deficient practice, all storage rooms or offices required to have self-closing devices will be equipped as required by Maintenance Supervisor.** **Maintenance will inspect door closures during monthly surveillance to ensure that doors are functioning and are in good repair. Documentation of surveillance will be reported to Quality Improvement Committee for continued compliance.**	**05/22/2016**

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K 029	Continued From page 6 jurisdiction Findings: During a facility tour with staff on 4/13/16, the hazardous areas were observed. 1. At 11:40 a.m., the corridor door to the Administration Office was not equipped with a self-closing device. The room was greater than 50 square feet (approximately 300 square feet) and contained multiple card board boxes with paper files, and other combustible storage. The finding was confirmed in an interview at the time with Staff 2. 2. At 12:00 p.m., the corridor door to the Main Linen Room was not equipped with a self-closing device. The room was greater than 50 square feet (approximately 60 square feet) and contained multiple wooden shelving with various linen supplies and storage. The finding was confirmed in an interview at the time with Staff 2. 3. At 12:58 p.m., the corridor door to the Maintenance Supply-Repair Shop was not equipped with a self-closing device. The room was greater than 50 square feet (approximately 80 square feet) and contained multiple combustible supplies and storage. The finding was confirmed in an interview at the time with Staff 2.	K 029	**K052** **Temporary and Permanent Correction** **It is the policy of this facility to maintain a fire alarm system required for life safety that will be tested and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code.** **Alarm company was contacted by Assistant Administrator and testing for all smoke detectors was scheduled.** **Fire Alarm System Inspection was completed by testing company to include in the report that visual and functional test for control unit, lamps, supervision, battery condition, load voltage, and for station monitoring was completed. Report also provided locations and testing results (pass or fail) for notification, initiation supervisory, and interface devices, and functional test for 29 smoke detectors. Written report is on file at facility.** **To ensure that all current and future residents are not affected by this deficient practice, the Administrator will review all Inspection and Testing**	05/22/2016
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily	K 052		

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K 052	Continued From page 7 available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review, and interview, the facility failed to maintain the fire alarm system. This was evidenced by incomplete testing records for the annual fire alarm inspection report. This affected seven of seven smoke compartments and could result in a system malfunction or delay in notification in the event of a fire. NFPA 101, 2000 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 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, 1999 1-6.3 Records. A complete, unalterable record of the tests and operations of each system shall be kept until the next test and for 1 year thereafter. The record shall be available for examination and, if required, reported to the authority having jurisdiction. Archiving of records by any means shall be permitted if hard copies of the records can be provided promptly when requested. Exception: If off-premises monitoring is provided, records of all signals, tests, and operations recorded at the supervising station shall be	K 052	**records to ensure that all documentations meets requirements and that Testing is completed as required. Administrator will meet with Safety Committee monthly to ensure that documentation and tested is completed timely and accurately. Meetings will be documented and reported to the Quality Improvement Committee for continued compliance.**	**05/22/2016**

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K 052	Continued From page 8 maintained for not less than 1 year. 7-2.2 Fire alarm systems and other systems and equipment that are associated with fire alarm systems and accessory equipment shall be tested according to Table 7-2.2. Table 7-3.2 Testing Frequencies 15. Initiating Devices. h. All Smoke Detectors - Functional Annually 7-5.2.2 A permanent record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 7-5.2.2. (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(s) tested, for example, " Tests performed in accordance with Section _____. " (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturers (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative (15)Disposition of problems identified during test	K 052		

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K 052	Continued From page 9 (for example, owner notified, problem corrected/successfully retested, device abandoned in place) Findings: During document review and interview with staff on 4/13/16, the annual fire alarm inspection report was reviewed. At 9:50 a.m., the documentation titled "System Record of Inspection and Testing" dated 4/21/15, four of four pages was incomplete. The report indicated visual and functional test for control unit, lamps, supervision, battery condition, load voltage, and for station monitoring. The report did not provide locations and testing results (pass or fail) for notification, initiation, supervisory, and interface devices, and no functional test for 29 smoke detectors. In an interview at the time Staff 2 confirmed the alarm activity report did not indicate all devices were tested, and that he would notify the alarm company. No other report was submitted for review.	K 052	K054 **It is the policy of this facility to provide all required smoke detectors, including those activating door hold-open device, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.** **05/22/2016** **Alarm company was contacted by Assistant Administrator and testing for all smoke detectors was scheduled and completed.** **To ensure that all current and future residents are not affected by this deficient practice sensitivity tests will be completed on all smoke detectors to ensure they are in good working order.** **To ensure continued compliance sensitivity will be checked every alternate year are required for at least two required periods. If sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time may be extended to a maximum of 5 years. If time is extended nuisance logs will be maintained.**	
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 document review, and interview, the facility failed to maintain the smoke detectors. This was evidenced by the failure to provide and maintain a smoke detector caused nuisance alarm record for 29 of 29 smoke detectors. This affected seven of seven smoke compartments, and could result in delayed notification or false	K 054		

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K 054	Continued From page 10 alarm of a fire due to a malfunctioning smoke detector. NFPA 101, 2000 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 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, 1999 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the	K 054	**Administrator will review tests to ensure they are complete and accurate. Safety Committee meets monthly and will review scheduling of required testing to ensure that testing is maintained as required. Safety Committee documentation is maintained and reviewed by the Quality Improvement Committee for continued compliance.**	**05/22/2016**

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	056495	A. BUILDING 01 B. WING _____	04/13/2016

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K 054	Continued From page 11 purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. Findings: During document review, and interview with staff on 4/13/16, the smoke detector sensitivity report was requested. At 11:00 a.m., the facility provided two smoke detector sensitivity reports which were dated 3/6/14 and 6/11/12. Both reports reflected normal sensitivity ranges for 29 of 29 smoke detectors. Staff 2 indicated in an interview at the time that the facility had elected to extend the sensitivity testing to every 5 years after the last testing. No record for detector caused nuisance alarms and trends, or calibration (if required) was available for review at this time. This finding was also	K 054		

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K 054	Continued From page 12 confirmed in an interview at the time with Staff 2.	K 054	**K062** **Temporary and Permanent Correction**	
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 document review, and interview, the facility failed to maintain the integrity of the automatic fire sprinkler system. This was evidenced by deficiencies noted on the annual sprinkler report. This affected seven of seven smoke compartments, and could result in the ineffective operation of the automatic fire sprinkler system in the event of a fire. NFPA 101, 2000 19.7.6 Maintenance and Testing (see 4.6.12) 4.6.12 4.6.12 Maintenance and Testing. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision 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 25, 1998 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. 2-2.1.1*. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical	K 062	**It is the policy of this facility of maintain required automatic sprinkler systems that are continuously maintained in reliable operating condition and are inspected and tested periodically.** **To ensure that all current residents are not affected by this deficient practice, repairs from testing were completed, and documentation is maintained of work completed at facility.** **To ensure that all future residents are not affected by this deficient practice, all testing will be completed ant documented as required.P** **All corrections listed in the ":Annual Inspection Testing , and Maintenance" dated 03/08/2016, were corrected by the Alarm maintenance company**	**05/22/2016**

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K 062	Continued From page 13 damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Findings: During document review, and interview with staff on 4/13/16, the sprinkler inspection report was reviewed. At 11:10 a.m., the documentation titled, "Annual Inspection, Testing, and Maintenance," dated 3/8/16, was marked "Failed with six deficiencies." The deficiencies included 5 corroded or discolored sprinkler heads in shower rooms, and one sprinkler head with improper orientation. Staff 2 indicated in an interview at the time that the sprinkler heads were scheduled for repair on 4/18/16.	K 062	**K 062 continued** **Administrator will monitor all testing that is scheduled and repairs to be completed through monthly meeting of the Safety Committee which are conducted monthly. Documentation of meetings will be maintained and reported to the Quality Improvement Committee for continued compliance.**	**05/22/2016**
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the means of egress. This was evidenced by a stored items in the corridors. This affected two of seven smoke compartments, and could result in a delay in evacuating the facility in the event of an emergency.	K 072		

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K 072	Continued From page 14 NFPA 101, 2000 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. 7.1.2 Definitions. Means of Egress. See 3.3.121 3.3.121* Means of Egress. A continuous and unobstructed way of travel from any point in a building or structure to a public way consisting of three separate and distinct parts: (1) the exit access, (2) the exit, and (3) the exit discharge. 3.3.121.1 Means of Egress, Accessible. A path of travel, usable by a person with a severe mobility impairment, that leads to a public way or an area of refuge. 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2 Furnishings and Decorations in Means of Egress. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. Findings: During a tour of the facility, and interview with staff on 4/13/16, the means of egress was observed. 1. At 12:20 p.m., the Nursing Station 2 corridor directly beyond the station was observed. Five	K 072	**K072** **Temporary and Permanent Correction** **It is the policy of this facility to maintain means of egress that shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.** **To ensure that all current and future residents are not affected by this deficient practice Administrator inspected corridors and ensured all impediments were removed.** **Chairs in Nursing Station 2 corridor directly beyond the station were removed.** **The floor fan was removed.** **Inservice will be provided by the Staff Development Coordinator to all staff on Fire Safety including keeping corridors clear for means of egress, without obstructions or impediments to provide full instant use in the case of fire or other emergency.**	05/22/2016

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K 072	Continued From page 15 chairs were stationed in the corridor. Staff 1 confirmed the finding in an interview at the time stating "the chairs are used for clients to sit in, and they have wheels on the back legs so that they can be moved if needed." 2. At 12:50 p.m., the corridor by Room 58 was observed. A floor standing fan was stationed along the side of the corridor. Staff 2 confirmed the finding in an interview at the time stating "that he thought that it was ok to have the fan there."	K 072	**Staff Developer will monitor corridors daily five days each week for one month. If good compliance is maintained, monitoring will be reduced to monthly safety committee surveillance reports which are documented and reported to the Quality Improvement Committee for continued compliance.**	05/22/2016
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the decorations. This was evidenced by combustible decoration in the corridor. This affected one of seven smoke compartments, and could lead to an increased spread of smoke and/or fire. NFPA 101 Life Safety Code, 2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. Findings: During a tour of the facility, and interview with staff on 4/13/16, the furnishings and decorations	K 073		

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K 073	Continued From page 16 were observed. At 1:00 p.m., the corridor side of the corridor door to the North Dining was covered top to bottom with paper decorations. Nothing indicated the decoration was inherently flame resistant and/or treated with a flame retardant. This was confirmed in an interview at the time with Staff 2.	K 073	**K073** **Temporary and Permanent Correction** **It is the policy of this facility to prohibit combustible decorations unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present.**	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard 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. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the Oxygen Storage. This was evidenced by the failure to secure two of two rooms from unauthorized entry. This affected two of seven smoke compartments, and could result in an increased safety risk due to the unauthorized access to oxygen. NFPA 101, 2000 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, 1999 4-5.5.2.2 Storage of Cylinders and Containers	K 076	**To ensure that all current and future residents are not affected by this deficient practice, all decorations on corridor walls that were not on bulletin board were removed.** **Administrator provided inserve to Activity staff on facility policy including using decoration in limited quantity so that hazard of fire development or spread is not present.** **Administrator will monitor corridors weekly for one month to ensure that facility policy regarding combustible decorations is followed and that decorations do not present a hazard of fire development or spread. If good compliance is maintained, monitoring will be reduced to Monthly.**	**05/22/2016**

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K 076	Continued From page 17 (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. 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft2 (85 m3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors or (gates outdoors) that can be secured against unauthorized entry. Findings: During a facility tour with staff on 4/13/16, the Oxygen Storage was observed. 1. At 11:45 a.m., the Twenty Wing Oxygen Storage Room was observed. The door was not equipped with a lock to secure against unauthorized entry. 2. At 11:55 a.m., the 2-F Oxygen Storage Room was observed. The door was not equipped with a lock to secure against unauthorized entry.	K 076	surveillance by the Safety Committee that is documented and reported to the Quality Improvement Committee for continued compliance. K076 Temporary and Permanent Correction It is the policy of this facility to ensure that Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. 05/22/2016 To ensure that all current and future residents are not affected by this deficient practice, locks were placed on Twenty Wing Oxygen Storage Room and the 2-F Oxygen Storage Room. Administrator will monitor door daily five days each week for one month to ensure that doors are closed and locked and they are secure against unauthorized entry. If good compliance is maintained, monitoring will be reduced to monthly surveillance by safety committee that is documented and reported to the	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the electrical equipment and	K 147		

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K 147	Continued From page 18 connections. This was evidenced by the use of power strips, wall adaptors, and extension cords as a substitute for permanent wiring. This affected five of seven smoke compartments, and could potentially result in the ignition of an electrical fire. NFPA 101, 2000 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1 9.1.2 Electric. Electric 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, 1999 edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 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	K 147	**Quality Improvement Committee for continued compliance.** **K147** **Temporary and Permanent Correction** **It is the policy of this facility to maintain wiring and equipment that shall be in accordance with the National Electrical Code 9-1.2** **To ensure that current and future residents are not affected by this deficient practice:** **Six outlet electrical adaptor, attached with a screw and plugged into a duplex wall outlet, was removed.** **Power Strip for Fish Tank at Station 3 was removed.** **Extension Cord with power strip, air-purifier machine, and fan plugged into it in the Front Office by Station 3 was removed.** **Extension cord with power strip and fan plugged into it in the Maintenance Repair-Supply Room was removed.**	**05/22/2016**

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K 147	Continued From page 19 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 otherwise permitted in this Code. 406.6 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface. Findings: During a facility tour, and interview with staff on 4/13/16, the electrical equipment and connections were observed. 1. At 11:30 a.m., a six outlet electrical adaptor, attached with a screw and plugged into a duplex wall outlet, had a copier-printer machine plugged into it in the Director of Nursing (DON) Office. 2. At 12:25 p.m., a fish tank pump was plugged into a power strip at Nursing Station 3. 3. At 12:30 p.m., an extension cord had a power a power strip, air-purifier machine, and fan plugged into it in the Front Office by Station 3. 4. At 12:55 p.m., an extension cord had a power strip and fan plugged into it in the Maintenance Repair-Supply Room. The finding was confirmed	K 147	**Inservice will be provided to all staff by the Staff Development Coordinator that covers facility policy not to use extension cords or power strips for items with motors.** **Administrator or her designee will monitor offices, work areas and corridors daily five days each week to ensure that no power strips or extension cords are used. If good compliance is maintained, monitoring will be reduced to monthly surveillance by the safety committee that is documented and reported to the Quality Improvement Committee for continued compliance.**	5/22/2016

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K 147	Continued From page 20 in an interview at the time with Staff 2. 5. At 1:10 p.m., a power strip had a fan plugged into it, and a six outlet electrical adaptor was plugged into a duplex wall adaptor attached by a screw, in the Business Office.	K 147	**K211** **Temporary and Permanent Correction** **It is the policy of the facility to maintain Alcohol Based Hand Rub dispensers in manner that is compliant with all requirements including not mounting Alcohol Based Hand Rub dispensers above an ignition source.** **To ensure that all current and future residents are not affected by this deficient practice, the Alcohol Based Hand Rub dispenser was removed. Administrator inspected all other Alcohol Based Hand Rub dispensers to ensure that they were not located above an ignition source.** **Safety committee will meet monthly and during facility surveillance, corridors including dispensers will be inspected to make sure they are in good repair and are not near an ignition source.** **Documentation of Safety Committee is maintained and reported to the Quality Insurance Committee for continued Compliance.**	5/22/2016
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed: 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 shall 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. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the installation of the alcohol based hand rub dispensers (ABHR). This was evidenced by the mounting of one dispenser over an ignition source. This affected one of seven smoke compartments and could result in an alcohol based hand rub ignited fire. Findings: During a facility tour with staff on 4/13/16, the alcohol based hand rub dispensers were observed.	K 211		

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K 211	Continued From page 21 At 12:56 p.m., an alcohol based hand rub dispenser was mounted directly above an electrical extension cord outlet that had a fan plugged into it in the Maintenance Repair Room. The finding was confirmed in an interview at the time with Staff 2.	K 211		