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

PRINTED: 06/05/2013
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
	055935	A. BUILDING 01 B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HA-LE ALOHA CONVALESCENT HOSPITAL	1711 RICHLAND AVENUE CERES, CA 95307

(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: 1977 K7 SURVEY UNDER: 2000 Existing STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111) FULLY SPRINKLERED Census: 44 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, HFE I The facility is not in compliance with 42 CFR 483.70 for Long Term Care Facilities.	K 000		
K 012 SS=E	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	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Maxine Mckain, RN, Administrator — 6-17-13

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.

6/17/13 - POC Acceptable per Maxine Mckain

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K 012	Continued From page 1 maintain the building construction. This was evidenced by a ceiling access hatch that was left partially open and by two wall penetrations around sprinkler pipes. This could result in the spread of smoke, in the event of a fire, affecting two of three smoke compartments. Findings: During a tour of the facility with Maintenance Staff 1, on 5/29/13, the walls and ceilings were observed. At 5:29 p.m., there was an approximately four inch by sixteen inch penetration in the ceiling of the utility closet between Rooms 2 and 4. The ceiling hatch failed to cover the attic access cut out. At 5:30 p.m., there were two approximately 1/4 by 1 1/2 inch crescent shaped penetrations around sprinkler pipes, in the back wall of the closet, in the Director of Nursing office.	K 012	K012 Penetrations in the ceiling of utility room between rooms 2 & 4 and the Director of Nursing Office's office by 6/21/13 by the maintenance staff. Maintenance staff will check all areas of potential penetrations monthly and will document those checks on the monthly check sheets. The maintenance supervisor will do rounds with at least 1 maintenance staff every 6 months to ensure that the monthly checks are being done and conducted correctly	6/21/13 06/17/13 06/17/13
K 018 SS=E	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 Roller latches are prohibited by CMS regulations	K 018	K018 By 6/21/13 the maintenance staff will adjust all automatic doors that were not shutting completely in the dining room and the infectious waste utility room will shut completely. The doors will be checked monthly by the maintenance staff and any repairs that are required will be fixed at that time. The maintenance supervisor will do rounds with at least 1 maintenance person every 6 months to ensure that the monthly checks are being done and conducted correctly.	6/21/13 6/17/13 6/17/13

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K 018	Continued From page 2 in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors. This was evidenced by one utility door and two dining room doors that failed to close completely and latch. This could result in the spread of fire or smoke, in the event of a fire, affecting two of three smoke compartments. Finding: During fire alarm testing with Maintenance Staff 1, on 5/29/13, the automatic closing doors were observed. At 3:53 p.m., doors to the dining room from two adjacent hallways failed to close completely and latch. At 5:10 p.m., the infectious waste utility room door was obstructed from closing by the door frame. During an interview, Maintenance staff 1 explained that the top hinge was loose which caused interference between the door and the frame.	K 018		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K052		

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K 052 SS=E	Continued From page 3 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, document review, and interview the facility failed to maintain the fire alarm system, as evidenced by no records of annual testing for heat detectors located throughout the facility. This could result in a delay in evacuation and an increased exposure to fire or smoke. This affected three of three smoke compartments. NFPA 72 National Fire Alarm Code 1999 Edition 7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. 7-5.2.2 A permanent record of all inspections, testing and maintenance shall be provided that includes the information regarding tests and all	K052	K052 Matson Alarm company who does all of our fire system checks will be out on 06/18/2013 to complete the fire alarm system heat detectors testing requirements. Matson will provide the facility with a report that includes all information listed under 7-5.2.2 Those reports will be kept with the maintenance logs and will be monitored by the Maintenance Supervisor annually so he can ensure that the proper testing is being done in a timely manner and that the each detector has been tested over the 5 year time period.	6/18/13 6/17/13

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K 052	Continued From page 4 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 the 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 (for example, owner notified, problem corrected/success-fully retested, device abandoned in place) Findings: During the facility tour, from 3:30 p.m. to 5:10 p.m., heat detectors were observed throughout two of three smoke compartments.	K052		

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K 052	Continued From page 5 During record review and a tour of the facility with Maintenance Staff 1, on 5/29/13, the testing records were requested for the fire alarm system heat detectors. The vendor report dated 6/18/12 did not indicate that the heat detectors were tested. During an interview on 5/29/13 at 3:30 p.m., Maintenance Staff 1 stated that they would look for heat detector testing records, and agreed to fax any records they located. As of 5 p.m. on 5/30/13, no faxed documents were received.	K052		
K 062 SS=E	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 observation, interview and record review, the facility failed to maintain their automatic sprinkler system. This was evidenced by no records for three of four quarterly testing periods. This could result in a failure of the sprinkler system and the spread of fire or smoke. NFPA 25 Standard for the Inspection, Testing, and maintenance of Water-Based Fire Protection Systems 1998 Edition, 2-3.3 Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type water flow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.	K062	K062 Matson Fire Alarm Company is contracted to do all of our quarterly sprinkler testing. They are due out again on 6/18/13. These records will be kept on sight and a copy taken by the Maintenance Supervisor so he can keep them at this office to ensure that he has got the next quarters inspection scheduled. The Maintenance Supervisor will provide the Administrator with a list of scheduled outside vendor testing for the sprinkler testing for the rest of the year by 6/29/13 to ensure that the tests are scheduled in advance and will not be missed.	6/18/13 6/17/13 6/29/13

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K 062	Continued From page 6 Findings: During record review and the facility tour with Maintenance Staff 1, on 5/29/13, the sprinkler system was observed. At 2:25 p.m., there were no sprinkler testing records for three of four quarters. Maintenance Staff 1 confirmed there were no other records available for quarterly testing of the fire sprinkler system. During an interview on 5/29/13 at 3:30 p.m., Maintenance Staff 1 stated that they would be looking for the missing documents and would fax any records they located by the end of the following business day. As of 5 p.m., on 6/3/13, the five year fire sprinkler certification was received in the district office. There were no additional records for quarterly testing.	K062		
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6. NFPA 10 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure fire extinguishers were inspected as required. This was evidenced by no fire extinguisher checks during one month. This could result in a delay in extinguishing a fire if a	K064		

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K 064	Continued From page 7 fire extinguisher failed. This affected all staff and residents in three of three smoke compartments. NFPA 10 Standard for Portable Fire Extinguishers, 1998 Edition. 4-3.1*Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Findings: During record review with maintenance staff on 5/29/13, the fire extinguisher log was reviewed. At 2:10 p.m., the log sheet labeled "Fire Extinguishers Year 2013" included a column for the month of April that contained no inspection check-offs. Routine inspections of the portable manual fire extinguishers are necessary to ensure that the equipment is in good working condition and will effectively perform in the event of a fire emergency. During the facility tour with maintenance staff on 05/29/13, from 3:10 p.m. to 5:10 p.m., the portable fire extinguisher tags were checked for monthly inspections. There were no April inspection sign offs on the inspection tags. Maintenance staff confirmed that there was no documentation of inspection on the individual fire extinguishers for the month of April 2013.	K064	K064 Maintenance staff will do the monthly fire extinguisher inspections as required and note those inspections on the log and on the fire extinguisher tag. The maintenance supervisor will do rounds with at least 1 maintenance person every 6 months to ensure that the monthly checks are being done and conducted correctly.	6/17/13 6/17/13
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K069		

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K 069	Continued From page 8 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to inspect and test the kitchen hood suppression system every six months. This was evidenced by no records for one of two inspections during the last year. This could result in the spread of fire or smoke affecting one of three smoke compartments. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 edition 8-2 inspection An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. 8-2.2 Fusible links. (including fusible links on fire-actuated damper assemblies) and automatic sprinkler heads shall be replaced at least annually, or more frequently if necessary, to ensure proper operation of the system. Other detection devices shall be serviced, or replaced in accordance with the manufacturer's recommendations. Exception: Where automatic bulb-type sprinklers or spray nozzles are used and annual examination shows no buildup of grease or other material on the sprinkler or spray nozzles. Findings: During record review with Maintenance Staff 1, on 5/29/13, the kitchen range exhaust hood suppression system inspection and testing reports were requested.	K069	K069 The Maintenance Supervisor will ensure that the hood suppression system in the kitchen is being tested every 6 months by Pyro Corp. The Maintenance Supervisor will keep the original test record at the facility in the Maintenance Inspection binder and will keep a copy for himself in the Main maintenance office So he can ensure that the hood suppression system test has been scheduled on time. The maintenance Supervisor will provide the Administrator a list of all tests scheduled by outside vendors at the beginning of each year and will notify the Administrator immediately of any scheduled changes.	6/17/13 6/17/13 6/29/13

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K 069	Continued From page 9 At 2:32 p.m., the facility provided documentation of the hood suppression system inspection on 1/2/13. There were no records for an inspection in July of 2012. During an interview on 5/29/13 at 3:30 p.m., Maintenance Staff 1 stated that they would look for the missing documents and fax any they found, by the end of the following business day. As of 5 p.m., on 5/30/13, no kitchen suppression system inspection documents were received.	K069		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case office or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their means of egress free from obstructions. This was evidenced by five geri chairs stored in a corridor next to Room 18. This affected one of three smoke compartments and could result in a delayed evacuation in the event of an emergency. Findings: During a facility tour with staff, on 5/29/13, the egress corridors were observed. At 5:31 p.m., the eight foot wide corridor was obstructed by five	K072	K072 Starting 6/18/13 the geri chairs when not in use will be stored in a corner of the dining room that is not obstructing exits, access to, egress from or visibility of exits. All staff will be inserviced on this change in storage policy by the Director of Staff Development on 6/25/13. The DSD and Housekeeping Supervisor will visually monitor to ensure that the geri chairs are not being stored there during regular business hours. The Licensed Charge nurses will be responsible for ensuring proper storage of unused geri chairs after normal business hours and on weekends and holidays.	6/18/13 6/25/13 6/17/13

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K 072	Continued From page 10 geri chairs (geriatric chair with foot rest), stored in the hallway along the wall next to Room 18. One was double parked. The chairs obstructed the corridor width for approximately 4 feet During an interview, Maintenance Staff 1 explained that the geri chairs are normally parked at this location when not in use.	K072		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20A L/sq m). A capacity of32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 **L)** are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure soiled linen containers were limited to 32 gallons in a 64 square foot area. This was evidenced by six 32 gallon containers stored in a hallway alcove measuring less than 64 square feet This could increase the risk of fire in one of three smoke compartments. Findings: During the facility tour and interview on 5/29/13,	K075	K075 The back hall utility room is marked for infectious waste storage and will be used for storage of the soiled linen utility carts when not in use as well as the alcove listed. These changes will be relayed to all staff by the DSD during the inservice on 6/25/13. The Housekeeping Supervisor and the Charge nurses will visual monitor these storage areas daily to ensure that the barrels being stored there do not exceed storage limits.	6/25/13 6/17/13

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K 075	Continued From page 11 the hallway soiled linen storage area was observed. From 4:25 p.m. to 5:38 p.m., there were six soiled linen carts stored together in the hallway alcove across from Room 19. The alcove was less than 64 square feet in area. At 5:39 p.m., Maintenance Staff 1 explained that there was no other place to store these containers. He stated that earlier in the day these move from room to room but are stored at this location when housekeeping is done.	K 075		
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 failed to perform all required weekly inspections and monthly load tests for the emergency generator. This was evidenced by generator logs that were missing documentation of weekly inspections during the last two months and missing monthly load tests during the last seven months. This could result in an increased risk of failure of the emergency power system and complete loss of electrical power during a utility	K 144	K144 The Maintenance staff will have completed all weekly testing of the generator and completed a test under load for 30 minutes by 6/29/13. An annual load test was done by Energy Systems Power Systems on 2/11/2013. See attached report. All logs will be completed as indicated once testing is done by the maintenance staff. The Maintenance Supervisor will complete the weekly testing at least 1 time per month and the monthly load testing with another maintenance staff member at least every quarter to ensure that the procedure is being done properly and documented correctly. The maintenance supervisor will provide the Administrator with a quarterly report of all generator tests that were completed within that quarter by providing a copy of the logs.	6/29/13 6/17/13 6/17/13 6/29/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055935	A. BUILDING 01 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HA-LE ALOHA CONVALESCENT HOSPITAL	1711 RICHLAND AVENUE CERES, CA 95307

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K 144	Continued From page 12 power outage. This affected 39 of 39 residents. Findings: During record review and interview with Maintenance Staff 1 on 5/29/13, the emergency generator testing process and testing records were reviewed. At 3:10 p.m., the documents labeled "Generator Log" were provided for 2012 and 2013. There was no indication of "Load Transfer Time" for seven of the last twelve months. The log for the last seven months indicated "No Load" under comments. Maintenance Staff 1 could not confirm if any load tests were performed since of September of 2012. At 3:15 p.m., the document labeled "Generator Log Year 2013" indicated the last inspection and testing was performed on 5/1/13. Four of the last five weekly inspections were missed since 4/19/13.	K 144		
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 their electrical wiring and equipment. This was evidenced by beds plugged into surge protectors, by a damaged outlet and by the use of an extension cord. This could result in harm from electrical shock or an electrical fire and affected two of three smoke compartments. NFPA 70, National Electrical Code, 1999 Edition 400-8. Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used	K 147		

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	055935	A. BUILDING 01 B.WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HA-LE ALOHA CONVALESCENT HOSPITAL	1711 RICHLAND AVENUE CERES, CA 95307

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K 147	Continued From page 13 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 otherwise permitted in this Code. 410-56(e). After installation, receptacle faces shall be flush with or project from faceplates of insulating material and shall project a minimum of 0.015 in. (0.381 mm) from metal faceplates. Faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Findings: During the facility tour with the Maintenance Staff 1 on 5/29/13, the electrical equipment and wiring connections were observed. At 5:28 p.m., in Room 2, Bed A was plugged into a surge protector which was plugged into a 25 foot orange extension cord connected to a wall outlet. At 5:30 p.m., in Room 16, Bed B was plugged into a surge protector which was plugged into a wall outlet.	K 147	K147 All surge protectors have been removed from rooms 2A, 15B and 16B. Those rooms have been given additional wall receptacles that meet the criteria as indicated in 410-56(e). All staff will be inserviced by the DSD on 6/25/13 that the use of surge protectors is not allowed in the facility. She will direct them to report the use of such items immediately to the maintenance department for further evaluation. The damaged wall outlet in the employee lounge will be replaced by maintenance staff on 6/18/13. The maintenance staff shall perform monthly inspections on all outlets to ensure that no surge protectors are in use and that there are no damaged outlets that need to be repaired. All repairs will be noted on the maintenance log.	6/19/13 6/25/13 6/18/13 6/29/13

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	055935	A. BUILDING 01 B. WING	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HA-LE ALOHA CONVALESCENT HOSPITAL	1711 RICHLAND AVENUE CERES, CA 95307

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K 147	Continued From page 14 At 5:32 p.m., in the employee lounge, there were two vending machines plugged into a damaged wall outlet. The electrical outlet and cover plate extended approximately 1/4 inch above the wall, next to the vending machines. At 5:41 p.m., in Room 15, Bed B was plugged into a surge protector connected to a wall outlet.	K 147		