(X2) MULTIPLE CONSTRUCTION

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

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

ATEMENT OF DEFICIENCIES  D PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING B. WING	01 - MAIN BUILDING 01	08/2	9/2012
	OVIDER OR SUPPLIES	ARE AND REHAB - SMITH RANCH	1550	T ADDRESS, CITY, STATE, ZIP CODE D SILVEIRA PARKWAY N RAFAEL, CA 94903		
(X4) ID PREFIX TAG	SUMMARY \$	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
K 000	INITIAL COMME		K 000			
		DVAL: 1994 DER: 2000 Existing				
	STRUCTURE TO WOOD FRAME SPRINKLERED	PE: TWO STORY, TYPE V, CONSTRUCTION, FULLY				
	Department of P Life Safety Code findings are in ac Federal Regulati (National Fire Pr Safety Code 200	lects the findings of the California ublic Health, during an annual re-certification survey. The ecordance with 42 CFR (Code of ions) 483.70 (a) and NFPA otection Association) 101, Life 00 edition, Existing codes.				
	Health Life Safe	e California Department of Public ty Code Unit: 31201 t in compliance with 42 CFR ong Term Care Facilities.				
K 012		SAFETY CODE STANDARD	K 012			
S\$=E	Building constru of the following. 19,3,5,1	ction type and height meets one 19.1.6.2, 19.1.6.3, 19.1.6.4,				
	Based on obse	D is not met as evidenced by: evation, the facility failed to egrity of the building construction, y penetrations in walls and ould result in the passage of				(X5) 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 any solicitation.

FORM CMS-2567(02-89) Previous Versions Obsolete

Event D: YLXL21

Facility ID: CA220000772

larian

If continuation sheet Page 1 of 8

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

ATEMENT	S FOR MEDICAR OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555595	(X2) MULTIF A. BUILDING B. WING		(X3) DATE SU COMPLE 08/29	
	TRANSITIONAL C	ARE AND REHAB - SMITH RANCH	1:	EET ADDRESS, CITY, STATE, ZIP CODE 550 SILVEIRA PARKWAY AN RAFAEL, CA 94903		
(X4) ID PREFIX TAG	THE PROPERTY OF THE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE	(X5) COMPLETION DATE
K 012	three smoke com level, and one of the Ground Floor Findings:	nt of a fire. This affected two of partments on the First Floor two smoke compartments on	K 012	This I lan of Correction is Kindred Transi and Rehabilitation - Smith Ranch's credib of compliance.  Preparation and/or execution of this plan does not constitute admission or agreemel provider of the truth of the facts alleged o set forth in the statement of deficiencies, correction is prepared and/or executed so it is required by the provisions of federal. It is the practice of Kindred Trans Care and Rehabilitation - Smith Fassure that all miscellaneous life issues are within compliance at a include:	of correction of correction of the plan of lely because and state law. Sitional Ranch to safety	
	nenetrations in t	there were two 1/8 inch circular he ceiling with cable wire running ident Room 104.		Ceiling penetration in room 104, room 112, room 119 and unseale wiring and pipe in the medical re will be sealed with fire barrier se	d telephone cord room	9-14-12
	2. At 9:30 a.m., inch penetration running through  3. At 9:38 a.m., inch penetration running through  4. At 9:58 a.m., inch penetration	there was an approximately 1/8 in the ceiling with cable wire it, in resident Room 105.  there was an approximately 1/4 in the ceiling with cable wire it, in resident Room 112.  there was an approximately 1/4 in the ceiling with cable wire it, by Bed 2, in resident Room		All rooms, offices, mechanical at rooms will be inspected for wall/penetrations, and unsealed condu 9-14-12. Any found will be seale All rooms, offices, mechanical at rooms will be inspected for wall/penetrations, and unsealed conduquarterly for one year and annual thereafter. These inspections will documented in the centers Preven Maintenance Program.	ceiling it pipes by d per code.  Ind clectrical ceiling it pipes lly l be	9-14-12
K 02:	inch penetration wiring and pipe Record Room lo	evel:  i., there was an approximately 1/4 in the ceiling with telephone running through it, in the Medical ocated in the Central Supply  E SAFETY CODE STANDARD	K 025		arterly to	

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

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TATEMENT	ENTERS FOR MEDICARE & MEDICAID SERVICE  (X1) PROVIDER/SUPPLIER/CL  (X2) PROVIDER/SUPPLIER/CL  (X3) PROVIDER/SUPPLIER/CL  (X4) PROVIDER/SUPPLIER/CL  (X5) PROVIDER/SUPPLIER/CL  (X6) PROVIDER/SUPPLIER/CL  (X6) PROVIDER/SUPPLIER/CL  (X7) PROVIDER/SUPPLIER/CL  (X7) PROVIDER/SUPPLIER/CL  (X7) PROVIDER/SUPPLIER/CL  (X8) PROVIDER/SUPPLIER/CL  (X8) PROVIDER/SUPPLIER/CL  (X9) PROVIDER/SUPPLIER/SUPPLIER/CL  (X9) PROVIDER/SUPPLIER/SUP		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2012	
	ROVIDER OR SUPPLIE	R CARE AND REHAB - SMITH RANCH	155	ET ADDRESS, CITY, STATE, ZIP COD O SILVEIRA PARKWAY N RAFAEL, CA 94903	E	
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
K 025 SS=E	least a one half haccordance with terminate at an a protected by fire-panels and steel separate comparations. Dampers a penetrations of sheating, ventilation 19.3.7.3, 19.3.7.  This STANDARI Based on obsermaintain the sm wall, as evidence two smoke barrismoke compartifinding could restire, and increas and staff in the NFPA 101, 200, 8.3.6.1 Pipes, cair ducts, pneur building service floors and smoke follows:  (1) The space to the smoke barrismoke b	are constructed to provide at mour fire resistance rating in 8.3. Smoke barriers may atrium wall. Windows are rated glazing or by wired glass frames. A minimum of two are not required in duct smoke barriers in fully ducted and, and air conditioning systems. 5, 19.1.6.3, 19.1.6.4  D is not met as evidenced by: rvation, the facility failed to oke integrity of the smoke barrier ed by unsealed penetrations in the walls. This affected one of two ments, on the Ground Floor. This sult in the spread of smoke and se the risk of injury to residents event of a fire.	K 025			

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

STATEMENT	S FOR MEDICAN OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER: 555595	A, BUILDING		(X3) DATE SURVEY COMPLETED 08/29/201	
	TRANSITIONAL C	CARE AND REHAB - SMITH RANCH	15	EET ADDRESS, CITY, STATE, ZIP CODE 50 SILVEIRA PARKWAY AN RAFAEL, CA 94903		
(X4) ID PREFIX TAG	I A ALL DESIGN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
K 025	Continued From b. It shall be protis designed for the (2) Where the perpenetrate the sm solidly set in the between the item of the following of a. It shall be filled of maintaining the barrier.  b. It shall be protis designed for the (3) Where designed for the a. It shall be made barrier.  b. It shall be made barrier.  c. It shall be made barrier.  b. It shall be made barrier.  c. At 9:29 a.m.	page 3 ected by an approved device that he specific purpose. Inetrating item uses a sleeve to hoke barrier, the sleeve shall be smoke barrier, and the space had the sleeve shall meet one conditions: d with a material that is capable he smoke resistance of the smoke he specific purpose. In take transmission of vibration had, any vibration isolation shall following conditions: de on either side of the smoke he specific purpose. It is specific purpose.  It is specific purpose.  It is the smoke barrier walls were had the smoke barrier wall by  It is the smoke barrier wall by	K 025	This I'lan of Correction is Kindred Transand Rehabilitation - Smith Ranch's credit of compliance.  Preparation and/or execution of this plan does not constitute admission or agreem provider of the truth of the facts alleged set forth in the statement of deficiencles, correction is prepared and/or executed sit is required by the provisions of federal Care and Rehabilitation - Smith assure that all fire/smoke cubicle within compliance at all times to Circular penetrations in smoke be the Classroom and Housekeepin repaired by 9-7-12 using material specifically for this purpose.  All smoke barrier walls will be inspected/sealed by 9-14-12 to ecompliance throughout center.  All smoke/fire barrier walls will quarterly for one year and annual thereafter. These inspections will documented in the center Prevential Maintenance Log.  Preventive Maintenance Logs wereviewed by the PI committee quanter of following the noted issue.	n of correction ent by the or conclusions The plan of colely because and state law.  sitional Ranch to es remain include: arriers by g room were als designed  he inspected ally be inspected artive	9-7-12
K 06:	the Housekeep NFPA 101 LIFE	ing Room. SAFETY CODE STANDARD	K 062			

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

TATEMENT	AN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED 08/29/2012	
	ROVIDER OR SUPPLIE	CARE AND REHAB - SMITH RANCH	155	ET ADDRESS, CITY, STATE, ZIP COD 0 SILVEIRA PARKWAY N RAFAEL, CA 94903	E	
(X4) ID PREFIX TAG	AT A DEL DECIDIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
K 062	continuously mai condition and are periodically. 19 25, 9.7.5  This STANDARD Based on obser maintain its auto	ntic sprinkler systems are ntained in reliable operating inspected and tested 9.7.6, 4.6.12, NFPA 13, NFPA is not met as evidenced by: vation, the facility failed to matic sprinkler system. This was	K 062			
	evidenced by pa sprinkler heads, maintained flush deflector diverts pattern when the could result in an spray pattern, an This affected two in the First Floor	int or debris on and by escutcheon rings not with the ceiling. The sprinkler the water to create a spray esprinkler is activated. This hobstruction to the sprinkler and a delay in extinguishing a fire, of three smoke compartments level, and one of two smoke a Ground Floor level.				
	and Maintenance Systems, 1998 I 2-2.1.1 Sprinkle floor level annua corrosion, foreig damage and sha orientation (e.g. Any sprinkler sh	ard for the Inspection, Testing, e of Water-Based Fire Protection Edition ers shall be inspected from the ally. Sprinklers shall be free of an materials, paint, and physical all be installed in the proper upright, pendant, or sidewall). It is replaced that is painted, ged, loaded, or in the improper				£
	concealed space	: Sprinklers installed in es such as above suspended t require inspection.				

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

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DATE SU COMPLET	TED
	555595		B. WING		08/29	9/2012
	ROVIDER OR SUPPLIER	ARE AND REHAB - SMITH RANCH	15	EET ADDRESS, CITY, STATE, ZIP CODE 50 SILVEIRA PARKWAY AN RAFAEL, CA 94903		
(X4) ID PREFIX TAG	- COLUMNICATION	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (ENCY)	ULD BE	(X5) COMPLETION DATE
K 062	Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.  Findings:  During a tour of the facility with the Maintenance Director on 8/29/12, the automatic sprinkler system was observed.  First Floor Level:  1. At 9:40 a.m., there was an approximately 1/2 inch penetration around the escutcheon ring, in the bathroom of resident Room 115.  2. At 9:45 a.m., the escutcheon ring in the bathroom of resident Room 116 was not		K 062	This Plan of Correction is Kindred Trans and Rehabilitation - Smith Ranch's credit of compliance.  Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged a set forth in the statement of deficiencies, correction is prepared and/or executed sit is required by the provisions of federal	t of correction and by the or conclusions The plan of olely because	10.64
	Director on 8/29/system was observed.  First Floor Level:  1. At 9:40 a.m., inch penetration the bathroom of resimal pathroom of resimal peroximately 1/3. At 10:06 a.m., head, in resident 4. At 10:13 a.m., Room 137 was reciling, and expense penetration.  Ground Floor Level:  5. At 11:12 a.m., head, in the Food in the Kitchen.	there was an approximately 1/2 around the escutcheon ring, in resident Room 115.  the escutcheon ring in the dent Room 116 was not with the ceiling, and exposed an 4 inch penetration.  the was debris on the sprinkler Room 129.  the escutcheon ring in resident not maintained flush with the escut an approximately 1/2 inch		It is the practice of Kindred Trans Care and Rehabilitation - Smith R assure that the sprinkler system is maintained and inspected to ensure compliance at all times to include a. ½ inch penetration around the cring in bathroom of room 115 will with fire barrier sealant. b, in rooms 116 and 137 ¼ and ½ penetrations will be sealed with fisealant and escutcheon rings will to flush with ceiling. c. In room 129, Food Service Dirlocated in the kitchen, and behind machine in the Laundry room del cleaned from sprinkler heads by 9. The Automatic Sprinkler System inspected quarterly by a Licensect to ensure compliance with NFPA Plant Operations Director and Lic Contractor will inspect sprinkler quarterly to ensure future compliance Sprinkler System inspection door quarterly for one year following issue.	escutcheon I be scaled ire barrier be adjusted ector Office I the drycr oris was 2-7-12 is I Contractor 13 and 25. censed system ance. utomatic umentation	9-14-12 9-14-12 9-7-12

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555595	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2012	
	ME OF PROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODS		
		ARE AND REHAB - SMITH RANCH	155	0 SILVEIRA PARKWAY N RAFAEL, CA 94903		
(X4) ID PREFIX TAG	SUMMARY 5	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 062 K 147 SS=D	Room. NFPA 101 LIFE S	page 6 SAFETY CODE STANDARD and equipment is in accordance lational Electrical Code, 9.1.2	K 062 K 147			
	Based on intervifailed to maintain This was evidence receptacle facepto protectors. This of an electrical fill affected one of the First Floor lecompartments of the First Floor lecompartments of NFPA 70, 1999 240-4 Flexible contected agains (a) Ampacities, by an overcurrent ampacity as specified in Table overcurrent in a specified in Table overcurrent protected be permitted to providing this previous Unless specified in Table of the following (1) As a substitutive substitutive substitutive in the following (1) As a substitutive receptance i	and fixture wires shall be st overcurrent by either (a) or (b). Flexible cord shall be protected in device in accordance with its sciffed in Tables 400-5(A) and (B). If the protected against accordance with its ampacity as le 402-5. Supplementary section, as in Section 240-10, shall be an acceptable means for otection. Decifically permitted in Section and cables shall not be used		This Plan of Correction is Kindred T and Rehabilitation - Smith Ranch's conformaliance.  Preparation and/or execution of this does not constitute admission or agre provider of the truth of the facts allegest firth in the statement of deficience correction is prepared and/or execution is required by the provisions of fed	redible allegation  plan of correction  pement by the  red or conclusions  ies. The plan of  ed solely because	

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

STATEMENT	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555595		555595  A BUILDING 01 - MAIN BUILDING 01  B. WING			URVEY ETED 19/2012
	ROVIDER OR SUPPLIER	ARE AND REHAB - SMITH RANCH	15	EET ADDRESS, CITY, STATE, ZIP CODE 550 SILVEIRA PARKWAY AN RAFAEL, CA 94903		
(X4) ID PREFIX TAG	CANDED DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE
K147	ceilings, suspender floors (3) Where run the similar openings (4) Where attach (5) Where conce structural ceilings ceilings, or floors (6) Where installed otherwise permitted by the service of the serv	ed ceilings, dropped ceilings, or rough doorways, windows, or ed to building surfaces aled behind building walls, suspended ceilings, dropped ed in raceways, except as ed in this Code  the facility with the Maintenance 12, the electrical wiring was in the Vestibule Room by 28, an electrical receptacle ssing. Maintenance Director in electrical receptacle faceplate	K 147	It is the practice of Kindred Tra Care and Rehabilitation - Smith assure compliance with NFPA Electrical Code at all times to be In the vestibule room by reside Receptacle cover was replaced Coffee maker In the Medical Oconnected directly to a wall electrical Closet Room to protector was removed on 8-29 two walkie talkies chargers and charger were removed also on telephone box was connected divall electric outlet  All rooms will be inspected for cords, receptacle covers and retightness by 9-14-12 to assure with NFPA 70.  Plant Operations Director will going Monthly Room Inspection this practice will not re-occur. inspections will be documented centers Preventive Maintenance. The facility Safety Committee Room Inspection documentation monitor through periodic inspecinsure compliance with NFPA Preventative Maintenance Progressions and the proventative Maintenance Progressions will be decumentation of the periodic inspections with NFPA Preventative Maintenance Progressions with NFPA Preventative Maintenance Progressions and the proventative Maintenance Progressions with NFPA Preventative Maintenance Progressions with NF	Ranch to 70, National aclude:  Int room 128 by 8-29-12  Iffice was ctric outlet.  The surge -12 and the 1 cell phone 8-29-12 and irectly to a ceptacle compliance conduct onceptacle compliance These d in the e Logs.  Will review on and sections to 70 and the	8-29-12 8-29-12 8-29-12