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

PRINTED: 04/30/2013
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
	555466	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY CARE CENTER	2270 ASHBY AVE BERKELEY, CA 94705

(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: 1981 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE V WOOD 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: 27994 The facility is not in compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 28	K 000	F 000 The management of Ashby Care Center offers its response, credible allegation of compliance and Plan of Correction as part of its on-going effort to provide quality care to our residents. Submission of this Plan of Correction is not an admission of guilt. Preparation and/or execution of this Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth of the Statement of Deficiencies. This plan of correction is prepared required by the Provisions of Health and Safety Code Section 1280 and 42 CFR 483.	5-10-13
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022	K-022 the item/area cited as deficient practice has been corrected as follows:	

[redacted] SIGNATURE [redacted]

[redacted] which the [redacted] 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.

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ASHBY CARE CENTER	2270 ASHBY AVE BERKELEY, CA 94706

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K 022	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their exit locations. This was evidenced by failure to provide exit signs in the approved path of egress. This affected two of two smoke compartments and could result in a delayed evacuation when an exit path is not identified in the event of an emergency. Findings: During a tour of the facility with staff on 4/23/13, the exit pathways were observed. 1. At 9:49 a.m., the exit gate at the Smoking area was missing an exit sign. The path to the exit gate was obstructed by shrubberies and the gate latch/door were hard to release. The gate lead to Ashby avenue. 2. At 10:10 a.m., the exit gate between the Laundry and the outside Storage room was missing an exit sign. The gate lead to the front parking lot. 3. At 10:20 a.m., the exit by Room 6 and 7 was missing an exit sign with arrow directing to the right. Exiting from the right will direct the pathway toward Smoking area gate that will lead to Ashby avenue.	K 022	1. An exit sign was posted at the gate at the smoking area. Path to the exit gate has been cleared and latch door replaced so it can be released easily. The gate lead to Ashby avenue 2. An exit sign was placed to the gate between laundry and outside storage leading to the front parking lot. 5- 3. Exit sign was placed by room 6 and directing to the right towards the smoking area gate leading to Ashby Avenue. 10- To ensure that this deficiency practice does not recur in future, DOS, DSD and Administrator will monitor on daily rounds that compliance is achieved and improving on practices. 13 Findings will be reported to our quality assurance meetings.	
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		

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K 046	Continued From page 2 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency back-up lighting. This was evidenced by failing to test the back-up lighting at 30 seconds monthly. This affected 28 of 28 residents, and could result in a failure of a normal lighting. NFPA 101, 2000. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. A annual test shall be be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During document review and interview with staff on 4/23/13, the emergency back-up lighting were observed. At 11:08 a.m., the documentation indicated there was no monthly 30 seconds testing in May 2012. Staff stated the facility could not locate May log.	K 046	Maintenance Director will do rounds to identify same on a similar practice does not recur; that compliance is achieved and improving on practices by integrating the plan of corrections into the facility quality assurance program. DON/Administrator will monitor overall compliance. K.046 The cited deficient practice has been corrected. 1. Emergency backup lighting has been tested monthly at least 30 seconds starting May 2013. A functional test done and documented as required by law. An annual test shall be conducted on every required battery-powered emergency lighting system by outside contractor licensed by the state.	5- 10- 13
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047		

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K 047	Continued From page 3 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their emergency exit signs. This was evidenced by emergency exit sign that was not tested for 30 seconds monthly. This affected 28 of 28 residents, and could result in a failure of a normal lighting. NFPA 101, 7.10.5.2 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of section 7.8. 7.10.9.2 Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. A annual test shall be be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During document review and interview with staff on 4/23/13, the emergency exit signs were observed. At 11:10 a.m., there was no documentation indicated a monthly 30 second test was conducted. Staff stated the facility do not have a monthly log for the emergency exit signs.	K 047	Maintenance director will routinely oversee equipment fully operational for duration required and reports to administrator on going deficient practice and be integrated into our ongoing quality assurance system. K047 NFPA101-Life Safety Code Standard	5-10-13
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050 SS=D	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that fire drills were conducted in accordance with NFPA 101, 2000 edition. This was evidenced by failure to activate an alarm during fire drill, missing fire drill, and fire drills conducted at the same time. This affected 28 and 28 residents and could result in a malfunction alarm in the event of an emergency. Findings During documents review and interview with staff on 4/23/13, the fire drills were reviewed. 1. At 10:41 a.m., the fire drill log was missing one of twelve drills. A drill was missing in the third quarter NOC shift. Two AM shift were conducted instead. Administrator stated one of twelve drills was missing. 2. At 10:45 a.m., the fire drill documentation indicated no device was activated each time a drill was performed after 6 a.m. and before 9 p.m.	K 050	K050 NFPA101-Life Safety Code Standard: The facility has corrected cited deficiency by ensuring that: fire drills are conducted by activating an alarm before 9pm and 6am. No device is required to be activated before 6am or after 9pm. Record of fire drill is maintained. If alarm is activated, facility staff can request of copy to be emailed to facility for compliance of records. In order to monitor compliance and same or similar practice does not occur and solutions are sustained by integrating the plan of correction into the facility quality assurance program. Administrator/DON will monitor overall compliance.	5_ 10_ 13

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K 050	Continued From page 5 Administrator stated no device was activated on each drill because it was all simulated. 3. At 10:47 a.m., the fire drill documentation indicated drills were conducted at the same time. AM shift for January 14 and April 3 were conducted at 12 noon. AM shift for July 3 and October 5 were conducted at 9 a.m. PM shift for May 9, August 21, and November 6 were conducted at 4 p.m. Administrator stated the facility will vary the time from now on.	K 050	Facility has corrected cited deficiency by conducting fire drills according to regulations with charges/ongoing corrective actions below. Systemic changes in place to ensure that the same or similar practice does not recur.	5-
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 document review and interview, the facility failed to maintain their fire alarm system. This was evidenced by incomplete annual fire alarm testing records. This affected 28 of 28 residents, and could result in a malfunction of fire alarm system during an emergency. Findings:	K 052	DSD/Administrator will conduct monthly fire drills, activate fire alarm as regulation required. Fire Alarm Company will print activated summary provided by company's monitoring alarm. For residents with the potential of being affected by this deficient practice, all nursing staff are reminded to participate in all fire drills. This plan of correction will be integrated into our ongoing quality assurance system through a review of the plan of correction at each quality assurance meeting.	10- 13

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K 062	Continued From page 6 During document review and interview with staff on 4/23/13, the fire alarm records were requested. At 10:59 a.m., the documentation titled, "Fire Alarm Certification and Testing Report with Smoke Detector Sensitivity," dated 4/22/13 failed to indicated two duct detectors were tested. The report indicated five smoke detectors, four manual pull stations, water flow, tamper, and bells/chimes were tested. Administrator stated the facility was not aware of duct detectors were not tested.	K 052	Quality assurance committee shall review compliance date and reevaluate set threshold and offer recommendations. NFPA101 Life Safety Code Standard	5_
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 observation, document review, and interview, the facility failed to maintain the integrity of the automatic sprinkler. This was evidenced by sprinkler head that had paint on it and missing quarterly sprinkler test. This affected two of two smoke compartments, and could result in the ineffective operation of the automatic sprinkler system in the event of a fire. NFPA 25, 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. 2-1. The minimum requirements for annual routine inspection, testing, and maintenance of sprinkler systems shall conform to Table 2-1 that	K 062	Facility has contracted outside contractor to inspect and replaced items cited as deficient sprinkler heads due to presence of paint on deflector plate, in room 9, infectious waste room 10 and kitchen. Missing records of sprinkler have been requested from outside vendor. All residents have the potential to be affected by deficient practice. Measures in place to prevent same or similar practice does not recur	10_ 13

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K 062	Continued From page 7 shall be used to determine the system components to be tested and the minimum required frequencies for inspection, testing, and maintenance. 2-2.5. Annually, prior to the onset of freezing weather, buildings with wet pipe systems shall be inspected to verify that windows, skylights, doors, ventilators, other openings and closures, blind spaces, unused attics, stair towers, roof houses, and low spaces under buildings do not expose water-filled sprinkler piping to freezing and to verify that adequate heat [minimum 40°F (4.4°C)] is available. 2-2.1.1*. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical 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. 2-3.3* Alarm Devices. 2 Waterflow alarm devices including,but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 13 3-2.6.3 Unless applied by the manufacture, sprinklers shall not be painted, and any sprinklers that have been painted shall be replaced with new listed sprinklers of the same characteristics, including orifice size, thermal response, and water distribution. Findings: During a tour, document review, and interview	K 062	Maintenance/House Keeping personnel have been in serviced on corrective measures and practices on sprinklers. Outside contractor have also been notified of negative findings This plan of correction will be integrated into our ongoing quality assurance system through a review of the plan of correction at each 2A meeting during which maintenance/administrator will report findings specific to sustaining compliance. The 2A committee shall offer recommendation upon review of compliance data.	5-10-13

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K 062	Continued From page 8 with staff on 4/23/13, the sprinkler head were observed and report was requested. 1. At 10 a.m., two of three sprinklers in Room 9 had paint on deflector plate and spoke. 2. At 10:03 a.m., a sprinkler in the Infectious waste room had paint on the head. 3. At 10:05 a.m., three of three sprinklers in the Kitchen had paint on the frame and head. 4. At 10:06 a.m., a sprinkler in Room 10 had paint on the head. 5. At 10:41 a.m., the facility sprinkler log were missing two of four quarterly test. Quarterly were missing for first quarter 2013 and fourth quarter 2012. Administrator stated the first quarter test was conducted in 4/2013 which fall into the second quarter of 2013 and could not locate the fourth quarter.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	K066 NFPA 101 Life Safety Code Standard The item/area cited as deficient practice has been corrected. Maintenance/Housekeeping personnel have been in serviced on the proper way of disposing cigarette butts from approved ash tray of noncombustible material with self-closing device. All cigarette butts must be all extinguished with water prior to empting it to garbage container outside.	5- 10- 13

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K 068	Continued From page 9 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoking areas. This was evidenced by mixing cigarette butts with combustible items. This affected 28 of 28 residents, and could lead to an increased risk for fire. Findings: During a tour of the facility with staff on 4/23/13, the smoking areas were observed. At 9:47 a.m., the resident smoking area was located outside by the Dining room. There was a metal trash bin that had cigarette butts mixed with combustible items.	K 068		