STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. BUILDING 02 B. WING	04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HEALTH 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
E 000	Initial Comments Surveyor: 32973 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 32973 Census: 117	E 000		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013	E 013 **Temporary and Permanent Correction** It is the policy of this facility to develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. This facility will update policies and procedures regarding providing care and treatment at an alternate site, including policy and procedures indicating the facility's role in providing treatment and care under an 1135 waiver at an alternate care site in the event of an emergency.	05/23/2018

[redacted]

LABO... TITLE Administrator (X6) DATE May 6, 2018

Any ... institution may be excused from correcting providing it is determined that other ... 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.

5/10/18 – Approved by Cynthia

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	056495	A. BUILDING 02 B. WING	04/23/2018

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E 013	Continued From page 1 emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on record review and interview, the facility failed to provide policies and procedures to provide care and treatment at an alternate site. This was evidenced by no policy and procedure indicating the facility's role in providing treatment and care under an 1135 waiver at an alternate care site in the event of an emergency. This affected 117 residents and staff, and could result in the facility being inadequately prepared to provide care at an alternate location. (b) Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E 013	E 013 Continued The Policies and Procedures will be updated to address all provisions including: (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. (2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility will document the specific name and location of the receiving facility or other location. (3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	05/23/2018

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	050495	A. BUILDING 02 B. WING _____	04/23/2018

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E 013	Continued From page 2 section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain- (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal. (2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location. (3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. (4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility.	E 013	Continued (4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility. (5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency (7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents.	05/23/2018

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E 013	Continued From page 3 (5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. (7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents. (8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings: During record review and interview with administrative staff on 4/23/18, the emergency preparedness policies and procedures were requested and reviewed. At 2:30 p.m., there was no policy and procedure outlining the facility's plan in providing care and treatment at an alternate location under an 1135 waiver, in the event of an emergency. Upon interview, Staff 1 confirmed the finding.	E 013	Continued (8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the ACT, in the provision of care and treatment at an alternate care site identified by emergency management officials. Emergency Plan will be updated by the Administrator and approved by the Patient Care Policy Committee. Inservice will be provided to all staff by the Staff Development Coordinator on the Emergency Preparedness Plan including the role of this facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	05/23/2018
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 041		

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E 041	Continued From page 4 (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source	E 041		

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E 041	Continued From page 5 to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical Interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition,	E 041	E 013 Continued **To ensure that this deficient practice does not reoccur and that future residents are not affected, The Patient Care Policy Committee will review and update Emergency Preparedness Plan at least annually. Facility Staff Development Coordinator will also conduct Education and training, including drills and exercises, are utilized in this facility to achieve proficiency during emergency response and ensure the effectiveness of our EOP. In compliance with state and federal regulations, our facility conducts initial training on the EOP during the orientation of new staff, and annually to all staff.** 05/23/2018 **E 041** **Temporary and Permanent Correction** **It is the policy of this facility to maintain an Emergency Plan that includes provisions to ensure on-site fuel reserve to power the emergency generator for a minimum of 96 hours.** 05/23/2018	

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	056405	A. BUILDING 02 B. WING	04/23/2018

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CASA COLOMA HEALTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

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E 041	Continued From page 6 Issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on record review and interview, the facility failed to maintain the emergency standby power system. This was evidenced by the failure to maintain a minimal 96 hour on-site fuel reserve to power the emergency generator. This affected 117 residents and staff. This had the potential to have an ineffective Emergency Preparedness (EP) plan. Findings: During record review and interview with Administrative Staff on 4/23/18, the EP plan was requested and reviewed. At 1:30 p.m., the facility was observed with a permanent 20 kilowatt diesel generator, with an 80 gallon capacity fuel tank. The gauge on the tank registered at half-full (40 gallons). Upon interview, Staff 2 confirmed that the fuel supply (40 gallons) was the equivalent of approximately one gallon for each hour of run time, which calculated to 40 hours of fuel supply reserve.	E 041	Plant Operations Supervisor will maintain 80 gallon diesel tank full and a reserve tank of at least 16 gallons diesel will be maintained to ensure that at least 96 gallons of fuel is maintained at the facility. This will ensure that at least 96 hours of generator power can be supplied in the event of a power outage. To ensure that this deficient practice to not reoccur and that future residents are not affected. Inservice will be provided by the Administrator to the Plant Operations Supervisor and Maintenance Staff on facility EOP including requirements to maintain at least 96 gallons of diesel fuel on site to provide the required 96 hours of power to emergency generator in the event of an emergency. 05/23/2018	

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K 000	Continued From page 7	K 000	E 041 Continued	
K 000	INITIAL COMMENTS Surveyor: 32973 K3 BUILDING: 01 K6 PLAN APPROVAL: 1963 & 1987 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, 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 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 32973 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 117	K 000	The Administrator will monitor the generator fuel supply weekly for two months. If good compliance is maintained, monitoring will be reduced to Generator Checks that are conducted monthly by the Plant Operations Supervisor and reviewed quarterly by the Administrator. 05/23/2018	
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		

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K 161	Continued From page 8 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, the facility failed to maintain the integrity of the building construction. This was evidenced by a ceiling penetration. This affected one of seven smoke compartments, and	K 161	**K 161** **Temporary and Permanent Correction** It is the policy of this facility to maintain the integrity of the building construction as required. The one inch diameter penetration in the laundry room was repaired by the Plant Operations Supervisor with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier to insure the integrity of the building construction, and prevent the passage of smoke to other areas in the event of fire. To ensure that this deficient practice does not reoccur and that future residents are not affected, the Plant Operations Supervisor will conduct monthly surveillance of the facility for three months. If good compliance surveillance will be reduced to quarterly surveillance reports that are maintained and reviewed by the Administrator quarterly. 05/23/2018	

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K 161	Continued From page 9 could result in the passage of smoke to other areas in the event of a fire. Findings: During a tour of the facility with staff on 4/23/18, the walls and ceiling were observed. At 11:34 a.m., the walls and ceiling in the Laundry Room, were observed. There was an approximately one inch diameter penetration, with a metal conduit traveling through it, located in the ceiling above the washing machines.	K 161	**K 211** **Temporary and Permanent Correction** **It is the policy of this facility to provide Means of Egress as required. It is the policy of this facility to maintain 90 minute fire rated door assemblies and to ensure that Fire Door Assemblies will be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.** **Plant Operation Supervisor will have testing completed for all doors and certification of testing will be provided to the Administrator for review.** **To ensure that this deficient practice does not reoccur and that future residents are not affected, the Administrator will provide inservice on testing requirement for 90 minute fire rated door assemblies to Plant Operations Supervisor and Maintenance Staff.**	05/23/2018
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, document review, and interview, the facility failed to maintain the 90 minute fire rated door assemblies. This was evidenced by the absence of an annual inspection and certification. This affected seven of seven smoke compartments, and could result in the malfunction of the doors to contain fire to a compartment. NFPA 101, Life Safety Code, 2012 Edition Chapter 19 Existing Health Care Occupancies	K 211		

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K 211	Continued From page 10 19.1 General Requirements. 19.1.1 Application. 19.1.1.1 General. 19.1.1.1.3 General. The provisions of Chapter 4, General, shall apply. 4.5.3 Means of Egress. 4.5.7 System Design/Installation. Any fire protection system, building service equipment, feature of protection, or safeguard provided to achieve the goals of this Code shall be designed, installed, and approved in accordance with applicable NFPA standards. 4.5.9 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained, unless the Code exempts such maintenance. 8.3.3 Fire Doors and Windows. 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices,	K 211	K 211 continued Administrator will review testing quarterly to ensure that all required testing is being completed as required. Administrator will report to the Quality Assurance Performance Improvement Committee at least annually during review of the facility's Emergency Preparedness Plan.	05/23/2018

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K 211	Continued From page 11 anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protective's, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protective's, 2010 edition. Chapter 5 Care and Maintenance 5.1* General. 5.1.1 Application. 5.1.1.1 This chapter shall cover the care and maintenance of fire doors and fire windows. 5.2.14 Maintenance of Closing Mechanisms 5.2.14.1 Self-closing devices shall be kept in working condition at all times. 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. Findings: During a facility tour, document review, and interview with staff on 4/23/18, the annual inspection and testing for fire/exit doors was requested. At 2:30 p.m., the facility was observed with six sets of double-door (90 minute) fire rated cross-corridor doors, in the two hour wall openings, located inside the corridors. No certification for annual testing and inspection was available for review. Upon interview, Staff 2 confirmed that no annual testing/inspection was performed on the doors.	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. BUILDING 02 B. WING	04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, document review, and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by the failure to perform a semi-annual FAS inspection. 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, Life Safety Code, 2012 Edition 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* General. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling	K 345	K 345 **Temporary and Permanent Correction** It is the policy of this facility to maintain the Fire Alarm System including Testing and Maintenance as required. Plant Operations Supervisor will schedule (FAS), fire alarm system semi-annual inspection to be done six months after testing completed 04/18/2018 to maintain semi-annual testing as required. To ensure that this deficient practice does not reoccur and that future residents are not affected, inservice will be provided to Plant Operations Supervisor and Maintenance Staff that reviews required testing intervals of fire alarm systems, including testing of doors semi-annually. Required testing will be reviewed by the Administrator quarterly and reviewed by the Quality Assurance Performance Improvement Committee annually during review of Emergency Preparedness Plan. 05/23/2018	

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K 345	Continued From page 13 Code, 2010 Edition. Chapter 14 Inspection, Testing, and Maintenance 14.1 Application. 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 14.3.2 Devices or equipment that is inaccessible for safety considerations (e.g., continuous process operations, energized electrical equipment, radiation, and excessive height) shall be permitted to be inspected during scheduled shutdowns if approved by the authority having jurisdiction. 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance. Table 14.3.1 Visual Inspection Frequencies-semiannually 3. Batteries 4. Transient suppressors 5. Fire alarm control unit trouble signals 7. In- building fire emergency voice/alarm communications equipment 8. Remote annunciators 9. Initiating devices	K 345		

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K 345	Continued From page 14 10. Guard's tour equipment 11. Combination systems (a) Fire extinguisher electronic monitoring device/systems (b) Carbon monoxide detectors/systems 12. Interface equipment 13. Alarm notification appliances 14. Exit marking audible notification appliances 15. Supervising station alarm systems-transmitters 16. Special procedures 17. Supervising station alarm systems-receivers 18. Public emergency alarm reporting system transmission equipment 20. Mass notification system, non-supervised systems installed prior to adoption of this edition 14.6.2 Maintenance, Inspection, and Testing Records. 14.6.2.1 Records shall be retained until the next test and for 1 year thereafter. 14.6.2.4* A 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 14.6.2.4: (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(	K 345		

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K 345	Continued From page 16 automatic FAS. The current Annual Fire Alarm Report was dated 4/17/18. No semi-annual inspection prior to the annual testing was available for review. Upon interview, Staff 2 confirmed that the FAS was inspected and tested on an annual basis.	K 345	K 353 **Temporary and Permanent Correction** It is the policy of this facility to Maintain Maintenance and Testing	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, document review, and interview, the facility failed to maintain the integrity of the automatic fire sprinkler system. This was evidenced by the failure to perform one of four quarterly test and inspections, and sprinkler components with corrosion. This affected seven of seven smoke compartments,	K 353	CFR(s): NFPA 101 as required. It is the policy of this facility to test sprinkler System quarterly and to inspect sprinkler components. The Plant Operations Supervisor will replace the three pendant style sprinklers that are located directly above the dish washing area. To ensure that this deficient practice does not reoccur and that future residents are not affected, an inservice will be provided to the Plant Operations Supervisor and Maintenance staff by the Administrator that reviews facility policy to have sprinklers inspected quarterly, and to replace any sprinklers that show signs of Leakage, Corrosion, Physical damage, Loss of fluid in the glass bulb heat responsive element, *Loading, Painting unless painted by the sprinkler manufacturer.	05/23/2018

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K 345	Continued From page 15 vies) (7) Designation of the detector(S) tested (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) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer ' S published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) Findings: During a facility tour, document review, and interview with staff on 4/23/18, the FAS was observed and records were requested. At 1:00 p.m., the facility was observed with an	K 345		

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K 353	Continued From page 17 and could result in the ineffective operation of the automatic fire sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 4.3 Records 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. Chapter 5 Sprinkler Systems. 5.1.1 Minimum Requirements. 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing,	K 353	Administrator will review testing quarterly to ensure compliance and testing will be reported annually to the Quality Assurance Performance Improvement Committee during annual review of Emergency Preparedness Procedures. 05/23/2018	

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K 353	Continued From page 18 and maintenance of sprinkler systems. 5.2.1 Sprinklers. 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarms and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 13.2.6 Alarm Devices. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and	K 353		

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K 353	Continued From page 19 operating properly. (6) The fire department connection clapper(s) is in place and operating properly. Findings: During a facility tour, document review, and interview with staff on 4/23/18, the automatic fire sprinkler system was observed. 1. At 11:50 a.m., the sprinkler heads inside the Kitchen, were observed. Three pendant style sprinklers located directly above the dish washing area, were covered in a light green colored corrosion build-up. Upon interview, Staff 2 confirmed the finding. 2. At 1:05 p.m., the facility was observed with a wet automatic fire sprinkler system. No record for testing and inspection was available for the second quarter (April, May, June) 2017-2018. Upon interview, Staff 2 confirmed the finding.	K 353	**K 355** **Temporary and Permanent Correction** **It is the policy of this facility to maintain portable fire extinguishers as required. Portable fire extinguishers will be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.** **Plant Operations Staff will lower portable fire extinguisher in the laundry room so that the top of the fire extinguisher is not more than 5 ft. above the floor.**	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by a fire extinguisher that was mounted higher than the maximum allowed	K 355	**To ensure that this deficient practice does not reoccur and that future residents are not affected, Inservice will be provided to the Plant Operations Supervisor and the Maintenance staff on NFPA 101 Life Safety Code, 2012 including, requirement that fire extinguishers weighing less that 40lbs shall be installed so that the top of the fire extinguisher is not more than 5 ft.**	05/23/2018

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K 355	Continued From page 20 height of sixty inches. This affected one of seven smoke compartments, and could result in the inability of staff to readily access the fire extinguisher in the event of a fire. NFPA 101 Life Safety Code, 2012 edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010, edition. 6.1.3.8 Installation Height. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. 6.1.3.8.2 Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm).	K 355	05/23/2018 K 355 Continued Fire extinguishers will be inspected by the Plant Operations Supervisor quarterly to ensure they are in good repair and that they are at the required height. Documentation of inspections will be maintained and reviewed by the Administrator quarterly.	

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K 355	Continued From page 21 Findings: During a tour of the facility and interview with staff on 4/23/18, the portable fire extinguishers were observed. At 11:30 a.m., the portable ABC fire extinguisher located in the Laundry Room, was observed. The extinguisher was mounted to the wall with the top of the operative handle at 62 inches above the floor. The extinguisher weighed less than 40 pounds. Upon interview, Staff 2 confirmed the finding.	K 355		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ If the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7	K 362	**K 362** **Temporary and Permanent Correction** **It is the policy of this facility to ensure that corridors are separated from use areas by walls constructed with at ½-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke.** **Plant Operations Supervisor sealed ceiling penetration in ceiling by Room 69 with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier.** **05/23/2018**	

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K 362	Continued From page 22 This REQUIREMENT is not met as evidenced by: Surveyor: 32979 Based on observation, the facility failed to maintain the integrity of the building corridor construction. This was evidenced by an unsealed ceiling penetration. This affected one of seven smoke compartments, and could result in the passage of smoke to other areas in the event of a fire, leading to a full facility evacuation. Findings: During a tour of the facility with staff on 4/23/18, the corridor walls and ceiling were observed. At 11:40 a.m., there was an approximately one-half inch diameter penetration located in the corridor ceiling by Room 69.	K 362	K 362 continued To ensure that this deficient practice does not reoccur and that future residents are not affected by this deficient practice, inservice will be provided by the Administrator to the Plant Operations Supervisor and Maintenance staff that covers facility policy to maintain partitions that will resist the transfer of smoke, including sealing penetrations. Plant Operations Supervisor will inspect corridors weekly for one month to ensure that no penetrations are present. If no penetrations are found. Monitoring will be reduced to quarterly surveillance that is conducted by maintenance and reviewed by the Administrator Quarterly. 05/23/2018	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors	K 363		

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

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K 363	Continued From page 23 complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by doors that were obstructed from fully closing and latching. This affected three of seven smoke compartments, and could result in the inability to contain smoke and/or fire to a room. Findings: During a tour of the facility and interview with staff on 4/23/18, the doors were observed. 1. At 11:10 a.m., the corridor door to the Station One Utility Room, was observed. The door was	K 363	**K 363** **Temporary and Permanent Correction** It is the policy of this facility to provide Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. It is the policy of this facility to maintain doors that are not obstructed from fully closing and latch. Plant Operations Supervisor made the following corrections: 1. The corridor door to the Station One Utility room was adjusted so that it fully closed and positively latched. 2. Room 25 obstruction was removed. Arm chair that obstructed door from fully closing was relocated so that it was not in the swing path of the door. 3. The obstruction of the corridor door to Dining room 4 was removed. Arm chair was removed from swing path of door. 05/23/2018	

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	056485	A. BUILDING 02 B. WING	04/23/2018

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CASA COLOMA HEALTH 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 363	Continued From page 24 equipped with a self-closing device. The door was opened to the fullest extent, and allowed to close. The door failed to fully close and positive latch. Upon interview, Staff 2 confirmed the finding. 2. At 11:14 a.m., the corridor door to Resident Room 25, was observed. The door was obstructed from fully closing and latching by an arm chair stationed in the swing path of the door. Upon interview, Staff 2 confirmed the finding. 3. At 11:45 a.m., the corridor door to Dining Room 4, was observed. The door was equipped with self-closing and magnetic hold open devices. The door was obstructed from closing and latching by an arm chair placed against the door. Upon interview, Staff 2 confirmed the finding.	K 363	K 363 Continued To ensure that this deficient practice does not reoccur and that future residents are not affected by this practice. Inservice will be provided to all staff by the Staff Development Coordinator on facility policy not obstruct doorways from closing. Staff Developer will monitor corridors and doorways daily five days per week for one month, to ensure that obstructions are not in doorways, if no obstructions are found, monitoring will be reduced to surveillance during monthly fire drills that are conducted monthly by Staff Development Coordinator.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 32973	K 372		05/23/2018

2018 MAY -7 PM 3:47
CERTIFICATION PROGRAM

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. BUILDING 02 B. WING	04/23/2018

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K 372	Continued From page 25 Based on observation and interview, the facility failed to maintain the integrity of the fire/smoke barrier walls. This was evidenced by an unsealed penetration. This affected two of seven smoke compartments, and could potentially allow the spread of smoke and/or fire to other areas of the facility, being unable to defend in-place, exposing residents to a full facility evacuation. NFPA 101, Life Safety Code, 2012 Edition. 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following: (1)This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a)Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b)Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the	K 372	**K 372** **Temporary and Permanent Correction** It is the policy of this facility to provide smoke barriers that are constructed to a ½ hour fire resistance rating per 8.5. This facility will maintain the integrity of the fire/smoke barrier walls. The Plant Operations Supervisor made the following correction: 1. The fire/smoke barrier wall located in the attic above the 90 minute cross-corridor doors by Room 42 with two inches unsealed penetration in the lower right wall area was sealed with a material that is approved and capable of maintaining the smoke resistance of the smoke barrier.	05/23/2018

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K 372	Continued From page 26 transfer of smoke. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. 8.5.6.4 Where sprinklers penetrate a single membrane of a fire resistance-rated assembly in buildings equipped throughout with an approved automatic fire sprinkler system, noncombustible escutcheon plates shall be permitted, provided that the space around each sprinkler penetration does not exceed 1/2 in. (13 mm), measured between the edge of the membrane and the sprinkler. 8.5.6.5 Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke. Findings: During a facility tour and interview with staff on 4/23/18, the fire/smoke barrier walls were observed. At 12:30 p.m., the fire/smoke barrier wall located in the attic above the 90 minute cross-corridor doors by Room 42, was observed. There was an approximately two inches unsealed penetration in the lower right wall area, with multiple cables traveling through it. Upon interview, Staff 2 confirmed the finding after viewing the wall.	K 372	To ensure that this deficient practice does not reoccur and that future residents are not affected Plant Operations Supervisor will inspect fire/smoke barrier walls at least semi-annually and when any cables are run in the attic area. A Log of inspections will be maintained by the Plant Operations Supervisor and reviewed by the Administrator quarterly. 05/23/2018	

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	056405	A. BUILDING 02 B. WING	04/23/2018

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K 923 K 923 SS=D	Continued From page 27 Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 6.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.	K 923 K 923	**K 923** **Temporary and Permanent Correction** It is the policy of this facility to maintain oxygen storage as required. It is the policy of this facility that oxygen storage room door be equipped with signage as required. The sign will include the minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING. Sign was immediately placed on door by maintenance. To ensure that this deficient practice does not reoccur and the future residents are not affected the Staff Development Coordinator will provide inservice to all personnel on facility policy to maintain required signage on oxygen storage rooms that includes the minimum: : CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.	05/23/2018

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K 923	Continued From page 28 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, the facility failed to maintain oxygen storage. This was evidenced by an oxygen storage room door that did not have the minimal required signage. This affected one of seven smoke compartments, and could result in the unsafe storage of oxygen. NFPA 99, Health Care Facilities Code, 2012 Edition. 11.3.2.1 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. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.6 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING Findings: During a tour of the facility with staff on 4/23/18, the oxygen storage was observed. At 11:45 a.m., the Station One Oxygen Storage Room, was observed. The room contained approximately 500 cubic feet of stored oxygen. The room door was not equipped with a No Smoking sign.	K 923	Staff Development Coordinator will monitor oxygen storage areas daily five days each week for one month to ensure that signage is maintained. If signage is maintained monitoring will be reduced to quarterly surveillance that is conducted by Plant Operations Supervisor and reviewed by the Safety Committee.	05/23/2018

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