DEPARTMENT OF HEALTH AND HUMAN SERVICES  CENTERS POR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDERSUPPLIERCIA A BUILDING 01				MSTRUCTION M - MAIN BUILDING 01	FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		585143	B. WING			12/2	28/2012		
NAME OF PROVIDER OR SUPPLIER WESTLAND HOUSE			1	STREET ACCRESS. CITY, STATE, ZIF CODE 100 BARNET SEGAL LANE MONTEREY, CA. 93940					
makan sala	SI SHEADY ST	ATEMENT OF DEFICIENCIES	<u> </u>	1	PROMINER'S PLAN OF COR	RECTION	COMPLETION		
(X4) NO PROPIN TAG	REACH DEFICIENC	Y MINT BE PRECEDED BY FULL LBC (DENTRYING INFORMATION)	PREFIX TAG	Ç	(BACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE UPPROPRIATE	CAYE		
K 000	INITIAL COMMEN	TS .	K 000						
	K3 BUILDING: 01	Į.		[]			[]		
· '	, KB PLAN APPROV	/AL: 05/01/1992		1	CE.		i		
	K7 SURVEY UND	er: 2000 EXISTING			0,00				
	STRUCTURE TYP PROTECTED WO FULLY SPRINKLE	OD PRAME, TYPE V (111), 🔠		: : : :	AN TO THE		A.A. IV. 14 - A.M. 1880		
	Department of Put Life Safety Code R findings are in acc Federal Regulation (National Fire Prot	cts the findings of the California blic Health, during an annual decertification survey. The ordance with 42 CFR (Code of hs) 483.70 (a) and NFPA section Association) 101, Life edition, Existing codes.		9	CALLOWING TO SERVICE THE CONTROL OF THE PARTY OF THE CONTROL OF TH	~ <b>%</b>			
	Representing the 6 Health: Surveyor: 31070	California Department of Public		ı			ļ!		
	CENSUS: 15			1			İ		
Kota	42 CFR(Code of F for long term care	n substantial compliance with instance with produced Regulations   483,70(e) facilities.	K 01	   			4		
88 <b>=</b> D	Doors protecting or required enclosure hazardous ereas a those constructed wood, or capable minutes. Doors in required to resist to	cordor openings in other than is of vertical openings, exits, or are substantial doors, such as of 1% inch solid-bonded core of resisting fire for at least 20 sprintdered buildings are only the passage of smoke. There is the closing of the doors. Ogors		į   .					
LABOR/INI	1	REPRESENTATIVES GO	NATURE	<del>. —</del>	TITLE		pus betti		

Any deficiency statement ending with an esterial (\*) denotes a dendency which the restrictions.) Except for rurning homes, the Bridge stated above are disclossible 90 days following the date of survey whether or not a plan of correction is provided. For rurning homes, the above findings and plane of correction are disclosed to days following the date of survey whether or not a plan of correction is provided. For rurning homes, the above findings and plane of correction are disclosed 14 days following the date these documents are made evaluable to the facility. If desidencies are olded, an approved plan of correction is requisite to continued program participation.

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIERICUA IDENTIFICATION NUMBER: OLD MULTIPLE CONSTRUCTION STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION A. BLIEDING 01 - MAIN BUILDING 01 12/24/2012 555143 STREET ADDRESS, CITY, STATE, ZP CODE NAME OF PROMOER OR SUPPLIER 100 BARNET SEGAL LANE WESTLAND HOUSE MONTEREY, CA 13940 PROVIDER'S PLAN OF CORRECTION
(BACK CORRECTIVE ACTION SHOULD BE
UROSE-REFERENCED TO THE APPROPRIATE
DEPICIENCY) BLAMMARY STATEMENT OF DEFICIENCIES (EACH DILPICKIONCY NUST BE PRECEDED BY FULL, REGULATORY OR LEC IDENTIFYING INFORMATION) COMPLETION DATE (X4) ID PREFIX TAG TAG K018 1. K 018 K 018 Continued From page 1 a. Work order issued to correct are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.5,3.6 WO #60754 b.Check all doors quarterly. are permitted. 19.3.5.3 c. Check all doors quarterly. Roller latches are prohibited by CMS regulations d. Monitor doors during fire drills in all health care facilities. - increase inspections if 5% of doors fail. e. Latching of door was corrected on January 4, 2013 KO18 2. This STANDARD is not met as evidenced by: Bezed on observation, the facility failed to a. Work order issued to correct maintain their fire doors, as evidenced one fire door that failed to latch and a door stucked in WO#59530 closed position. This deficient practice could b. Check all doors quarterly. result in the faster spread of smoke and fire. This c. Check all doors quarterly. affected 2 of 9 smoke compartments. d. Monitor doors during fire drills Finding: - increaseInspections if 5% of doors fail. During fire alerm testing with the Administrator, Assistant Director and the Safety Coordinator on e. Unlatching of door was 12/28/12, the fire doors were observed. corrected on December 31, 2012 1. At 4:00 p.m., the fire door to the Dining room released from the magnetic hold open device during fire starm testing but failed to latch. 2. At 4:19 p.m., the two fire doors to the Kilchen were observed. The leftside door was not on the magnetic hold-open device and was stuck in the closed position. The Assistant Director tried to open the door but was unsuccessful.

CENTERS FOR MELICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICARE & MEDICAID SERVICES  ENCIES TION  (X1) PROVIDENTIFICATION NUMBERS  565143		OCS MULTIPLE CONSTRUCTION  A, BUILDING 61 - MAIN SUILDING 61  B. WING			(XS) DAYE SURVEY COMPLETED 12/28/2012	
	ROVIDER OR SUPPLIER	000110	STREET ADDRESS, CITY, STATE, 2P CODE 180 BARRIET SEGAL LANE MONTEREY, CA 93840					
(X4) IO PREFIX TAG		NYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID FINE! YAY	nx !	PROVIDER'S PLAN OF COM- (EACH CORRECTIVE ACTION & GROSS-REFERENCED TO THE A OCTICIENCY)	ECTION HOULD BE PPROPRIATE	CONTLATA	
K 027 SS=E	Door openings in a 20-minute fire prote 1%-inch thick solid protective plates it from the bottom of Horizontal silding of Doors are self-clor accordance with 1 not required to swillatching is not required to smoke barrier of deficient practice of smoke and fire effected 5 of 9 am Findings:  During fire alarm to Assistant Director 12/28/12, the smootheart Director observed.  1. At 3/59 p.m., the hold-open device tailed to latch.	AFETY CODE STANDARD  Imake barriers have at least a sction rating or are at least a bonded wood core. Non-rated the door are permitted.  Isoars comply with 7.2.1,14. Ising or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive lired. 19.3.7.5, 19.3,7.6,  Is not met as evidenced by: Ition, the facility failed to like barrier doors, as evidenced doors that failed to latch. This could result in the faster spread in the event of a fire. This oke compartments.  In the exert of a fire. This oke compartments.  In the Safety Coordinator on the barrier doors were the smoke barrier doors to the seed from the magnetic during fire aterm testing but	K	027	KO27 1.  a. Work order issued to a WO #59529 b. Check all doors quarted. Monitor doors during — increase Inspections if doors fall. e. Latching of door was on December 31, 2012.  KO27 2.  a. Work order issued to WO #61311 b. Check all doors quarted. Monitor doors during — increase inspections in doors fail. e. Latching of door was on January 8, 2013.	erly. erly. fire drills 5% of corrected correct erly. erly. fire drills		
	Mr. Cose with rek	ne smoke barrier doors to the eased from the magnetic during fire alarm testing but						

#### PRINTED: 01/04/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER OCT) DATE SURVEY (PE) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLILDING 01 B. WING. 655143 12/28/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 BARNET SEGAL LANS WESTLAND HOUSE MONTEREY, CA 85040 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBICED TO THE APPROPRIATE, DEPICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEMCHINCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ÇM) COMPLETION DATE (NA) ID PRÉFEK TAG K027 3. K 027 Continued From page 3 K 027 a. Work order issued to correct failed to latch. WO #59531 At 4:06 p.m., the smoke barrier doors located b. Check all doors quarterly. by the Dock released from the magnetic c. Check all doors quarterly. hold-open device during fire elarm testing but , failed to latch. d. Monitor doors during fire drills - increase inspections if 5% The Safety Coordinator stated the smoke barrier doors fail. doors had recently been checked and all worked properly. e. Latching of door ws corrected K 052 NFPA 101 LIFE SAFETY CODE STANDARD K 052 on December 31, 2012. \$6=E A fire alarm system required for ille safety is installed, tested, and maintained in accordance K052 with NFPA 70 National Electrical Code and NFPA a. Letter to monitoring company 72. The system has an approved insintenance dated January 8, 2013. and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 b. Review quarterly to assure monthly reports are supplied report annually to Environment of Care Committee. c. Review quarterly to assure monthly reports are supplied report annually to Environment of Care Committee. This STANDARD is not met as evidenced by: d. Review quarterly to assure Based on document review, and interview, the facility failed to maintain its fire aterm system, as monthly reports are supplied evidenced by missing documentation for testing report annually to Environment alarm transmission with the outside monitoring of Care Committee. station for the last twelve months. This deficient practice could result in a malfunction of the fire e.Letter from monitoring alarm system going undetected and failure of the company listing all alarms for fire alerm system in the event of a fire. This 2012, on site by January 27, affected 9 of 9 smoke compartments.

FORM APPROVED OMB NO. 0938-0301 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (XX) DATE SURVEY COMPLETED (12) MULTIPLE CONSTRUCTION (X1) PROVIDER/GUPPLIER/GUA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER! **41 - MAIN BUILDING 01** D. WING. 12/28/2012 556143 SYREET ADDRESS, OITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 100 BARNET SEGAL LANE MONTERRY, CA 93940 WESTLAND HOUSE PROVIDER'S PLAN OF CONRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE BURBLAY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MILEY BE PRECEDED BY FULL REQUILATORY OR LISC IDENTIFYING INFORMATION) (X4) (D PROFIX TAG K052 K 052 K 052 Continued From page 4 a. Letter to monitoring company : Findings: dated January 8, 2013. During document review with the Administrator, b. Review quarterly to assure Assistant Director and the Safety Coordinator on monthly reports are supplied -12/2B/12, monthly alarm transmission signal report annually to Environment verification record were requested. of Care Committee. At 3:30 p.m., the were no records provided to c. Review quarterly to assure indicate the fire atom signals had been verified monthly reports are supplied for the past 12 months from the 24 hour report annually to Environment monitoring central station. of Care Committee. Upon interview the Assistant Director stated a d. Review quarterly to assure device had not been activated monthly except for the months the fire drills had been conducted and monthly reports are supplied no monthly alarm transmission signal verification report annually to Environment records had been kept. K 054 of Care Committee. K 054 NFPA 101 LIFE SAFETY CODE STANDARD e.Letter from monitoring 59**-**C All required amoke detectors, including those company listing all alarms for activating door hold-open devices, are approved. 2012, on site by January 27, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 2013. **K054** This STANDARD is not met as evidenced by: a. Letter to inspecting company Based on document review, the facility falled to to perform bi-annual sensitivity ensure the maintenance, inspection and testing of testing of the smoke detectors. the smoke detectors was performed, as evidenced by no documentation provided for the b. Letter to inspecting company amoke detector sensitivity test. This deficient to perform bi-annual sensitivity practice could result in a malfunction of the testing of the smoke detectors. smoke detectors and the delay in notification of fire. This affected 9 of 9 smoke compartments. c. Letter to inspecting company to perform bi-annual sensitivity NFPA 72, 7-5,2.1, Detector sensitivity shall be testing of the smoke detectors. checked within 1 year after installation and every

### PRINTED: 01/04/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES **4B NO. 0938-0391** STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (COMPLETED A. BUILDING 91 - MAIN BUILDING 61 B. WING\_ 565143 12/28/2012 HAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 100 BARNET BEGAL LANE WESTLAND HOUSE MONTEREY, CA 63940 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIAT (X4) ID PREFIX YAG (765) MPLETION OATE Ю PREFIX TAG MOPPLATE DEFICIENCY (K054) K 054 Continued From page 5 K 054 d. Review bi-annual testing, bialternate year thereafter. After the second required calibration test, if sensitivity tests annually and report to indicate that the detector has remained within its Environment of Care Committee, fished and marked sensitivity range (or 4 percent Testing of smoke detectors obscuration light gray smoke, if not marked), the length of time between calibration tests shall be with sensitivity testing will be permitted to be extended to a maximum of 5 completed by January 27, 2013. years. If the frequency is extended, records of detector-caused nuisance atarms and subsequent trends of these alarms shall be impinizined, in zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. : To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using eny of the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the ригрова. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity renge. (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction. Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Findings: During document review with the Administrator, Assistant Director and the Safety Coordinator on

12/28/12, the smoke detector sensitivity records

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

PRINTED: 01/04/2013 FORM APPROVED OMB NO. 0838-0391

STATEMENT OF DEPICENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555143		ULTIPI LDING IG	DE CONSTRUCTION  01 - MAIN BUILDING 01	COMPLETED 12/28/201	
NAME OF PROVIDER OR SUPPLIER WESTLAND HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BARNET SEGAL LANE MONTEREY, CA \$3849			
(K4) ID PREFIX TAG	WACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION 8 CROSS-REFERENCED TO YING AN DEPICIENCY)	HOULD BE	COMPLETION QUTE
	required calibration indicate that the delisted and marked to becuration light griength of time betw permitted to be extracted in zone alarms show any in calibration tests extracted using any of (1) Calibrated test (2) Manufacturer's instrument.  (3) Listed control expurpose.  (4) Smoke detector whereby the detector signal at the sensitivity is outside transported by the aujurts diction, sensitivity outside the marked sensitivity	sefter. After the second it set, if sensitivity tests tector has remained within its sensitivity range (or 4 percent ay smoke, if not marked), the sen calibration tests shall be sended to a maximum of 5 anded to a maximum of 5 action as and of these alarms shall be set or in areas where nuisance acresse over the previous year, all be performed. In amote detector is within its sensitivity range, it shall be the following methods: method. calibrated sensitivity test or causes a control unit arrangement or causes a its its de analitivity de sensitivity test methods thority having Detectors found to have a the listed and litivity range shall be cleaned	K	254	a.Letter to inspecting contoperform bi-annual service testing of the smoke decided by Letter to inspecting contoperform bi-annual servicesting of the smoke detic. Letter to inspecting conperform bi-annual sensitivesting of the smoke detic decided. Review bi-annual testing annually and report to Environment of Care Contoperform by January 27.	asitivity itors. impany asitivity ectors. impany to ivity ectors. ing, bi- mmittee. ectors	

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

PRINTED: 01/04/2013 FORM APPROVED OMB NO. 0838-0391

STATEMENT AND PLAN O	**************************************		1	LDING.	CONSTRUCTION 01 - MAIN BUILDING 51	COMB NO. 18530-039 COMPLETED 12/28/2012	
	ROVIDER ÖR SUPPLIER ND H <b>ÓUS</b> E			1001	T ADDRESS, CITY, STATE, ZIP CODE BARNET SEGAL LAME NTEREY, CA 83840		
(X4) IO PRISEIX TAG	(PACH OFFICIENC	ATOMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LEG IDENTIFYING INFORMATION	PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION B CROSS-REFERENCED TO THE AC DEFICIENCY)	ECTION HOULD BE PROPRIATE	OCHPLETON DATE
	Continued From page 8 were requested.  At 3:16 p.m., there were no documents provided to show that the facility had conducted the sensitivity testing of the smoke detectors. There was no report for testing, including a complete fast of smoke detectors, results of the sensitivity testing, or the name of the person conducting the tests. There was no documentation indicating that the smoke detectors were tested as required.  The last record for the smoke detector sensitivity was dated 2/20/10.  NFPA 101 LIFE SAPETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9,7.4.1. 19.3.5.8, NFPA 10			K 054  a. Letter to inspecting companies to perform bi-annual sensitivity testing of the smoke dectors. b. Letter to inspecting companies to perform bi-annual sensitivity testing of the smoke detectors. c. Letter to inspecting companies to perform bi-annual sensitivity testing of the smoke detectors. d. Review bi-annual testing, bi annually and report to Environment of Care Committee. Testing of smoke detectors with sensitivity testing will be completed by January 27, 201			
	Based on observementain their port evidenced by one was overcharged, result in the fire at extinguish a fire a This affected 1 of NFPA 10, 1998 E 1-6.2 Portable fire maintained in a fur condition, and key	is not mat as evidenced by: ation, the facility failed to table fire extinguisher. This was portable fire extinguisher that This deficient practice could dinguishers inability to nd being non-operable. 9 emoke compartments, dition extinguishers shall be tly charged and operable of in their designated places at y are not being use.			K064 a. Work order to remove extinguishers from serv WO#61326 and replace properly charge extinguish. During monthly Inspectinguisher not in the zone will be removed. c. Additional fire extinguisher had at a fire drills.	ice. with lishers. action any green uisher	

### FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (XX) DATE BURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEPICIONCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 B. WING . 655143 12/28/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 BARNET SEGAL LANE WESTLAND HOUSE MONTEREY, CA 93940 PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION BHOULD BE OROSS-REPERBIGED TO THE APPROPRIATE BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) COMPLETION DATE DGI) ID PRIEFIX TAG PREFIX TAG DEFICIENCY) (KO64) K 064 K 064 Continued From page 7 d. Monitor failures on a monthly 4-3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and basis and report finding annually thereafter at approximately 30-day intervals. Fire to Environment of Care extinguishers shall be inspected at more frequent Committee. intervals when circumstances require. e. Extinguisher was replaced on 4-3.2" Procedures. Periodic inspection of fire January 8, 2013. extinguishers shall include a check of a least the following items: (a) Location in designated Place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) "Safety seats and tamper indicators not K064 broken or missing a. Work order to remove fire (e) Fullness determined by weighing or "hefting" extinguishers from service. (f) Examination for obvious physical damage, WQ#61326 and replace with correation, leakings, or clogged nozzle properly charge extinguishers. (g) Pressure gauge reading or indicator in the b. During monthly inspection any operable range or position extinguisher not in the green zone (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) will be removed. (i) HM#8 tabel in place c. Additional fire extinguisher Findings: checks will be made at time of fire drills. During the facility tour with the Administrator. d. Monitor failures on a monthly Assistant Director and the Safety Coordinator on , 12/26/12, the portable fire extinguisher's were basis and report finding annually observed. to Environment of Care Committee. At 5:27 p.m., the portable fire extinguisher located in the Staff Lounge was overcharged. The e. Extinguisher was replaced on needle pointed to the red zone marked January 8, 2013. overcharged. The Assistant Director confirmed the fire

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XX) DATE SURVEY COMPLETED STATEMENT OF CEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIERICLIA (K2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. A. BUILDING O1 - MAIN BUILDING O1 B, YUNG 12/28/2017 555143 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 100 BARNET SEGAL LANE WESTLAND HOUSE MONTEREY, CA 93040 PROVIDER'S PLAN OF CORRECTION
(EACH CONTRECTIVE AUTION BHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) COMPLETION DATE (X4) ID PREPIX TAG BLAIMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL Ю PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION K 084 K 064 Continued From page 8 extinguisher was overcharged and the needle K147 pointed to the red zone marked overcharged. a. Work order issued to remove. K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 WO#61310 88=D Electrical wiring and equipment is in accordance b.All multi plug strips will be with NFPA 70. National Electrical Code. 9.1.2 removed from service by January 27. 2013. c.All multi plug strips will be This STANDARD is not met as evidenced by: removed from service by January Based on observation, the facility failed to maintain electrical safety. This was evidenced by 27, 2013. the use of multi-plug strip. This deficient practice d.All multi plug strips will be could result in a electrical fire. This affected 1 of removed from service by January 9 amoke compartments. 27, 2013. NFPA 70, 1999 edition e.All multi plug strips will be 240-4 Flexible cord, including tinsel cord and removed from service by January extension cords, and flature wires shall be protected against overcurrent by either (a) or (b). 27, 2013. (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixure wire shall be protected against overcurrent in accordance with its empacity as specified in Table 402-5. Supplementary overpurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or , (3) Where run through doorways, windows, or

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0838-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (XXI) DATE SURVEY STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: A. BUILDING \$1 - MAIN BUILDING 01 B, WING 12/28/2012 555143 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 100 BARNET SEGAL LANE WESTLAND HOUSE MONTEREY, CA 93840 PROVIDERS PLAY OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REPERENCED TO THE APPROPRIATE
DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATIONS PLETTON OK4) ED PREMITIX | YAG PREFIX ! TAG K147 K 147 K 147 Continued From page 9 a. Work order issued to remove. similar openings WO#61310 (4) Where attached to building surfaces (5) Where concealed behind building walls, b.All multi plug strips will be structural ceilings, suspended ceilings, dropped removed from service by January ceilings, or floors 27, 2013. (f) Where installed in raceways; except as otherwise permitted in this Code c.Ali multi plug strips will be removed from service by January Findings: 27, 2013. During the facility tour with the Administrator, d.All multi plug strips will be Assistant Director and the Safety Coordinator on removed from service by January 12/28/12, the electrical equipment and wiring 27, 2013. were observed. e,All multi plug strips will be , At 4:58 p.m., there was a lamp plugged to 9 removed from service by January multi-plug strip located in the entrance lobby. The tamp was not plugged directly into the wall outlet 27, 2013.