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

PRINTED: 01/04/2013
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
	555143	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAND HOUSE	100 BARNET SEGAL LANE MONTEREY, CA 93940

(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: 05/01/1992 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, PROTECTED WOOD FRAME, TYPE V (111), 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: Surveyor: 31070 CENSUS: 15 The facility is not in substantial compliance with 42 CFR(Code of Federal Regulations) 483.70(a) for long term care facilities.	K 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JAN 18 2013 L & C DIVISION SAN JOSE	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors	K 018		

LABOR/ [redacted] REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 1-17-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their fire doors, as evidenced one fire door that failed to latch and a door stucked in closed position. This deficient practice could result in the faster spread of smoke and fire. This affected 2 of 9 smoke compartments. Finding: During fire alarm testing with the Administrator, Assistant Director and the Safety Coordinator on 12/28/12, the fire doors were observed. 1. At 4:00 p.m., the fire door to the Dining room released from the magnetic hold open device during fire alarm testing but failed to latch. 2. At 4:10 p.m., the two fire doors to the Kitchen 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.	K 018	K018 1. a. Work order issued to correct WO #60754 b.Check all doors quarterly. c. Check all doors quarterly. d. Monitor doors during fire drills – increase inspections if 5% of doors fail. e. Latching of door was corrected on January 4, 2013 K018 2. a.Work order issued to correct WO#59530 b. Check all doors quarterly. c. Check all doors quarterly. d. Monitor doors during fire drills – increaseInspections if 5% of doors fail. e. Unlatching of door was corrected on December 31, 2012	

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K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke barrier doors, as evidenced by smoke barrier doors that failed to latch. This deficient practice could result in the faster spread of smoke and fire in the event of a fire. This effected 6 of 9 smoke compartments. Findings: During fire alarm testing with the Administrator, Assistant Director and the Safety Coordinator on 12/28/12, the smoke barrier doors were observed. 1. At 3:59 p.m., the smoke barrier doors to the Rehab. Dept. released from the magnetic hold-open device during fire alarm testing but failed to latch. 2. At 4:05 p.m., the smoke barrier doors to the Mc Cone wing released from the magnetic hold-open device during fire alarm testing but	K 027	K027 1. a.Work order issued to correct WO #59529 b. Check all doors quarterly. c. Check all doors quarterly. d. Monitor doors during fire drills – increase inspections if 5% of doors fail. e. Latching of door was corrected on December 31, 2012. K027 2. a.Work order issued to correct WO #61311 b. Check all doors quarterly. c. Check all doors quarterly. d. Monitor doors during fire drills – increase inspections if 5% doors fail. e. Latching of door was corrected on January 8, 2013.	

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K 027	Continued From page 3 failed to latch. 3. At 4:06 p.m., the smoke barrier doors located by the Dock released from the magnetic hold-open device during fire alarm testing but failed to latch. The Safety Coordinator stated the smoke barrier doors had recently been checked and all worked properly.	K 027	K027 3. a.Work order issued to correct WO #59531 b. Check all doors quarterly. c. Check all doors quarterly. d. Monitor doors during fire drills – increase inspections if 5% doors fail. e. Latching of door ws corrected on December 31, 2012.	
K 052 S&E	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 its fire alarm system, as evidenced by missing documentation for testing alarm transmission with the outside monitoring station for the last twelve months. This deficient practice could result in a malfunction of the fire alarm system going undetected and failure of the fire alarm system in the event of a fire. This affected 9 of 9 smoke compartments.	K 052	K052 a. Letter to monitoring company dated January 8, 2013. 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. d. Review quarterly to assure monthly reports are supplied – report annually to Environment of Care Committee. e.Letter from monitoring company listing all alarms for 2012, on site by January 27, 2013.	

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K 052	Continued From page 4 Findings: During document review with the Administrator, Assistant Director and the Safety Coordinator on 12/28/12, monthly alarm transmission signal verification record were requested. At 3:30 p.m., the were no records provided to indicate the fire alarm signals had been verified for the past 12 months from the 24 hour monitoring central station. Upon interview the Assistant Director stated a device had not been activated monthly except for the months the fire drills had been conducted and no monthly alarm transmission signal verification records had been kept.	K 052	K052 a. Letter to monitoring company dated January 8, 2013. 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. d. Review quarterly to assure monthly reports are supplied – report annually to Environment of Care Committee. e.Letter from monitoring company listing all alarms for 2012, on site by January 27, 2013.	
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review, the facility failed to ensure the maintenance, inspection and testing of the smoke detectors was performed, as evidenced by no documentation provided for the smoke detector sensitivity test. This deficient practice could result in a malfunction of the smoke detectors and the delay in notification of fire. This affected 9 of 9 smoke compartments. NFPA 72, 7-3.2.1, Detector sensitivity shall be checked within 1 year after installation and every	K 054	K054 a. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors. b. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors. c. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors.	

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K 054	Continued From page 5 alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. 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 any of the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (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	K 054	(K054) d. Review bi-annual testing, bi-annually and report to Environment of Care Committee. e. Testing of smoke detectors with sensitivity testing will be completed by January 27, 2013.	

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K 054	Continued From page 5 alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. 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 any of the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (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	K 054	K054 a. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke dectors. b. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors. c. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors. d. Review bi-annual testing, bi-annually and report to Environment of Care Committee. e. Testing of smoke detectors with sensitivity testing will be completed by January 27, 2013.	

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K 054	Continued From page 6 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 list 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.	K 054	K054 a.Letter to inspecting company to perform bi-annual sensitivity testing of the smoke dectors. b. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors. c. Letter to inspecting company to perform bi-annual sensitivity testing of the smoke detectors. d. Review bi-annual testing, bi-annually and report to Environment of Care Committee. e. Testing of smoke detectors with sensitivity testing will be completed by January 27, 2013.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguisher. This was evidenced by one portable fire extinguisher that was overcharged. This deficient practice could result in the fire extinguishers inability to extinguish a fire and being non-operable. This affected 1 of 9 smoke compartments. NFPA 10, 1998 Edition 1-6.2 Portable fire extinguishers shall be maintained in a fully charged and operable condition, and kept in their designated places at all time when they are not being use.	K 064	K064 a.Work order to remove fire extinguishers from service. WO#61326 and replace with properly charge extinguishers. b. During monthly inspection any extinguisher not in the green zone will be removed. c. Additional fire extinguisher checks will be made at time of fire drills.	

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K 064	Continued From page 7 4-3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. 4-3.2* Procedures. Periodic inspection of fire 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 seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place Findings: During the facility tour with the Administrator, Assistant Director and the Safety Coordinator on 12/28/12, the portable fire extinguisher's were observed. At 5:27 p.m., the portable fire extinguisher located in the Staff Lounge was overcharged. The needle pointed to the red zone marked overcharged. The Assistant Director confirmed the fire	K 064	(K064) d. Monitor failures on a monthly basis and report finding annually to Environment of Care Committee. e. Extinguisher was replaced on January 8, 2013. K064 a.Work order to remove fire extinguishers from service. WO#61326 and replace with properly charge extinguishers. b. During monthly inspection any extinguisher not in the green zone will be removed. c. Additional fire extinguisher checks will be made at time of fire drills. d. Monitor failures on a monthly basis and report finding annually to Environment of Care Committee. e. Extinguisher was replaced on January 8, 2013.	

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K 084	Continued From page 8 extinguisher was overcharged and the needle pointed to the red zone marked overcharged.	K 084		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain electrical safety. This was evidenced by the use of multi-plug strip. This deficient practice could result in a electrical fire. This affected 1 of 9 smoke compartments. NFPA 70, 1999 edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (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). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent 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 floors (3) Where run through doorways, windows, or	K 147	K147 a.Work order issued to remove. WO#61310 b.All multi plug strips will be removed from service by January 27, 2013. c.All multi plug strips will be removed from service by January 27, 2013. d.All multi plug strips will be removed from service by January 27, 2013. e.All multi plug strips will be removed from service by January 27, 2013.	

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K 147	Continued From page 9 similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code Findings: During the facility tour with the Administrator, Assistant Director and the Safety Coordinator on 12/28/12, the electrical equipment and wiring were observed. At 4:58 p.m., there was a lamp plugged to a multi-plug strip located in the entrance lobby. The lamp was not plugged directly into the wall outlet.	K 147	K147 a.Work order issued to remove. WO#61310 b.All multi plug strips will be removed from service by January 27, 2013. c.All multi plug strips will be removed from service by January 27, 2013. d.All multi plug strips will be removed from service by January 27, 2013. e.All multi plug strips will be removed from service by January 27, 2013.	