STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555268	A. BUILDING 01 B. WING _____	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE VILLAGE	5555 MONTGOMERY DRIVE SANTA ROSA, CA 95409

(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: 1986 K7 SURVEY UNDER: 2000 EXISTING K8 SNF TYPE OF STRUCTURE: ONE STORY CONSTRUCTION, TYPE V (111), FULLY SPRINKLERED The following represents the findings of the California Department of Public Health, Life Safety Code Unit, during an annual Recertification Life Safety Code survey of the facility utilizing the NFPA (National Fire Protection Association) 101, 2000 Edition (existing) of the Life Safety Code. The facility was surveyed under 42 CFR (Code of Federal Regulations) 483.70 (a) for Long Term Care facilities. Representing the California Department of Public Health, Life Safety Code Unit: 21101 Census: 53	K 000	Spring Lake Village Nursing Center (Facility) makes its best effort to operate in substantial compliance with both Federal and State Law. Nothing in this Plan of Correction is an admission otherwise. The facility has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. The facility is submitting this plan of correction as required by law as its written credible allegation of compliance for the alleged deficiencies noted.	
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	K 018	**Corrective action for residents affected by alleged deficient practice:** No residents were affected by this life safety code standard not being met	10/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 10/4/11

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.

POC acceptable per Marian DeMeire 10/7/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555268	A. BUILDING 01 B. WING _____	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE VILLAGE	5555 MONTGOMERY DRIVE SANTA ROSA, CA 95409

(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 018	Continued From page 1 no impediment to the closing of the doors. Doors 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 the integrity of the corridor doors. This was evidenced by failing to keep impediments from obstructing the closing of doors. This failure could result in the spread of fire and smoke in the event of a fire, and could result in potential harm to residents in 1 of 6 smoke compartments. Findings: During a tour of the facility with the Director of Facility Services on September 21, 2011, the corridor doors were observed. 1. At 10:36 a.m., the door to Resident Room 106 failed to latch upon closure. The door was observed to have a gait belt that was hanging from the the door handle, that impeded the latching mechanism. 2. At 10:39 a.m., the door to Resident Room 109	K 018	**How facility will identify residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice; therefore, the facility immediately removed the gait belts from the door handles in all affected rooms **Measures or systemic changes made to ensure alleged deficient practice does not recur:** Maintenance is installing hooks inside the resident rooms for the gait belts to be placed. Nursing staff were notified of this deficient practice immediately and all staff will be educated as to the need to use hooks rather than the door handles and that nothing should be placed on door handles that could impede the latching mechanism.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555268	A. BUILDING 01 B. WING _____	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE VILLAGE	5555 MONTGOMERY DRIVE SANTA ROSA, CA 95409

(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 018	Continued From page 2 failed to latch upon closure. The door was observed to have a gait belt that was hanging from the the door handle, that impeded the latching mechanism.	K 018	**How facility will monitor corrective action:** Monitoring will be conducted through daily rounds by the Administrator, DSD, DON and Nursing Supervisors to ensure compliance. **How facility will evaluate corrective action:** Reports of rounds will be given to the monthly Quality Assurance Committee to track and trend compliance. Any findings that are not in compliance will be corrected immediately and staff education provided.	10/21/11