

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

PRINTED: 10/02/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>630012194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/01/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERSIDE PD CENTRAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3660 PARK SIERRA DRIVE, SUITE 108 RIVERSIDE, CA 92505</b>	
(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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18928 The following reflects the findings of the California Department of Public Health during an Initial Certification visit conducted on 4/17/09.</p> <p>Representing the Department: Karen A. Eggleston, HFEN Octavio E. Relopez, HFEN Lourdes Singh, HFEN Jerry Leggett, HFEI</p> <p>All regulations met for Initial Certification, recommend Certification effective April 17, 2009.</p> <p>Surveyor: 26387 The following represents the findings of the Department of Public Health, Life Safety Code Unit, during an Initial Certification 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) 416.44 (b) for Ambulatory Surgery Centers.</p> <p>K3 BUILDING: 01 K6 PLAN APPROVAL: 2008 K7 SURVEY UNDER: 2000 NEW</p> <p>STRUCTURE TYPE: Two Story Building, Type V (III), Fully Sprinklered, B Class Occupancy, single suite in a business occupancy.</p> <p>The facility is not in compliance with 42 CFR 416.44 (b) for Ambulatory Surgery Centers.</p> <p>Census: 1</p>	V 000		
V 417	494.60(e)(1) FIRE SAFETY	V 417		7/3/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

PRINTED: 10/02/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>630012194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERSIDE PD CENTRAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3660 PARK SIERRA DRIVE, SUITE 108 RIVERSIDE, CA 92505</b>		
(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	
V 417	Continued From page 1  Except as provided in paragraph (e)(2) of this section, by February 9, 2009. The dialysis facility must comply with applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference at §403.744(a)(1)(i) of this chapter).  This STANDARD is not met as evidenced by: Surveyor: 26387 This Standard is not met as evidenced by: K114 Based on observation, the facility failed to maintain the integrity of the building construction as evidenced by unsealed penetrations in the smoke barrier walls. This would allow smoke and fire to travel through compartments in the building and cause potential harm to patients and staff in the event of a fire emergency. This affected 1 patient and staff.  Findings:  During the facility tour with Staff 1 on July 1, 2009, the building construction was examined.  At 11:31 a.m., there were two unsealed penetrations in the South wall before the entrance to the facility from the hallway. One penetration was a 3/4 inch unsealed pipe sleeve and the other penetration was a 1/2 inch unsealed hole in the wall.  At 11:43 a.m., there were two unsealed	V 417			

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

PRINTED: 10/02/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>630012194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERSIDE PD CENTRAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3660 PARK SIERRA DRIVE, SUITE 108 RIVERSIDE, CA 92505</b>		
(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	
V 417	<p>Continued From page 2</p> <p>penetrations in the smoke barrier wall in Exam Room 2. One penetration was above a ¾ inch black pipe that was 1 inch in size and the other penetration was near a 2 inch by 6 inch wooden beam and was 6 inches by ½ inch in size in the drywall.</p> <p>This Standard is not met as evidenced by: K147 Based on observation, the facility failed to maintain the electrical system in accordance with NFPA 70, as evidenced by appliances plugged into a multi-plug power strip and not directly into the wall. This could potentially cause a fire and potential harm to patients and staff. This affected 1 patient and staff.</p> <p>Findings:</p> <p>During a tour of the facility with Staff 1 on July 1, 2009, the electrical system was examined.</p> <p>At 10:16 a.m., there was a microwave oven and a toaster oven that was plugged into a multi-plug power strip in the staff break room.</p> <p>This Standard is not met as evidenced by: K051 Based on observation, the facility failed to maintain the fire alarm system as evidenced by the failure of the Inspector Test Valve to sound an alarm and the Post Indicator Valve was unsecured. Someone could turn off the water to the sprinkler system and the sprinkler could be activated and the alarm would not notify the tenants in the building. This could cause harm to patients and staff in the event of a fire emergency. This affected 1 patient and staff.</p>	V 417			

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

PRINTED: 10/02/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>630012194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERSIDE PD CENTRAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3660 PARK SIERRA DRIVE, SUITE 108 RIVERSIDE, CA 92505</b>		
(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
V 417	Continued From page 3 Findings:  During the facility tour with facility staff 1, 2, and 3, on July 1, 2009, the fire alarm system was tested and examined.  At 12:37 p.m., the Inspector Test Valve was opened and the water flowed for 95 seconds and the alarm failed to sound. The valve was opened a second time for 100 seconds and the alarm system failed to sound an alarm.  At 12:42 p.m., the Post Indicator Valve was inspected, the valve located outside on the West side of the building was unsecured.  At 2:28 p.m., the Inspector Test Valve was retested and the flow switch was manually pressed and switch failed to activate an alarm. The facility Administrator initiated a fire watch until the fire alarm system was repaired.	V 417		