STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055408	A. BUILDING 01 - MAIN BUILDING 01 [redacted] B. WING _____	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLFLOWER POST ACUTE	9710 E. ARTESIA AVE BELLFLOWER, CA 90706

(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 The following represents the findings of the Department of Public Health Services during the Life Safety Code Survey. Representing the Department of Public Health: Surveyor ID #12007, REHS, HFE-I Census: 49 Highest Scope and Severity - F	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code and Code of Federal Regulations	9/16/16
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B or C flame spread rating finish in wall by having unsealed penetrations through the walls in medical and nurses lounge rooms, in housekeeping room, in laundry room and inside the MDS office, thereby, compromising the fire rating and containment of smoke and/or fire by the fire rated surfaces. The deficiency affected two of three smoke compartments. Findings: On 8/19/16 at 7:55 a.m., during the Life Safety	K 015	This plan of correction serves as the written credible allegation of compliance by Bellflower Post Acute. K 015 It is the policy of this facility to comply with the standards of K 015, especially in maintaining a Class A, B, or C flame spread rating finish in all walls; particularly of having no unsealed penetrations. The following corrective actions were promptly undertaken when the evaluator pointed them out: 1. 1-inch penetrations in the wall inside medication room and the nurses' lounge rooms were accordingly sealed; using fire retardant sealant (8/19/16). 2. The penetration in the wall measuring 3-inches inside the housekeeping closet	

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HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Agustin | TITLE: Administrator | (X6) DATE: 9/2/16

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 015	Continued From page 1 Code (LSC) tour in the presence of maintenance supervisor, the following deficiencies were noted: 1. The evaluator observed 1-inch penetrations in the wall inside medication and the nurses' lounge rooms. 2. The evaluator noted a penetration in the wall measuring 3-inches inside the house-keeping closet located next to Room 28. 3. The evaluator observed a 2-inch penetration in laundry room wall located behind the laundry washer and hand-washing sink. 4. There evaluator observed a penetration in the wall measuring 8-inches inside the MDS (Minimum Data Set) office. In an interview on the same date at 8:25 a.m., the maintenance supervisor acknowledged the findings and stated that the penetrations will be sealed with a fire retardant sealant. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on 8/19/16.	K 015	located next to room 28 is accordingly sealed; using fire retardant sealant (8/19/16). 3. The 2-inch penetration in laundry room wall location behind the laundry washer and hand-washing sink is accordingly sealed; using fire retardant sealant 8/19/16). 4. The penetration in the wall measuring 8-inches inside the MDS office is accordingly sealed; fire retardant sealant (8/19/16). To identify other residents having the potential to be affected by this deficiency, the maintenance staff conducted a facility-wide inspection on 8/22/16; all penetrations are accordingly sealed. To ensure that this deficiency does not recur, the Maintenance Staff conducts daily physical plant rounds; addressing on a daily basis any identified penetrations. Weekly, the Maintenance Supervisor updates the administrator of any maintenance tasks related to addressing/sealing of identified penetrations. The administrator will conduct monthly quality assurance spot-checks; particularly in walls inside medication/nurse lounge, housekeeping closets and laundry room. Monthly, the Maintenance Supervisor will update the Quality Assurance Committee during its meeting of any planned/accomplished maintenance tasks/projects related to compliance with the I ntent of K 015.	
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 shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is	K 018		

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K 018	Continued From page 2 no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the exit corridor doors in residents' sleeping rooms were able to resist the passage of smoke by having the doors impeded from closing freely and without impediments. In the event of a fire emergency, rapid closure with a means suitable for keeping the doors closed without any impediments or penetrations are essential components in the containment of smoke and/or fire. The deficiency affected two of three smoke compartments. Findings: On 8/19/16, at 3:25 p.m., during the Life Safety Code (LSC) tour of the facility in the presence of the maintenance supervisor, the evaluator observed one over-bed table in Room 9 and two resident wheelchairs in Rooms 1 and 14 that impeded resident room doors from closing. The evaluator also observed four residents' doors in Rooms 8, 10, 11 and 26 that failed to positively latched when closed. In an interview on the same date at 4:05 p.m., the maintenance supervisor stated that residents' doors were supposed to be free from obstruction	K 018	Quality Assurance Committee will evaluate facility compliance during its quarterly Meetings. Administrator will monitor consistent compliance with K 015. K 018 It is the policy of this facility to ensure that the exit corridor doors in resident sleeping rooms are able to resist the passage of smoke by having the doors not impeded from closing freely and without impediments. When this matter was pointed-out by the evaluator, the following corrective measures were promptly undertaken: The over-bed table in Room 9 was removed from its impeding location at the door, the wheelchairs in room 1 and 14 were accordingly removed from its obstructing location. The aforementioned rooms have doors that freely close without impeding over-bed able or wheelchairs (8/19/16). The maintenance staff fixed the resident doors in rooms 8, 10, 11, and 26; these doors now positively latch (8/22/16). To identify other residents having the potential to be affected by this deficiency, the maintenance staff conducted a facility-wide check on 8/23/16; all doors positively latch in accordance with the intent of K 018. To ensure that this deficiency does not recur, the Maintenance Staff conducts daily physical plant rounds; addressing on a daily basis any identified doors that do not positively latch.	9/6/16

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K 018	Continued From page 3 at all times. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on 8/19/16.	K 018	Weekly, the Maintenance Supervisor updates the administrator of any maintenance tasks related to addressing/fixing of identified doors that are impeded to close freely and/or not positively latching. The administrator will conduct monthly quality assurance spot-checks; particularly the exit corridor doors in sleeping rooms that they are not impeded from closing freely and and without impediments. Monthly, the Maintenance Supervisor will update the Quality Assurance Committee during its meeting of any planned/accomplished maintenance tasks/projects related to compliance with the I intent of K 018. The Quality Assurance Committee will evaluate facility compliance during its quarterly meetings. Administrator will monitor consistent compliance with K 018.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire rated smoke barrier wall by having a penetration through the smoke barrier. Failure to maintain a half hour fire resistance rating may put residents, staffs and visitors at risk of fire and/or smoke during a fire/smoke emergency. This deficiency had the potential to affect two of three smoke compartments. Findings: During an inspection of the smoke barrier wall on 8/19/16 at 4:30 p.m., in the presence of the maintenance supervisor, the evaluator observed a 2.5-inch penetration/opening in the smoke barrier wall above the cross-corridor double fire doors located between Rooms 20 and 21. During an interview on the same date (8/19/16) at 4:35 p.m., the maintenance supervisor acknowledged the findings and stated he would	K 025	**K 025** It is the policy of this facility to adhere to the standard of K 025; particularly in maintaining the fire rated smoke barrier wall has no penetration of the smoke barrier. The 2.5-inch penetration/opening in the smoke barrier wall above the cross-corridor double fire doors located between Rooms 20 and 21 is now accordingly sealed; using a fire resistant sealant (8/19/16). To identify other residents having potential to	9/16/16

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K 025	Continued From page 4 have the opening sealed with fire resistant sealant as soon as possible. This deficient practice was brought to the attention of the administrator and maintenance supervisor on 8/19/16, during the exit conference.	K 025	be affected by this deficiency; the maintenance staff conducted a facility-wide check on 8/19/16; no other fire rated smoke barrier wall has a penetration through the smoke barrier.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Standard: NFPA 101, Sect. 19.3.2.1 states that any hazardous areas shall have smoke-resisting doors that are self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 Square ft. (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 sq. ft. (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or	K 029	To ensure that this deficiency does not recur, the Maintenance Staff conducts daily physical plant rounds; addressing on a daily basis any identified doors that do not positively latch. Weekly, the Maintenance Supervisor updates the administrator of any maintenance tasks related to addressing/sealing/maintaining the fire rated smoke barrier wall not to have penetrations through the smoke barrier. The administrator will conduct monthly quality assurance spot-checks; particularly the smoke barrier walls. Monthly, the Maintenance Supervisor will update the Quality Assurance Committee during its meeting of any planned/accomplished maintenance tasks/projects related to compliance with K 025. Quality Assurance Committee will evaluate facility compliance during its quarterly meetings. Administrator will monitor consistent compliance with K 025. **K 029** It is the policy of this facility that its storage areas greater than 50 square feet are filled with combustible materials have corridor doors that are self-closing and positively latching.	9/16/16

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K 029	Continued From page 5 combustible materials in quantities less than those that would be considered a severe hazard. This requirement is not met as evidenced by: Based on observation and interview during the LSC inspection, the facility failed to ensure that storage areas greater than 50 square feet filled with combustible materials, had corridor doors that was self-closing and positively latching. In the event of a fire, containment of smoke and fire would not be achieved with non-latching self-closing doors in a hazardous use area. The deficiency affected one of three smoke compartments. Findings: On 8/19/16, at 3:00 p.m., during the LSC inspection tour of the facility in the presence of the maintenance supervisor, the evaluator observed that the door of medical storage room that opened to the facility corridor was not equipped with a self-closing door device. The size of the medical storage room which contained piles of medical record binders and folders that were stored on shelves was 65 square feet. In an interview on the same date at 3:15 p.m., the maintenance supervisor acknowledged the findings and stated that a self-closing device would be installed. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 8/19/16.	K 029	As a corrective action, the door of the medical records storage room is now equipped with a self-closing door device (8/24/16). To identify other residents having potential to be affected by this deficiency; the maintenance staff conducted a facility-wide check on 8/24/16; all storage areas in the context of the intent of K 029 are now equipped with self-enclosing device. To ensure that this deficiency does not recur, the Maintenance Staff conducts daily physical plant rounds; addressing on a daily basis any identified doors that do not have self-enclosing device as required by the intent of K 029. Weekly, the Maintenance Supervisor updates the administrator of any maintenance tasks related to repair/installation of self-enclosing devices on corridor doors as required under K 029. The administrator will conduct monthly quality assurance spot-checks; particularly in storage areas greater than 50 square feet filled with combustible materials. Monthly, the Maintenance Supervisor will update the Quality Assurance Committee during its meeting of any planned/accomplished maintenance tasks/projects related to compliance with K 029. Quality Assurance Committee will evaluate facility compliance during its quarterly meetings. Administrator will monitor consistent compliance with K 029.	

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K 061 K 061 SS=F	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the automatic sprinkler system shut off valve was supervised by at least a local alarm when the main water line to the sprinkler system was turned off. Because of the lack of an audible local alarm, the facility staff members will be unable to receive notification that the shut off valve had been deactivated and the facility would be without the protection of an automatic suppression system during a fire emergency. An effective audible local alarm at all times and under all conditions, is essential in alerting the facility's staff members that the water shut off from the automatic sprinkler system's shut off valve had been deactivated. The deficiency affected three of three smoke compartments. Findings: On 8/19/16, at 11:00 a.m., during a test of the facility's automatic sprinkler system, the maintenance supervisor tested the Butterfly-Valve tamper switch by shutting off the sprinkler main water line. The tamper switch was located in the street at the front exterior of the facility. During the test, the tamper switch failed to activate a local audible alarm at the facility's fire	K 061 K 061	K 061 It is policy of this facility to adhere to the requirement of K 061. The Tamper Switch functions properly and activates audible and visual trouble conditions at the annunciator panel (8/26/16). To identify other residents having potential to be affected by this deficiency; the maintenance staff conducted a facility-wide check on 8/19/16; the building has no other Tamper Switch that fails to provide audio and visual signals at the fire alarm annunciator panel. To ensure that this deficiency does not recur, the Maintenance Staff coordinates with the facility vendor that services its automatic sprinkler system on a monthly routine. During daily physical plant rounds; the maintenance supervisor will coordinate prompt repair of any observed/noticeable issues related to compliance with the intent of K 061. Weekly, the Maintenance Supervisor updates the administrator of any repair/installation of equipment in the	9/16/16

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K 061	Continued From page 7 alarm/trouble annunciator panel located inside Nurses' Station 1 next to the front lobby. The test was repeated twice times between 11:00 - 11:09 a.m. At the time the service repair company arrived at approximately 2:30 p.m., the tamper switch still failed to provide audio and visual signals (indicator light) at the fire alarm annunciator panel. In an interview, on the same date, at 3:40 p.m., the administrator stated that the alarm service company is and will continue to work on the repair of the defective tamper switch alarm. At 11:45 a.m., the facility activated a Fire Watch exercise pending the completion of the repair of the defective temper switch valve. A review of the Service Company's invoice #30028552 and dated 8/19/16 indicated that, due to age and type of device, the Temper Switch was defective and MUST be replaced. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 8/19/16.	K 061	context of complying with the intent K 069. Monthly, the Maintenance Supervisor will update the Quality Assurance Committee during its meeting of any planned/accomplished maintenance projects related to compliance with K 069. Quality Assurance Committee will evaluate facility compliance during its quarterly meetings. The administrator will monitor consistent compliance with K 061.	