STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555065	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

Annie Woods
Digitally signed by Annie Woods
DN: cn=Annie Woods, o=West District Office, ou=HFID, email=awoods@cdph.ca.gov, c=US
Date: 2012.12.07 09:54:53 -08'00'

(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 This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health Services during the Life Safety Code Survey. Representing the Department of Public Health Services: 13183, HFE I, Life Safety Code Specialist Licensed = 99 beds Census = 96 residents Highest Scope and Severity = F	K 000	View Park Convalescent Hospital makes its best efforts to operate in full compliance with both Federal and State regulations. Nothing included in this plan of correction is an admission otherwise. View Park Convalescent Hospital has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objection to the merit or form of allegation contained herein. The submission of this plan of correction constitutes our allegation for compliance.	
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 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.	K 018	K018 RECEIVED NOV 01 2012 By _____ a- Upon notification, 10/15/2012 the item (geri-chair) was immediately removed from blocking corridor door to Room 120 b-The Maintenance Supervisor and Safety Coordinator will monitor daily-through rounds to ensure that the corridor doors are free from all obstruction. In-service was given to all staff on 10/15/2012 regarding means of egress are continuously free of all obstructions or impediments to full instant use if case of fire or other emergency	10/15/2012 10/15/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Henry Mogomo	Administrator	11/01/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that there were no impediments to the closing of the corridor doors by blocking a sleeping room door open with a recliner. In the event of a fire emergency, rapid closure of doors, without any impediments, is an essential component in the containment of smoke and/or fire. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings: On October 15, 2012, from 8:45 a.m. to 10 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed that the corridor door to Room 120 would not close completely because the door was blocked open with a geri-chair (recliner). A review of the resident census revealed that there were three residents that resided in the room. During an interview with the maintenance supervisor at the time of the observation, he stated he could not explain why staff stored a geri-chair in front of the door. The deficiency affected one out of four smoke compartments on the sleeping room level.	K 018	c- All department head members and licensed nurses will monitor daily -- through observation & rounds to ensure egress is free of obstructions. Administrator will do random checks on the physical plant to ensure safe a environment. Finding will be reviewed in the monthly Safety Committee Meeting. d- The Maintenance Supervisor on a monthly basis will complete recapitulation of his finding regarding of physical plant condition and any issues compromising the safety of the environment at the Monthly Quality Assurance Committee Meeting for review and action indicated.	

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K 018	Continued From page 2 The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012.	K 018		
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 and interview, the facility failed to provide a 20-minute fire protection rating at one of four sets of cross-corridor smoke barrier doors by having a 1/2-inch gap between the double swinging doors when closed completely after the activation of the fire alarm system. In the event of a fire and/or smoke, the opening gaps between smoke barrier doors would allow smoke and/or fire to spread to the other smoke compartment. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings: On October 15, 2012, from 8:45 a.m. to 10 a.m., during a tour of the facility, the evaluator, in the	K 027	K027 a- Upon notification, Maintenance Supervisor installed the astragal to fill the gap between cross-corridor fire door on 10/16/2012 b-The Maintenance Supervisor and Safety Coordinator will monitor through environmental observation & rounds to ensure cross-corridor fire doors to have at least a 20-minute fire protection rating c- Dietary Supervisor and Maintenance Supervisor will complete environmental rounds to ensure a safe environment d-The Maintenance Supervisor will complete a recapitulation of his finding regarding physical plant condition and any issues compromising the safety of the environment at the Monthly Quality Assurance Committee Meeting for review and action as needed	10/16/2012

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K 027	Continued From page 3 presence of the maintenance supervisor, observed a 1/2-inch vertical gap between the cross-corridor fire doors by Room 124 when the doors were closed after the activation of the fire alarm system. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the requirement but would install an astragal to prevent the spread of smoke in the event of a fire. The deficiency affected two out of four smoke compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012.	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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: Based on observation and interview, the facility failed to separate the boiler room/ electrical panel	K 029	K029 a- The penetration in the ceiling containing the main electrical panel and gas-fueled water heater was fixed immediately. The door to the commercial laundry room was immediately fixed to self-close upon activation of fire alarm b-The Maintenance Supervisor will monitor through environmental round that there are no barriers between the water heater and electrical panel and all doors are self closing and latches during activation of fire alarm system	10/15/2012

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K 029	Continued From page 4 room (a hazardous area) from other spaces by having penetrations in the ceiling, and failed to separate the laundry room from other spaces by not having the door not self-close and latch completely. The separation of the water heater/ electrical panel room and laundry room from other smoke compartments would not be achieved in the event of fire and/or smoke emergency if there were penetrations in ceiling and non-latching doors. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings: On October 15, 2012, from 8:45 a.m. to 10 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed deficiencies with hazardous areas in the following areas: a. There were penetrations in the ceiling in the room that contained the main electrical panel and a gas-fueled water heater. There was a 3/4-inch by 1-ft penetration and three 1/2-inch penetrations in the ceiling. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the penetrations but would seal the penetrations with approved rated material. b. The door to the commercial laundry room failed to self-close and latch when the door automatically released from the electro-magnetic door holder upon activation of the fire alarm system. The deficiency affected one out of four smoke	K 029	c- The Administrator and Maintenance Supervisor will complete random checks of the fire alarm testing and checks on physical plant and ensure safe environment. d- The Maintenance Supervisor will complete a recapitulation of his finding regarding of physical plant condition and any issues compromising the safety of the environment at the Monthly Quality Assurance Committee Meeting for review and action indicated.	

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K 029	Continued From page 5 compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 7.1.10 Means of Egress Reliability. 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that means of egress shall be continuously maintained free of all obstructions or impediments by storing a dining room table in front of the exit door on the northwest side of the facility. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings: On October 15, 2012, from 8:45 a.m. to 10 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor,	K 038	K038 a- Upon notification, the semi-circle dining table (5-ft in length by 4 ft in width) was removed immediately on 10/15/2012 b-The Maintenance Supervisor and Safety Coordinator will conduct daily rounds to ensure all means of egress shall be continuously free of all obstructions to full instant use in case of fire or other emergency c- The Administrator and Maintenance Supervisor will do random checks on the physical plant to ensure a safe environment. Also, an in-service was completed on 10/15/2012 regarding the policy on ensuring facility is free of obstructions or impediments. d- The Maintenance Supervisor complete a recapitulation of his findings regarding the physical plant condition and any issues compromising the safety of the environment at the Monthly Quality Assurance Committee Meeting for review and action as indicated.	10/15/2012

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K 038	Continued From page 6 observed that a semi-circle dining table (5-ft in length by 4 ft in width) stored in front of the exit door near Room 131 and the kitchen. During an interview with the maintenance supervisor at the time of the observation, he stated he was could not explain why the dining table was stored in the corridor in front of the exit doors. According to the facility's emergency evacuation map, the deficiency affected one out of six exit routes on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012.	K 038		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition. Chapter 2 Sprinkler Systems 2-2.2 Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be	K 062	K062 a- Upon notification, a 5 Year Fire Sprinkler Test was done on 07/26/2012 by Pacific Fire Protection. A copy of the inspection certificate was submitted to DHS on 10/22/2012 via facsimile. All gaps between the sprinkler escutcheons and the ceiling were filled and patched on 10/15/2012. b-The Maintenance Supervisor will monitor through his daily rounds to ensure all emergency systems are continuously maintained and periodically tested.	07/26/2012 10/15/2012 10/22/2012

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K 062	Continued From page 7 subjected to external loads by materials either resting on the pipe or hung from the pipe. Chapter 9 Valves, Valve Components, and Trim 9-4 System Valves. 9-4.1.2 Alarm valves and their associated strainers, filters, and restriction orifices shall be inspected internally every 5 years unless tests indicate a greater required is necessary. 9-4.3.1.4 Strainers, filters, restricted orifices, and diaphragm chambers shall be inspected internally every 5 years unless tests indicate a greater frequency is necessary. This requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed: a) to inspect and test the automatic fire sprinkler system every 5 years in accordance with NFPA 25. b) to ensure that fire sprinkler heads were maintained by having gaps between the escutcheons (metal skirts around fire sprinkler heads) and ceiling space. In the event of a fire, the activation and effective operation of the automatic sprinkler system may occur if sprinkler heads are properly maintained, and all valves are maintained in good repair through routine maintenance. At the time of the survey, the facility was licensed for 99 beds and had a census of 87 residents. Findings:	K 062	c- The Administrator and Maintenance Supervisor will do random checks on the physical plant and to ensure a safe environment. An in-service was completed on 10/15/2012 regarding Sprinkler Inspections, policy on gaps and escutcheons and to ensure all emergency systems are tested in accordance with the proper regulation. d-The maintenance supervisor will complete his findings regarding the physical plant condition and any issues compromising the safety environment at the Monthly Quality Assurance Committee Meeting for review and action as indicated.	10/15/2012

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K 062	Continued From page 8 On October 15, 2012, from 8:54 a.m. to 10:00 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed or noted the following deficiencies with maintaining the automatic sprinkler system: a) There was no documented evidence that the automatic sprinkler system was serviced every 5 years in accordance with NFPA 25. The last five year test was performed on August 10, 2005. During an interview with the maintenance supervisor at the time of the observation, he could not explain why the five year sprinkler test was not done. b) There were 1/2-inch diameter gaps around the escutcheons to the fire sprinkler heads at the ceiling in the maintenance shop and under the car port on the east side of the facility. During an interview with the maintenance supervisor at the time of the observation, he stated that he was not aware that the sprinkler heads had gaps between the ceiling and escutcheons. The deficiency affected four out of four smoke compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012. THIS WAS A REPEAT DEFICIENCY FROM THE LIFE SAFETY CODE SURVEY THAT WAS CONDUCTED ON JULY 22, 2011.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with	K 064	K064 a- Upon notification, Class K Fire Extinguisher in the kitchen was	10/15/2012

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K 064	Continued From page 9 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: NFPA 10 Standard for Portable Fire Extinguishers. 1998 edition. 1-6 General Requirements 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.6 Fire extinguishers shall not be obstructed or obscured from view. This requirement was not met as evidenced by: Based on observation and interview, the facility failed to ensure that the Class K fire extinguisher stored in the kitchen was readily accessible. Fire extinguishers that are readily accessible without any obstructions may allow immediate access in the event of a fire. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings: On October 15, 2012, from 8:45 a.m. to 10 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed a Class K fire extinguisher obstructed	K 064	immediately moved to a readily accessible location on 10/15/2012 b- The Maintenance Supervisor will monitor through daily rounds to make sure all fire extinguishers are conspicuously available in case of emergency or fire c- The Administrator and Maintenance Supervisor will complete random checks on the physical plant to ensure a safe environment. d-The Maintenance Supervisor will do a recapitulation of his findings regarding the physical plant condition and any issues compromising the safety environment at the Monthly Quality Assurance Committee Meeting for review and action as indicated.	10/15/2012

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K 064	Continued From page 10 and not readily accessible in the kitchen. There was a metal table and utensils stored in front of the extinguisher. During an interview with the maintenance supervisor at the time of the observation, he stated he would relocate the fire extinguisher to allow immediate access. The deficiency affected one out of four smoke compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012.	K 064		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: 1) NFPA 99, Standards for Health Care Facilities, 1999 Edition, Section 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a)* Nonflammable Gases (Any Quantity; In-Storage, Connected or Both) 3. Provisions shall be made for racks or fastening to protect cylinders from accidental damage or dislocation. The standard was not met as evidenced by: Based on observation and interview, the facility	K 130	K130 a- All E Tanks in the oxygen room were immediately secured by moving to an oxygen racks on 10/15/2012 b- The Maintenance Supervisor, Safety Coordinator and Nursing Supervisor will conduct environmental rounds to make sure all oxygen tanks are properly secured and safe c- Administrator and Maintenance Supervisor will complete random checks on physical plant to ensure compliance. d- The Maintenance Supervisor will report his findings regarding physical plant condition and any issues that compromise the safety of the environment at the Monthly Quality Assessments Committee for review and action as indicated.	10/15/2012

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K 130	Continued From page 11 failed to ensure that free-standing oxygen cylinders were secured in the oxygen store room. Freestanding cylinders that are properly chained or supported in a proper cylinder stands or carts are protected from accidental damage or dislocation. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings: On October 15, 2012, from 8:45 a.m. to 10 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed 11 small E-tanks improperly secured in the oxygen storage room by Room 124. There was a chain that was loosely hanging around the cylinders that would allow the cylinders to tip over. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the improperly secured oxygen cylinders but would provide racks to ensure proper secured free-standing cylinders at all times. The deficiency affected one out of four smoke compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on October 15, 2012. 2) NFPA 101, 2000 edition, Life Safety Code Chapter 19 Existing Health Care Occupancies 19.5 Building Services 19.5.1 Utilities. Utilities shall comply with the provisions of	K 130		

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

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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
	555065	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW PARK CONV HOSP	3737 DON FELIPE DRIVE LOS ANGELES, CA 90008

(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 130	Continued From page 12 Section 9.1 Chapter 9 Building Services and Fire Protection Equipment Section 9.1 Utilities 9.1.1 Gas. Equipment using gas and related gas piping shall be in accordance with NFPA 54, National Fuel Gas Code, or NFPA 58, Liquefied Petroleum Gas Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 54, National Fuel Gas Code, 1999 edition. Chapter 5 Equipment Installation 5.1 General. 5.1.1 Appliances, Accessories, and Equipment to Be Approved. Gas appliances, accessories, and gas utilization equipment shall be approved. Approved shall mean "acceptable to the authority having jurisdiction." This requirement was not met as evidenced by: Based on observation and interview, the facility failed to ensure that a gas water heater was installed in accordance with NFPA 54 by installing a gas-fueled water heaters without submitting plans and obtaining permits and approval from OSHPD (Office of Statewide Health Planning and Development). Proper installation of utilities such as gas-fueled water heaters may ensure that accidental fires may not occur. At the time of the survey, the facility was licensed for 99 beds and had a census of 96 residents. Findings:	K 130	K130 a- Upon notification, Administrator contacted Corporate Safety Compliance Officer to obtain information regarding the permit. We do not have permit associated, therefore, architectural drawings will have to be submitted on December 10, 2012 to OSHPD and a permit obtained by the Corporate Safety Compliance Officer. b- The Administrator and Maintenance Supervisor will ensure water heater permits are obtained through our Corporate Safety Compliance Officer and OSHPD. c- Administrator in-serviced Maintenance Supervisor on 10/15/2012 regarding equipment installation/OSHPD permits. Also, Administrator will complete random checks on physical plant to ensure compliance. d- The Maintenance Supervisor will report his findings regarding physical plant condition and any issues such as permits that compromise the safety of the environment at the Monthly Quality Assessments Committee for review and action as indicated.	Estimated Date of Completion 04/30/2012