PRINTED: 10/17/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555772	A. BUILDING 01 B. WING _____	10/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT MANOR	8616 CHOLLA AVE YUCCA VALLEY, CA 92284

(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 Surveyor: 21101 K3 BUILDING: 01 K6 PLAN APPROVAL: 2001 K7 SURVEY UNDER: 2000 EXISTING TYPE OF STRUCTURE: ONE STORY TYPE V (111) CONSTRUCTION, FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification 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: 21101 The facility is not in substantial compliance with 42 CFR 483.70(a) for Long Term Care Facilities. Census: 56	K 000	This Plan of Correction constitutes our written credible allegation of compliance for the deficiencies noted. Nothing included in this Plan of Correction is an admission otherwise. Desert Manor Care Center 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 of any allegations contained herein. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM OCT [illegible] 2016 LIFE SAFETY CODE UNIT SAN BERNARDINO	
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 no impediment to the closing of the doors. Hold open devices that release when the door is	K 018	**ID Prefix Tag:** K 018 NFPA 101 LIFE SAFETY CODE STANDARD The facility will maintain the corridor doors to latch and resist the passage of smoke. **Corrective Actions for Identified Individual / Problem:** On 10/13/16, a latching device was placed on door identified to be missing the latching device.	10/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Cobb | TITLE: Administrator | (X6) DATE: 10/27/16

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.

10/31/16- PoC Acceptable Per Joel Yulung

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K 018	Continued From page 1 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: Surveyor: 21101 Based on observation and interview, the facility failed to maintain the corridor doors to latch and resist the passage of smoke. This was evidenced by a door that failed to latch. This could result in the failure to contain smoke to a room in the event of a fire and affected residents in 1 of 2 smoke compartments. NFPA 101, Life Safety Code (2000) Edition 19.3.6.3 Corridor Doors. 19.3.6.3.1* 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-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lb (22 N) is applied at the latch edge of the door.	K 018	**Immediate Measures to Prevent Reoccurrence:** On 10/13/16, the Maintenance Director implemented visual checks of doors in the facilty to ensure that doors will close and latch. Visual checks will be done monthly to prevent reoccurrence. **Monitoring Process and Responsible Individual:** By 11/13/16, QA Committee will develop a monitoring tool to monitor all corridor doors for latching device. Maintenance Director or designee will monitor and report findings to QA Committee on a monthly basis.	10/13/16 11/13/16

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K 018	Continued From page 2 Findings: During a tour of the facility with the Maintenance Staff on 10/13/16, the corridor doors were closed and observed. At 11:37 a.m., the corridor door to the shower room located next to storage room 8, failed to latch. The door was observed to be missing the latching device. During interview, the Maintenance Staff confirmed the door was not equipped with a latching device.	K 018		
K 027 SS=D	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: Surveyor: 21101 Based on observation and interview, the facility failed to maintain their smoke barrier doors to latch and prevent the passage of smoke. This was evidenced by the smoke barrier double door that failed to positive latch upon activation of the fire alarm system. This could result in the failure to contain smoke during a fire and affected residents in 2 of 2 smoke compartments. NFPA 101, Life Safety Code (2000) Edition	K 027	ID Prefix Tag: K 027 NFPA 101 LIFE SAFETY CODE STANDARD The facility will maintain smoke barrier doors to latch and prevent the passage of smoke. **Corrective Actions for Identified Individual / Problem:** On 10/13/16, the Maintenance Director made adjustments to the door hinges and door closer to ensure the door would close automatically when magnetic device releases. **Immediate Measures to Prevent Reoccurrence:**	10/13/16

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
LICENSING & CERTIFICATION PROGRAM

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K 027	Continued From page 3 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. NFPA 101, Life Safety Code (2000) Edition 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold open mechanism is released and the door becomes self-closing.	K 027	On 10/13/16, the Maintenance Director implemented visual checks of the door hinges, door closer and magnetic release device to ensure that the door will close and latch automatically. Visual checks will be done monthly to prevent reoccurrence. **Monitoring Process and Responsible Individual:** By 11/13/16, QA Committee will develop a monitoring tool to monitor visual checks of the smoke barrier doors. The Maintenance Director will monitor and report findings to QA Committee on a monthly basis. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM 0[illegible]16 LIFE SAFETY CODE UNIT SAN BERNARDINO	10/13/16 11/13/16

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K 027	Continued From page 4 (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair. Findings: During the testing of the facility fire alarm system with the Administrator and Maintenance Staff on 10/13/16, the smoke barrier doors were observed. At 1:57 p.m., the smoke barrier door leaf near room 107 failed to latch upon release of its hold open device during the testing of the fire alarm devices. The door was tested by maintenance staff twice and failed to latch. During interview, maintenance stated he recently adjusted the door closure device and the door latch after the adjustment.	K 027		
K 062 SS=D	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: Surveyor: 21101 Based on observation, document review and interview, the facility failed to maintain the automatic sprinkler system in accordance with NFPA 25, 1998 Edition. This was evidenced by no documentation for 2 of 4 quarterly testing reports for the Inspectors Test Valve (ITV) and by sprinklers that were obstructed. This had the potential for sprinkler system failure and affected residents in 2 of 2 smoke compartments.	K 062	ID Prefix Tag: K 062 NFPA LIFE SAFETY CODE STANDARD The facility will maintain the automatic sprinkler system by ensuring that quarterly testing of ITV is conducted. **Corrective Actions for Identified Individual / Problem:** Third quarter ITV test for 2016 is up to date, completed on 7/16/16. Fourth quarter testing is scheduled and will be completed on 11/3/16. On 10/13/16, all items identified to	11/3/16 10/18/16

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K 062	Continued From page 5 NFPA 101, Life Safety Code (2000) Edition 9.7.5 Maintenance and Testing. All Automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 13, Installation of Sprinkler Systems 1999, edition Chapter 12 System Inspection, Testing, and Maintenance 12-1 General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2 Unacceptable obstructions to spray patterns shall be corrected. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. 2-2.7 Hydraulic Nameplate. The hydraulic nameplate, if provided, shall be inspected quarterly to verify that it is attached securely to	K 062	be obstructing the sprinkler deflector in the closets were removed immediately. **Immediate Measures to Prevent Reoccurrence:** Maintenance Director will keep a log to monitor compliance with quarterly ITV testing. On 10/22/16, nursing staff were in-serviced regarding not placing items in closets on the shelves that can block the sprinkler deflectors. **Monitoring Process and Responsible Individual:** A log will be developed by QA Committee by 11/13/16 to monitor compliance with the quarterly ITV testing. The Maintenance Director or designee will present log to QA Committee on a quarterly basis. As of 10/13/16, department managers will monitor residents closets during assigned rounds to ensure no items are blocking sprinkler deflectors. Findings will be reported to QA Committee on a monthly basis. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM	10/22/16 11/13/16 10/13/16

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K 062	Continued From page 6 the sprinkler riser and is legible. 2-3.3 Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. Findings: During document review with Maintenance Staff on 10/13/16, the quarterly testing reports for the Inspectors Test Valve was requested. 1. At 10:10 a.m., the Maintenance Staff provided documentation for two quarterly testing reports of the ITV for the second and third quarters of 2016. During interview, the Maintenance Staff stated he did not have any additional records for review. 2. At 11:08 a.m., room 101, the sprinkler inside bed "B" closet was obstructed by residents personal items that were stored 1 inch from the sprinkler deflector. 3. At 11:10 a.m., room 102, the sprinkler inside bed "B" closet was obstructed by residents personal items that were stored 2 inches from the sprinkler deflector. 4. At 11:11 a.m., room 104, the sprinkler inside bed "B" closet was obstructed by residents personal items that were stored 2 inches from the sprinkler deflector.	K 062		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066	ID Prefix Tag: K 066 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 066	Continued From page 7 (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the International symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 21101 Based on observation and interview, the facility failed to manitain fire safety in their designated smoking area. This was evidenced by no container of safe design for the disposal of cigarettes in 1 of 2 designated areas where smoking is permitted. This had the potential to increase the risk of a fire and affected residents in 2 of 2 smoke compartments. Findings: During a tour of the facility with the Administrator and Maintenance Staff on 10/13/16, the designated smoking areas were observed. At 2:02 p.m., cigarette butts were observed on the ground outside the east emergency exit door near rooms 111 and 112. There was a sign	K 066	The facility will maintain fire safety in the designated smoking areas. **Corrective Actions for Identified Individual / Problem:** On 10/13/16, a container for disposal of cigarettes was placed in designated smoking area identified not to have a container. Cigarette butts that were observed on ground were cleaned up immediately. **Immediate Measures to Prevent Reoccurrence:** On 10/22/16, staff was in-serviced on the need for containers to dispose of cigarettes in designated smoking areas. Staff was asked not to remove containers from these areas. Facility will continue to monitor that containers remain in the designated smoking areas. **Monitoring Process and Responsible Individual:** By 11/13/16, QA Committee will develop a monitoring tool to monitor that designated smoking areas have containers to dispose of cigarettes. Housekeeping supervisor and or designee will monitor and report findings	10/13/16 10/22/16 11/13/16

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K 066	Continued From page 8 designating the area for smoking, a container of safe design for the disposal of cigarette material was not observed in the area. During interview, the Administrator stated the area was designated for staff only.	K 066	to QA Committee on a monthly basis. ID Prefix Tag: K 075 NFPA 101 LIFE SAFETY CODE STNDARD	
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Surveyor: 21101 Based on observation and interview, the facility failed to ensure soiled linen and trash receptacles exceeding 32 gallons were located in a room protected as a hazardous area when not attended. This was evidenced by 54 gallon soiled linen and trash receptacles left unattended in corridors. This failure affected 1 of 2 smoke compartments. Findings: During a tour of the facility with Maintenance Staff 10/13/16, the soiled linen and trash receptacles were observed. 1. At 11:19 a.m., there were two gray 54 gallon receptacle observed in the corridor unattended near room 108. One receptacle was for soiled linen and one receptacle was for trash.	K 075	The facility will ensure that soiled linen and trash receptacles do not exceed 32 gallons. **Corrective Actions for Identified Individual / Problem:** On 10/24/16, soiled linen and trash receptacles identified to be more that 32 gallons were replaced with receptacles that are 32 gallons. **Immediate Measures to Prevent Reoccurrence:** On 10/22/16, nursing staff was in-serviced on placing receptacles in the designated area after use. Receptacles are not to remain in corridor when not in use. **Monitoring Process and Responsible Individual:** By 11/13/16, QA Committee will develop a monitoring tool to monitor for proper placement of receptacles and that receptacles do not exceed 32 gallons.	10/24/16 10/22/16 11/13/16

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K 075	Continued From page 9 2. At 11:32 a.m., there were two gray 54 gallon receptacles unattended near the shower room and storage room 8. The receptacles were for soiled linen and trash. During interview, a CNA staff stated the receptacles were left in the corridor until lunch time at noon.	K 075	Director of Staff Development will monitor and report findings to QA Committee on a monthly basis.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 21101 Based on observation, the facility failed to maintain the electrical equipment and utilities in accordance with NFPA 70, 1999 Edition. This was evidenced by an electrical panel missing blank cover for an open space, by the use of an extension cord and six outlet wall adapter. This affected 2 of 2 smoke compartments and could increase the risk of an electrical fire. NFPA 70, National Electrical Code, 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	K 147	ID Prefix Tag: K 147 NFPA 101 LIFE SAFETY CODE STANDARD The facility will maintain the electrical equipment and utilities in accordance with NFPA 70, 1999 Edition. **Corrective Actions for Identified Individual / Problem:** On 10/13/16, a blank cover was placed on space 39 in the electrical panel. On 10/13/16, identified electric cord in the Staff Development Office was removed immediately and discarded. On 10/13/16, a six outlet adapter identified in room 112 was removed from room. **Immediate Measures to Prevent Reoccurrence:** Monthly rounds will be conducted by Maintenance Director and Staff Developer to ensure that no extension cords or electrical adapters are being	10/13/16 10/13/16 10/13/16 11/13/16

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LIFE SAFETY CODE UNIT
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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555772	A. BUILDING 01 B. WING	10/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT MANOR	8515 CHOLLA AVE YUCCA VALLEY, CA 92284

(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 147	Continued From page 10 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 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 NFPA 70, National Electrical Code, 1999 Edition. 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (a) Unused Openings. Unused opening in boxes, raceways, auxiliary gutters, cabinets, equipment cases, or housing shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Findings: During a tour of the facility with Maintenance Staff on 10/13/16, the electrical wiring and equipment was observed. 1. At 10:56 a.m., electrical panel "PNLE" located inside Utility closet two had a missing blank cover for space 39. This was acknowledged by maintenance during the survey. 2. At 11:01 a.m., there was a white extension cord plugged into a power strip inside the Staff Development office.	K 147	utilized in the facility. The Maintenance Director will conduct monthly rounds of all electrical panels to ensure they all have circuit directories or covers in place. **Monitoring Process and Responsible Individual:** The Maintenance Supervisor and the Staff Developer will conduct facility safety rounds of the entire facility to ensure that no extension cords or adapters are being utilized in the facility. These rounds will be documented on a QA Monitoring Tool and results will be reviewed monthly by the QA committee. The Maintenance Supervisor or Maintenance Assistant will conduct monthly rounds to visualize all electric panels and ensure that they all have directory labels and/or covers. This will also be documented on a QA Monitoring Tool and results will be reviewed by QA committee. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM OCT 2016 LIFE SAFETY CODE UNIT SAN BERNARDINO	11/18/16 11/18/16 11/18/16

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K 147	Continued From page 11 3. At 11:23 a.m., there was a white six outlet adapter in use that was plugged into a two wall outlet next to bed "A" in room 112. During interview, maintenance check the adapter and stated the adapter did not have overcurrent protection.	K 147	*PLEASE NOTE: All QA tools noted in this Plan of Correction take place at the direction and supervision of the Quality Assurance Committee. As such, the audits and tools may be revised, updated, changed or discontinued based on the findings of the QA Committee depending on the findings and/or determination of sustained compliance by the tools themselves and the QA Committee.* CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM OCT [illegible] 016 LIFE SAFETY CODE UNIT SAN BERNARDINO	