STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056351	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATSWORTH PARK HEALTH CARE CENTER	10610 OWENSMOUTH CHATSWORTH, CA 91311

(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 reflects the findings of the California Department of Public Health during the Life Safety Code Recertification Survey. This facility was surveyed under 42 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. Representing the Department of Public Health: Surveyor #: 16281, HFE I Bed capacity: 128 Resident census: 117	K 000	Allegation of Compliance: This plan of correction is prepared and submitted as required by the law. By submitting this plan of correction,Chatsworth Health Care Center does not admit that the deficiency listed on this form exits,nor does Chatsworth Park Health Care Center admit to any statements, findings, facts or conclusions that for the basis for the alleged deficiencies, statements, findings, facts and conclusions that form the basis of the deficiences.	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: NFPA 101 Life Safety Code, 2012 Edition 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or	K 211	How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1.On 4/24/24, Maintenance director immediately removed the "Not an exit sign from exit fire door by the RNA room. 2. On 4/24/24 Maintenance Director cut bottom of FRP to ensure the right leaf door opened properly. 3. On 4/24/24 Maintenance Director removed the bench on the exterior side of the exit door.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean Perry — TITLE: Administrator — (X6) DATE: 5/17/24

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 211	Continued From page 1 impediments to full instant use in the case of fire or other emergency. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. The Code was not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure instant use of two double leaf exit doors, and ensure one means of egress was free of obstruction. The deficiency had the potential to delay or prevent the rapid evacuation of occupants. The deficiencies affected two of seven smoke compartments. Findings: 1. On 04/24/2024 at 9:45 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed an exit door assembly by the RNA room consisted of two door leaves with panic bars. A closer observation revealed both leaves of the exit door assembly had signs on them that read "Not an Exit". During a concurrent interview, the Maintenance Director stated the signs were placed on the doors so that residents and visitors do not use the doors to leave the facility to the parking lot. The door was identified as an exit door by exit	K 211	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; -On 4/24/24 Maintenance Director made rounds on all emergency exit doors to check for any "Not an exit" signage. No signage noted. -Maintenance Director checked all double leaf exit doors and all double lead exit doors open readily. -Maintenance Director made rounds on all emergency doors and the exterior side of the emergency doors and checked for any obstructions, none observed. Administrator gave a 1:1 in-service to Maintenance Dept. on 4/24/24 that all emergency exit locations should be continuously be maintained free of all obstruction as well as the exterior side to full use in case of a fire or other emergency.No signage should on exit doors and all exit door shoud readily open.	

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K 211	Continued From page 2 sign above the door. A review of the facility's evacuation floor plan identified the door was an exit door. 2. On 04/24/2024 at 9:45 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed an exit door by the RNA room consisted of two door leaves with panic bars. During a test of the exit door, it was observed by the evaluator that the right leaf of the door failed to readily release and was stuck requiring extra effort by the Maintenance Director to open the door. During a concurrent interview, the Maintenance Director stated that the FRP panel attached to the door had dropped and was making the door stick. The door was identified as an exit door by exit sign above the door. A review of the facility's evacuation floor plan identified the door was an exit door. 3. On 04/24/2024 at 9:45 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA) the evaluator observed a bench placed at the path of egress on the exterior side of an exit door by the RNA room. During a concurrent interview, the Maintenance Director stated that he did not know why the bench was placed on the exterior side of the exit door, and that the bench would be removed from	K 211	What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur; -Maintenance Director/Designee will make daily rounds to ensure that all aisles, passageways, corridors, exit discharges, exit locations are free of all obstructions to full use in case of emergency. -Maintenance Director/Designee will check all door leaves quarterly to ensure they open readily in case of an emergency. How the facility plans to monitor its performance to make sure that the solutions are sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance systems; Administrator /Designee will do weekly checks to ensure all exit doors are free from obstructions.Administrator/Designee will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	

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K 211	Continued From page 3 the path of egress. The door was identified as an exit door by exit sign above the door. A review of the facility's evacuation floor plan identified the door was an exit door. This is a repeat deficiency. On 12/08/2021 during a Life Safety Code (LSC) deficiency the facility received a deficiency for failing to maintain means of egress (exit door and pathway) free from obstructions.	K 211		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be	K 222	How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -On 4/24/24, Maintenance Director immediately removed the padlock from the gate located between the gym and public way. -Maintenance Director immediately made rounds on all exit doors and checked if they are equiped with a lock that requires the use of a tool or key from the egress side, none observed.	

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K 222	Continued From page 4 electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: NFPA 101 Life Safety Code, 2012 Edition	K 222	How the facility will identify other residents found to having the potential to be affected by the same deficient practice and what corrective action will be taken; on 4/24/24, Administrator and Maintenance Director made roundson all exit doors and checked if they are equipped with a latch for a lock that requires the use of a tool or key, none was observed. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; Administrator gave a 1:1 in-service to Maintenance dept on 4/24/24 that no exit doors will be equipped with a latch or a lock that requires the use of a tool or key from the egress side.	

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K 222	Continued From page 5 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. The Code was not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure one of two gates between the Therapy Gym and the public way was arranged to be readily opened from the egress side without the use of a key. The deficiency had the potential to delay or prevent the rapid evacuation of the occupants to the public way. This deficiency affected one of seven smoke compartments. Finding: On 04/24/2024 at 11:30 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed an exit sign over a door in the Therapy Gym that opened to a patio that led to two gates. A closer observation revealed the gate on the right was padlocked. During a concurrent interview, the Maintenance Director stated that the gate had recently been replaced and the padlock would be removed.	K 222	How the facility plans to monitor its performance to make sure that the solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; Administrator /Designee will check monthly all exit doors to ensure that no exit doors has any lock that requires the use of a tool or key from the egress side.Administrator/Designee will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	

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K 222	Continued From page 6 A review of the facility's evacuation floor plan indicated the padlocked gate was located between the Therapy Gym and the public way at Kingsbury Street.	K 222		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: NFPA 101 Life Safety Code 2012 Edition 7.10.1.2.2* Horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. 7.10.2 Directional Signs. 7.10.2.1* A sign complying with 7.10.3, with a directional indicator showing the direction of travel, shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.2.2 Directional exit signs shall be provided within horizontal components of the egress path within exit enclosures as required by 7.10.1.2.2. 7.10.4* Power Source. Where emergency lighting	K 293	How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. On 5/15/25 at around 2:02pm the Maintenance Director conducted a test in which he confirmed that all exit signs remain illuminated during a power emergency, they are connected to the facility's EES. 2. On 4/24/24, the Maintenance Director corrected the directional exit sign indicated the correct direction of travel during an evacuation emergency. Maintenance Director made rounds to check all directional exit signs throughout the facility to ensure correct direction of travel. All directional signs indicated the correct direction of travel in case of an emergency.	

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K 293	Continued From page 7 facilities are required by the applicable provisions of Chapters 11 through 43 for individual occupancies, the signs, other than approved self-luminous signs and listed photoluminescent signs in accordance with 7.10.7.2, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. NFPA 99 Health Care Facilities Code 2012 Edition 6.4 Essential Electrical System Requirements - Type 1. 6.4.2.2.3.2 The life safety branch shall supply power for lighting, receptacles, and equipment as follows: (2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code. 6.5 Essential Electrical System Requirements - Type 2. 6.5.2.2.2.1 The life safety and critical branches shall supply power for lighting, receptacles, and equipment as follows: (2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code. The Codes were not met as evidenced by:	K 293	How the facility will identify other residents found to having the potential to be affected by the same deficient practice and what corrective action will be taken; -Administrator and Maintenance Director made rounds and checked all exit directional signs to ensure the direction of travel indicated the correct direction of travel. All exit directional signs displayed the correct direction in case of an emergency. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur; Administrator gave 1:1 in-service to Maintenance Dept that all exit directional signs must indicate the direction of travel in case of an emergency. Maintenance director will check monthly all exit directional signs to ensure the direction of travel is correct.	

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K 293	Continued From page 8 1. Based on interview and observation, the facility failed to provide documented evidence that indicated the facility's exit signs and exit directional signs would be illuminated by the emergency lighting facilities in the event of a power emergency. The deficiency had the potential for not all exit and exit directional signs to remain illuminated during a power emergency, potentially delaying or preventing continuous egress during a power and evacuation emergency. The deficiency affected seven of seven smoke compartments. 2. Based on observation and interview, the facility failed to provide ensure a directional exit sign's directional indicator was showing the correct direction of travel. The deficiency had the potential to delay continuous egress during an evacuation emergency. The deficiency affected one of seven smoke compartments. Findings: 1. On 04/24/2024 at 9:05 a.m. during an interview, the Maintenance Director stated that all the facility's exit and exit directional signs were not connected to the facility's emergency electrical system (EES), and were dependent on back up batteries during power emergencies. He also stated that some of the exit and signs were replaced last year because the batteries no	K 293	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; Administrator /Designee will check monthly all exit directional signs to ensure they all reflect the correct direction of travel in case of an emergency.Administrator/Designee will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	

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K 293	Continued From page 9 longer provided back up power. The Maintenance Director further stated that he knows the exit and exit directional signs are not connected to the EES, and knows when he needs to replace the exit signs because when the facility is off normal utility power, he can see some exit signs have dim illumination indicating the back up battery is starting to fail and that the signs are not connected to the EES. At this time, during an interview with the Facility Administrator (FA), she stated that she believed the exit and exit directional signs were connected to the EES. During a concurrent interview, the evaluator requested documented evidence form the FA that the facility's exit and exit directional signs were connected to the EES. At 10:00 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and the FA, the evaluator observed exit and exit directional signs with battery test buttons throughout the facility. As of 04/26/2024, the evaluator has not received documented evidence the facility's exit and exit directional signs are connected to the EES. 2. On 04/24/2024 at 10:00 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed an exit directional sign at an exit corridor located between the RNA room and an exit door. Closer observation revealed the directional exit	K 293		

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K 293	Continued From page 10 sign's directional indicator was indicating the direction of travel was in the opposite direction of the exit into the RNA room. Further observation revealed there were no exits in the RNA room. During a concurrent interview, the Maintenance Director stated the exit directional sign had been flipped.	K 293	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 4/25/24 the Maintenance director installed the missing glass break rods on the five manual fire alarm boxes	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure five of ten manual fire alarm boxes (pull stations) maintained their glass break rods. This deficiency affected four of seven smoke compartments. Finding: On 04/24/2024 at 11:38 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator had observed	K 345	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; On 4/24/24 Maintenance director made rounds to check all manual fire alarm boxes that might be missing the glass break rods. No others observed. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not occur; Administrator gave a 1:1 in-service to Maintenance Dept. on ensuring that all manual fire alarm boxes must have the glass break rods in accordance with NFPA72.	

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K 345	Continued From page 11 five of ten manual pull stations were missing their glass break rods. During a concurrent interview, the Maintenance Director acknowledged the missing glass break rods and stated they would be replaced.	K 345	Administrator and Maintenance Director will check all manual fire alarm boxes and ensure they all have glass break rods in accordance with NFPA72.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 2010 Edition 6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler.	K 353	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrective action is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; Administrator /Designee will check monthly all manual fire alarm boxes to ensure we are compliant with NFPA72 .Administrator/Designee will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	

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K 353	Continued From page 12 6.7.4* Identification of Valves. 6.7.4.1 All control, drain, and test connection valves shall be provided with permanently marked weatherproof metal or rigid plastic identification signs. 6.7.4.2 The identification sign shall be secured with corrosion-resistant wire, chain, or other approved means. 8.16.1.1.8 Control Valve Identification. Identification signs shall be provided at each valve to indicate its function and what it controls. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation. Table E.1 Examples of Classifications of Needed Corrections and Repairs Chapter 5: Sprinkler Systems - Inspection Escutcheons missing, painted, or rusted. 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (6) Provided with applicable identification	K 353	How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. Missing sprinkler head escutcheon ordered and scheduled to come in on 5/30/24. 2. Signage for control valves have been ordered and are scheduled to come in on 5/30/24. Maintenance Director inspected all Escutcheon and signs and confirmed no others were missing. How the facility will identify other residents found to having the potential to be affected by the same deficient practice and what corrective action will be taken; Maintenance Supervisor will make rounds monthly and inspect sprinkler and signage to ensure they are working and clear and in place. A report to be given to the Administrator.	

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K 353	Continued From page 13 These Standards were not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire sprinkler system in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, and NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems by 1. Missing a sprinkler head escutcheon. An escutcheon is part of the sprinkler head listing. A missing escutcheon increases the possibility of a sprinkler not working as designed with its listing. The deficiency affected one of seven smoke compartments. 2. Failing to provide legible control valve signs. Missing or illegible information signs may result in system damage, liability, accidental discharge, or system failure in the event of a fire. The deficiency affected seven of seven smoke compartments. Findings: 1. On 04/24/2024 at 10:21 a.m., during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed a sprinkler head located at the station 2 dining room ceiling was missing it's escutcheon exposing the ceiling penetration and cavity above the ceiling.	K 353	What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur; Administrator gave in-service to Maintenance supervisor about having working sprinklers in good condition and clear and available signage. Administrator/Designee to make rounds monthly. Administrator will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	

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K 353	Continued From page 14 During a concurrent interview, the Maintenance Director and FA acknowledged the sprinkler head escutcheon was missing. 2. On 04/24/2024 at 11:45 a.m., during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed illegible sun faded control valve signs at the following control valves: a. Two Inspector Test Connection Valves (ITVs). b. One Main Drain. c. One Outside Stem and Yoke (OS&Y). d. One Butterfly Valve. e. One Post Indicator Valve (PIV). At 12:00 p.m., accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed a missing control valve sign at the Fire Department Connection (FDC). The ITV enables the inspector to ascertain that the sprinkler system is charged and ready to activate and is also utilized as a test connection of the audible fire alarm notifications of the occupants. The main drain is the primary drain connection located on the system riser and also utilized as a test connection. The OS&Y, butterfly valve, and PIV are indicating valves that have components that show if the sprinkler water supply valves are open or closed. The FDC is a connection through which the fire department can pump supplemental water into	K 353		

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K 353	Continued From page 15 the fixed water-based fire-fighting system, sprinkler system, standpipe system, or other systems furnishing water for fire suppression and extinguishment to supplement existing water supplies. This is a repeat deficiency. On 12/08/2021 during a Life Safety Code (LSC) deficiency the facility received a deficiency for failing to provide and maintain identification signs for control valves.	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363	How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.On 4/24/24 Maintenance Director removed door holder behind door. 2. On 4/24/24 Maintenance Director repaired the self closing door in the RNA room and ensured the door closed when shut.	

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K 363	Continued From page 16 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: NFPA 101: Life Safety Code, 2012 Edition 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbs (22 N) is applied at the latch edge of the door. This Code was not met as evidenced by: Based on observation and interview, the facility failed to: 1. Ensure a corridor door was arranged to be readily closed in an emergency. 2. Maintain a corridor door to allow the door to hold closed. The deficiencies had the potential to impede or delay the rapid closing of the door and maintain the door closed during a smoke or fire emergency and create a condition conducive to the spread of	K 363	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; On 4/24/24, Maintenance Director made rounds in the facility and checked all corridor doors. All other corridor doors closed in its frame when shut. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; On 4/24/24 Administrator in-serviced the Maintenance Dept on ensuring that all self closing doors must be free from door holders and all corridor doors must shut when closed and maintain in good working condition. Maintenance Director will make rounds once a week to ensure that all self closing doors are free from door holders and corridor doors close when shut and maintained in good working condition.	

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K 363	Continued From page 17 fire, smoke, and heat. The deficiency affected one of seven smoke compartments. Findings: 1. On 04/24/2024 at 9:45 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director, the evaluator observed the self-closing corridor door to the conference room had a door holder behind the door. During a concurrent interview, the Maintenance Director was made aware of the deficiency. 2. On 04/24/2024 at 10:04 a.m. during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed the self-closing corridor door to the RNA program room was not holding closed when shut. During a concurrent interview, the Maintenance Director acknowledged the door failed to hold closed in its frame, and stated that he would fix it. This is a repeat deficiency. On 12/09/2021 during a Life Safety Code (LSC) deficiency the facility received a deficiency for failing to maintain corridor doors in good working condition to allow the door to hold closed.	K 363	How the facility plans to monitor its performance to make sure that the solutions are sustained. The facility must develop a plan for ensuring that the corrective action is achieved and sustained. This plan must be implemented, and the corrective action is evaluated for its effectiveness. The POC is inegrated into the quality assurance system; Administrator /Designee will check monthly all self closing doors and corridor doors to ensure compliance NFPA101 .Administrator/Designee will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	

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K 511	Continued From page 18 complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: NFPA 101: Life Safety Code, 2012 Edition 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70: National Electrical Code, 2011 Edition 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, \ nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground 0-150 Minimum Clear Distance	K 511	On 4/24/24, the rack of diapers was removed from the electrical panel room to allow access and adequate workspace around the electrical equipment. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Maintenance did rounds to check for any other racks that might be obstructing access to the electrical panels. None observed. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur; - On 4/24/24,Administrator in-serviced Maintenance dept and Housekeeping dept on the importance of not blocking and allowing workspace around electrical equipment. -Maintenance and Housekeeping dept will make weekly rounds to ensure the all electrical panels are free from any obstructions.	

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K 511	Continued From page 19 Condition 1 914 mm (3 ft) Condition 2 914 mm (3 ft) Condition 3 914 mm (3 ft) Nominal Voltage to 151-600 Condition 1 914 mm (3 ft) Condition 2 1.07 m (3 ft 6 in.) Condition 3 1.22 m (4 ft) (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. The Code was not met as evidenced by: Based on observation and interview, the facility failed to provide clear workspace from an electrical panel. Access and adequate workspace around electrical equipment allow ready and safe operation for workers servicing such equipment. The deficiency affected one of seven smoke compartments. Finding: On 04/24/2024 during a Life Safety Code (LSC) tour of the facility accompanied by the Maintenance Director and Facility Administrator (FA), the evaluator observed there was an electrical panel in the station one supply room. A closer observation revealed there was a rack of diapers stores directly in front of the electrical panel. During a concurrent interview, the Maintenance	K 511	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; Administrator /Designee will check weekly all electrial panel rooms to ensure they have adequate workspace and are free from obstructions. Administrator/Designee will report any findings to the monthly QA Committee x3 months for further review and evaluate for it's effectiveness or until compliance is achieved.	

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K 511	Continued From page 20 Director stated the rack of diapers would be removed.	K 511		

Acceptable POC 06/03/2024

PRINTED: 05/08/2024
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness Recertification survey. The findings are in accordance with Title 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the Department of Public Health: Surveyor #: 16281, HFE I Bed capacity: 128 Resident census: 117 No deficiencies were noted during the time of the survey. The facility was in substantial compliance.	E 000		

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

5/8/2024

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.