STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555143	A. BUILDING **02** B. WING _____	**05/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAND HOUSE	**100 BARNET SEGAL LANE** **MONTEREY, CA 93940**

(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
E 000	Initial Comments Surveyor: 50214 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 50214 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities Census: 28	E 000		
K 000	INITIAL COMMENTS Surveyor: 50214 K3 BUILDING: 02 K6 PLAN APPROVAL: 1/27/1982 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a) (b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition.	K 000		

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

Electronically Signed | 05/23/2024

5/24/2024: POC accepted per Brian Fenton, SSM-1

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K 000	Continued From page 1 Representing the California Department of Public Health: 50214 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 28 Licensed Beds: 28	K 000		
K 211 SS=D	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: Surveyor: 50214 Based on observation and interview, the facility failed to maintain the means of egress. This was evidenced by an egress door obstructed. This could result in a delay to evacuation from a fire or emergency. This affected 12 of 28 residents in one of four smoke compartments. Findings: During a tour of the facility and interview with the Facility Staff on 5/7/24, the means of egress was observed.	K 211	1. the corrective action taken: The carpet has been removed and will not be replaced not a function need for the carpet. 2. We removed the carpet from the opposite side of the building to remove any potential hazard in the future. 3. There is no further action needed to monitor the hazard that has been removed. 4. No monitoring is needed dur to the hazard being removed and not replaced. 5. The rugs were removed on 5/17/24 and disposed of them in the trash.	5/23/24

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K 211	Continued From page 2 At 11:48 a.m., in the McCone Lounge area a large carpet was obstructing the egress door from opening. Upon interview, the Facility Staff stated the carpet should not be there and needs to be moved.	K 211		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 50214 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by fire extinguishers that were not secure. This affected 16 of 28 residents in one of four smoke compartments and could result in a delay in accessing a fire extinguisher in the event of a fire. Findings: During a tour of the facility and interview with Facility Staff on 5/7/24, the facility's fire extinguishers were observed. At 12:16 p.m., fire extinguishers in the Maintenance Room were observed free standing and unsecured under a table. Upon interview, the Facility Staff stated they were spares and just	K 355	1. In-house Engineering staff secured all spare fire extinguishers on 5/7/24 ensuring they are no longer free-standing. 2. Maintenance activity for this fire extinguishing equipment was entered into the computerized maintenance program on 5/8/24 to ensure the activity is correctly documented. 3. All in-house engineering personnel will receive additional training on 5/23/24 pertaining to ensuring fire extinguishers, even if spares, are not to be left free-standing and must be secure. 4. Multi-disciplinary Environment of Care rounds will be conducted on a routine basis. Ensuring all fire extinguishing equipment is secure is a standing line item on EOC Rounds forms and any non-compliant conditions discovered will	5/17/24

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K 355	Continued From page 3 sitting there.	K 355	be corrected immediately. Additionally, fire extinguishing equipment will be inspected at least monthly by Engineering leadership for the next 6 months to ensure fire extinguishers are secured. All inspections will be documented and any failures to meet compliance will be corrected immediately. 5. Safety Coordinator and EOC multi-disciplinary team will conduct rounds a minimum of 2x annually.	
K 363 SS=D	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	K 363		5/17/24

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K 363	Continued From page 4 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other 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: Surveyor: 50214 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a door that failed to latch and an obstructed door. This affected 28 of 28 residents in four of four smoke compartments and could result in the spread of smoke and fire in the event of an emergency. Findings: During a tour of the facility and interview with the Facility Staff on 5/7/24, the facility's corridor doors were observed, and staff were interviewed. 1. At 12:12 p.m., the corridor door to the equipment room was observed. The door was equipped with a self-closing device that failed to latch when allowed to self-close. Upon interview, the Facility Staff stated the door was rubbing on the door frame.	K 363	1. In-house Engineering staff repaired the equipment room door on 5/8/24. Kitchen staff removed the metal cart from in front of the corridor door on 5/7/24. 2. Maintenance activity for the equipment room door was entered into the computerized maintenance program on 5/8/24 to ensure the activity is correctly documented. 3. All in-house engineering personnel will receive additional training on 5/23/24 pertaining to ensuring proper operation of any fire/smoke doors. Kitchen staff were instructed on the importance of ensuring carts and other items do not interfere with the automatic closing of corridor doors on 5/7/24. 4. Multi-disciplinary Environment of Care rounds will be conducted on a routine basis. Ensuring all fire/smoke rated doors	

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K 363	Continued From page 5 2. At 12:24 p.m., the corridor door to the Kitchen by the Dining Room was observed. The door was equipped with a self-closing device and was obstructed by a metal cart. Upon interview, the Facility Staff stated the Kitchen Staff temporarily placed it there and not permanent.	K 363	are functional and are not blocked by carts or any other items is a standing line item on EOC Rounds forms and any non-compliant conditions discovered will be corrected immediately. Additionally, fire/smoke rated doors in the facility will be checked for clearance and proper operation monthly for the next 6 months by Engineering leadership. All inspections will be documented and any failures to meet compliance will be corrected immediately. 5. Safety Coordinator and EOC multi-disciplinary team will conduct rounds a minimum of 2x annually.	