STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555287	A. BUILDING 02 B. WING	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND RIDGE HEALTHCARE CENTER	2351 LOVERIDGE ROAD PITTSBURG, CA 94565

(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 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: 31201 Census: 115	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting.	E 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ANTONIO MOYA, JR | TITLE: ADMINISTRATOR | (X6) DATE: 9/6/18

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.

Approved 09/10/2018 per Jose gonzalez, HFES

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	555287	A. BUILDING **02** B. WING _____	**08/23/2018**

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E 015	Continued From page 1 (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to provide policies and procedures for providing subsistence needs for residents, staff, and volunteers. This was evidenced by the no policy and procedure for sewage and waste disposal. This affected two of two smoke compartments and could result in unsafe conditions due to waste in the event of an emergency.	E 015		

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E 015	Continued From page 2 The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain- (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal. (2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location. (3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of	E 015		

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E 015	Continued From page 3 assistance. (4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility. (5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. (7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents. (8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings: During document review and interview with the Maintenance Supervisor on 8/23/18, the emergency preparedness policies and procedures were requested. 1. At 11:19 a.m., the facility was not able to provide a policy and procedure for sewage and waste disposal during a disaster. When interviewed, the Maintenance Supervisor stated	E 015		

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E 015	Continued From page 4 that he will fax the missing documentation on 8/24/18 by 10 a.m. On 8/24/18, at 11:30 a.m., no fax was received from the facility.	E 015		
K 000	INITIAL COMMENTS Surveyor: 31201 K3 BUILDING: 01 K6 PLAN APPROVAL: 10/2/1987 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), PARTIALLY 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. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census = 115	K 000		
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	K 363		9/21/18

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K 363	Continued From page 5 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 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: 31201 Based on observation and interview, the facility failed to maintain corridor doors to resist the	K 363		

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K 363	Continued From page 6 passage of smoke and/or fire. This was evidenced by a door that failed to latch. This affected one of two smoke compartments and could result in the passage smoke and flames in the event of a fire. Findings: During a tour of the facility with the Maintenance Supervisor and Director of Nursing on 8/23/18, the corridor doors were observed and staff interviewed. On 1:50 p.m., the door to Room 132 failed to latch when manually tested. The finding was confirmed by the Maintenance Supervisor.	K 363		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920		9/21/18

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K 920	Continued From page 7 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, the facility failed to maintain the electrical wiring. This was evidenced by the use of an extension cord and an adapter as substitutes for fixed wiring. This affected two of two smoke compartments. This could result in the ignition of an electrical fire. Findings: During a tour of the facility the Maintenance Supervisor and Director of Nursing on 8/23/18, the electrical wiring were observed. 1. At 1:29 p.m., a fan and a cellphone charger were plugged into a white extension cord, in Room 217, Bed B. The findings were confirmed by the Maintenance Supervisor. 2. At 1:54 p.m., a television and a headphone charger were plugged into an adapter in Room 135, Bed B. The findings were confirmed by the Maintenance Supervisor.	K 920		

Diamond Ridge Healthcare Center
2351 Loveridge Road
Pittsburg, CA 94565
925-427-4444

E 015 Subsistence Needs for Staff and Patients
It is the intention of Diamond Ridge Healthcare Center (DRHC) to develop and implement emergency preparedness policies and procedures (P&P), addressing the provision of subsistence needs for staff and patients, including sewage and waste disposal.

Corrective Action
No later than 9/21/18, DRHC will create and implement P&P for providing subsistence needs for residents, staff, and volunteers, including sewage and waste disposal.

Residents Affected
All residents' safeties have the potential to be affected by DRHC's failure to have P&P addressing the provision of subsistence needs for residents, staff and volunteers, including sewage and waste disposal.

Systemic Changes
DRHC will create and implement P&P for providing subsistence needs for residents, staff, and volunteers, including sewage and waste disposal.

No later than 9/21/18, Administrator will in-service staff regarding the facility's P&P on the provision of subsistence needs for residents, staff and volunteers, including sewage and waste disposal.

Administrator is responsible for overall compliance.

Monitoring
No later than 9/21/18, Administrator will review current Emergency Preparedness P&P for completeness. The P&P will be reviewed and updated at least annually.

Any issues will be immediately reported to the daily morning stand up meeting for immediate correction. Administrator will identify trends related to Emergency Preparedness P&P, and report them to the monthly Quality Assurance Performance Improvement (QAPI) meeting for evaluation, planning, and resolution.

Completion Date
9/21/18

Event ID 9RIQ21

Exit Date 8/23/18

9/6/18

Antonio Moya, Jr.
Administrator

Diamond Ridge Healthcare Center
2351 Loveridge Road
Pittsburg, CA 94565
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K 363 Corridor - Doors
It is the policy of DRHC to have in place and maintain doors that resist the passage of smoke, resist fire for at least 20 minutes, and prevent impediment to the closing of the doors.

Corrective Action
After the identification of this deficiency on 8/23/18, the Maintenance Supervisor (MS) immediately fixed the door to Room 132, which failed to latch. The door now fully closes and would prevent the passage of smoke and flames in the event of fire.

Residents Affected
All residents' safeties have the potential to be affected by DRHC's failure to maintain doors that fully latch and prevent the passage of smoke and flames in the event of fire.

Systemic Changes
No later than 9/21/18, Administrator will in-service MS and staff regarding facility's P&P on maintaining doors that resist the passage of smoke, resist fire for at least 20 minutes, and prevent impediment to the closing of the doors.

Administrator is responsible for overall compliance.

Monitoring
Moving forward, MS will perform Preventive Maintenance (PM) rounds on a weekly basis, including testing doors to ensure they fully latch and prevent the passage of smoke and flames in the event of fire.

In addition, Administrator will continue to conduct random facility rounds on a daily basis to ensure compliance with Life Safety regulations. Administrator will check the PM Log for completeness.

Any issues will be immediately reported to the daily morning stand up meeting for immediate correction. Administrator will identify trends related to the fire safety of doors, and report them to the monthly QAPI meeting for evaluation, planning, and resolution.

Completion Date
9/21/18

Event ID 9RIQ21

Exit Date 8/23/18

9/6/18

Antonio Moya, Jr.
Administrator

RECEIVED
By CDPH-LSC at 6:36 am, Sep 07, 2018

RECEIVED
By CDPH-LSC at 6:36 am, Sep 07, 2018

Diamond Ridge Healthcare Center
2351 Loveridge Road
Pittsburg, CA 94565
925-427-4444

K 920 Electrical Equipment – Power Cords and Extension
It is the policy of DRHC to prevent the use of power cords and extension cords in resident rooms and other areas.

Corrective Action
After the identification of this deficiency on 8/23/18, MS immediately removed the extension cord in Room 217. MS also immediately removed the power adapter in Room 135.

Residents Affected
All residents' safeties have the potential to be affected by DRHC's deficiency of using an extension cord and a power adapter as substitutes for fixed wiring.

Systemic Changes
No later than 9/21/18, Administrator will in-service MS and staff regarding facility's P&P on Electrical Equipment, including the risk of using power cords and extension cords.

Administrator is responsible for overall compliance.

Monitoring
Moving forward, MS will perform PM rounds on a weekly basis, including searching for unauthorized use of power cords and extension cords.

In addition, Administrator will continue to conduct random facility rounds on a daily basis to ensure compliance with Life Safety regulations. Administrator will check the PM Log for completeness.

Any issues will be immediately reported to the daily morning stand up meeting for immediate correction. Administrator will identify trends related to the unauthorized use of power cords and extension cords and report them to the monthly QAPI meeting for evaluation, planning, and resolution.

Completion Date
9/21/18

Event ID 9RIQ21 Exit Date 8/23/18

9/6/18

Antonio Moya, Jr.
Administrator