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

PRINTED: 08/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555251	A. BUILDING 02 B. WING _____	07/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLS WEST CONVALESCENT HOSPITAL	16890 GREEN TREE BLVD VICTORVILLE, CA 92395

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K 000	INITIAL COMMENTS K 3 BUILDING: K 6 PLAN APPROVAL: 1987 and 2011 K 7 SURVEY UNDER: STRUCTURE TYPE: Single Story, Type II (222), Fully Sprinklered The following reflects the findings of the California Department of Public Health, during a initial Life Safety Code certification survey. The findings are in accordance with 42 CFR (Code of Federal Regualtions) 483. 70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, New Codes. Representing the California Department of Public Health: 18996 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 111	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of the building construction. This was evidenced by penetrations in the walls.	K 012	**1A.** Maintenance & QA made full facility rounds to assure no other penetrations in dry wall exist on 07/31/2013, no other penetrations in drywall were found. **1B.** Facility added "check for penetrations in walls" to the monthly Facility QA rounds report on 08/07/2013. Administration will monitor effective 08/07/2013.	

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

DNHA 8.14.13

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.

8/15/13 - POC Acceptable per Jeri Cochran

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K 012	Continued From page 1 This effects 1 of 7 smoke compartments and may result in the spread of smoke smoke and flames in the event of a fire. Findings: On 7/30/13, during a tour of the facility the walls and ceilings were observed. AT 10:44 a.m., there was a approximately 1/4 inch penetration in the right wall of the utility room.	K 012	**1C.** QA will monitor by way of monthly rounds and involvement with maintenance projects to assure deficient practice does not recur as of 08/07/13. Maintenance staff was in-serviced on repairing all penetrations in dry wall when made or found on 07/31/2013. **2A.** Corrective action completed on 07/31/2013. **1A.** Maintenance Supervisor adjusted Station 1 Ice Room door and North Shower door to close completely on self closure on 07/30/13. **1B.** Maintenance Supervisor checked all self closing doors in the facility on 07/30/13 and did not find any other deficient practice. **1C.** QA will round with Maintenance Staff when conducting Fire Alarm testing 1 time per month to assure all doors are closing properly. Effective 08/07/13 **1D.** Fire door closure was added to QA monthly Maintenance rounds as of 08/07/13, this will be monitored by Administration monthly as of 08/07/13. **1E.** Corrective action was completed on 07/30/2013.	07.31.13 07.30.13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the corridor doors. This was evidenced by doors that failed to latch upon self closure. This affected 1 of 7 smoke compartments and could result in the passage of smoke and flames in the event of a fire. Findings: On 7/30/13, during a tour of the facility the doors were observed. Station 1 1. At 10:45 a.m., the door to the ice room failed to latch on self closure. 2. At 10:46 a.m., the door failed to latch to the north shower.			

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K 018	Continued From page 2 3. At 10:48 a.m., the door to the storage room failed to latch upon self closure.	K 018	**1A.** TRL (Fire Alarm Company) repaired all items on Annual Fire Report on 08/09/2013 (ie, chimes by room 7 and 13 as well as description changes to panel display for Therapy Storage to now read Medical Records Storage) All areas of concern identified on Annual Fire Alarm Testing Report have been corrected/repaired by TRL on 08/09/2013. System is fully operational and signed off by TRL. Administration will monitor Annual Report Annually to assure all areas of concern are followed up on in a timely manner Effective 08/01/13. Annual Report findings added to Maintenance QA effective 08/14/13. QA to monitor and report to Administration effective 08/14/13. **1B.** Maintenance Supervisor was in-serviced on 08/01/13 on importance of providing Administration a copy of Annual Report as well as importance of following up on items identified on report in need of repair immediately. **1C.** Corrective actions completed on 08/01/2013. **2A.** Facility followed Policy and Procedure in Fire/Disaster manual to implement walking "FIRE WATCH" rounds on Station 1 once it was determined that	08.01.13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on document review, interview, and observation, the facility failed to maintain the fire alarm system. This was evidenced by no documented evidence of corrections made for the deficiencies identified during the latest annual certification of their fire alarm system. This affected 2 of 7 smoke compartments, 15 smoke detectors and 36 of 111 residents, and could result in delayed notification of a fire. Findings: On 7/30/13, the fire alarm system was observed and documents reviewed. 1. At 9:57 a.m., during document review, the annual certification of the fire alarm system was reviewed. During the annual certification, the following devices were tested and failed. The chime between nurse station 1 and the bell by room 7, and the bell by room 13. No documentation was provided to indicate the corrections had been made for these failures. 2. At 11:20 a.m., the fire alarm panel near the	K 052		

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K 052	Continued From page 3 riser room was observed. The panel was in trouble mode. During an interview with the Maintenance Supervisor, when asked "why the system was in trouble, he stated that they were working on it, that it had to do with the smoke detectors in the old section of the facility". He stated the vendor was looking for a new module for the panel that controls the smoke detectors in the old section of the facility. When asked if the system was down for the facility he stated that only the smoke detectors for the old section. At 12:50 p.m., during an interview when asked when the trouble with the fire alarm system was first observed, he stated he received the call about 7:50 a.m., on 7/30/13. He stated the facility started a fire watch on at about 8:15 a.m., until the fire alarm panel was repaired and the smoke detectors were tested.	K 052	smoke detectors were down on Station 1. TRL (Fire Alarm Company) was notified and identified a "Bad Module" in the Fire Panel located on Residential side of building that coordinates with Fire Panel on Convalescent side of building. Bad Module replacement was ordered and installed on 08/01/2013, walking "Fire Watch" rounds continued until system was fully operational on 08/01/2013. **3A.** Administration and QA will monitor to assure facility continues to follow P&P for future malfunctions/repairs on a monthly and PRN basis as of 08/07/13. **4A.** Corrective action completed on 08/09/2013.	08.09.13
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to ensure that smoke detectors were functional and could provide early warning of a fire. Fifteen smoke detectors in the old facility were not operational and were not able to be tested. This affected 1 of 7 smoke compartments and could result in delayed response to a fire. Findings: On 7/30/13, during a tour of the facility and	K 054	**1A.** Facility followed Policy and Procedure in Fire/Disaster manual to implement walking "FIRE WATCH" rounds on Station 1 once it was determined that 15 smoke detectors were down on Station 1. Effective 07/30/13. **1B.** Maintenance tested all Smoke Detectors in facility and did not find any other Detectors that were not reporting to the panel on 07/31/2013. **1C.** QA & Maintenance will randomly select different detectors every 2 weeks to test to assure deficient practice does not recur effective 08/09/13.	

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K 054	Continued From page 4 interview with the Maintenance Staff, the fire alarm system was observed. At 11:20 a.m., during a tour of the facility the fire alarm panel was observed to be in trouble mode. During an interview with the maintenance supervisor he stated he was aware of it and that the vendor was working on it. He stated the vendor was looking for a new module for the fire alarm panel, this affected 15 smoke detectors in the old part of the facility. The 15 smoke detectors in the old section of the facility were not tested for compliance. The facility is conducting a fire watch in this section of the building until the system is repaired.	K 054	**1D.** Administration/QA will monitor via reporting system monthly, as of 08/07/13 **1E.** Corrective action completed on 08/07/13.	08.07.13
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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the automatic sprinkler system. This was evidenced by sprinklers with escutcheon rings missing. This affected 1 of 7 smoke compartments and could result affect the spray pattern of the sprinkler. Findings: On 7/30/13, during a tour of the facility the sprinklers were observed. At 10:52 a.m., the escutcheon ring was missing from the sprinkler above bed B in room 34.	K 062	**1A.** Escutcheon ring was replaced by Maintenance 07/30/13. Maintenance staff in-serviced on importance of the presence of Escutcheon rings for all fire sprinklers. **1B.** Full House Rounds made by Maintenance Dept, no other Escutcheon rings found to be missing on 07/31/13. **1C.** QA added Escutcheon Rings to Facility Rounds monitoring systems and will report to Administration monthly via report effective 08/07/13 1D. Corrective action completed on 07/31/13.	07.31.13
K 073	NFPA 101 LIFE SAFETY CODE STANDARD	K 073		

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K 073 SS=D	Continued From page 5 No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to provide documentation of the flame spread rating for decorations of a flammable nature. This affected 1 of 7 smoke compartments and could result in the spread of fire. Findings: On 7/30/13, during a tour of the facility with the Maintenance Supervisor, the decorations were observed. 1. At 10:41 a.m., a wreath of artifical flowers was hanging on the corridor side of the door to room 24, no flame spread information was provided. The Maintenance Staff stated they have not treated it. 2. At 10:50 a.m., a wreath of artifical flowers hanging on the corridor side of the door to room 32 with no flame spread information provided. 3. At 10:50 a.m., there was a small basket with artifical flowers hanging on the corridor side of the door to room 33.	K 073	**1A.** Maintenance Supervisor & Social Services removed artificial arrangements from resident rooms 24,32 and 33 fire doors on 07/30/13. **1B.** Full House Rounds made by Maintenance and Social Services Staff on 07/31/13 and no other deficient practices were found. **1C.** QA added to QA rounds on "Resident Rooms" to identify and items found to be placed on fire doors monthly effective 08/01/13 **1D.** Activities Supervisor will inform residents via Resident Council Meeting August 24th, 2013 and Admissions Department has updated admission information on facility rules to include not hanging objects on Resident Room and Bathroom Doors effective 08/14/13. **1E.** Admin will monitor effective 08/14/13.	EA. 08.14.13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain electrical safety. This was evidenced by	K 147		

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K 147	Continued From page 6 medical equipment plugged to extension cords instead of directly to wall outlets. This could result in electrical fire. This affected 2 of 7 smoke compartments. NEC 70, National Electrical Code, 1999 Edition 400-8. Uses Not Permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (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. Findings: On 7/30/13, during a tour of the facility the electrical wiring and equipment was observed. 1. At 10:57 a.m., the air mattress for bed A in room 38 was plugged into a 6 plug adapter. 2. At 11;16 a.m., the bed A was plugged into a surge protector.	K 147	**1A.** Surge Protectors/extension cords were removed as of 07/30/2013 by Maintenance Supervisor. **1B.** Full Facility rounds made and no other Surge protectors or extension cords were found to be in use on 07/30/13. **1C.** All Maintenance and Nursing staff were in-serviced on 08/07/2013 prohibiting use of Surge Bars/extension cords on any/all medical equipment. **1D.** QA added to Resident Room Monthly monitoring QA to check for items on All Fire Doors effective 08/14/13. **1E.** Admin will monitor effective 08/14/13.	08.14.13
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR)	K 211		

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K 211	Continued From page 7 dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that the Alcohol Based Hand Rub (ABHR) dispensers were not installed near an ignition source. This affects 1 of 7 smoke compartments and could result in a fire. Findings; On 7/30/13, during a tour of the facility the ABHR'S were observed. At 10:37 a.m., the ABHR was installed above an electrical outlet in the Sun Dining Room.	K 211	**1A.** Dispenser relocated by Maintenance Supervisor on 07/30/2013. **1B.** Full Facility rounds made and no other dispensers were found to be above an electrical outlet as of 07/31/2013 **1C.** All Maintenance staff were in-serviced on 08/07/2013 prohibiting placement of dispensers above electrical outlets. **1D.** Item added to Facility QA rounds monitoring system and will be monitored by QA and Administration monthly effective 08/07/13 **1E.** Corrective action completed on 08/07/13.	08/07/13