POC ACCEPTED
11-16-18 07598

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

PRINTED: 11/05/2018
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
	555707	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CARE CENTER	11441 VENTURA BLVD STUDIO CITY, CA 91604

(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 This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: 07598 Highest scope and severity= E Total licensed beds:130 Total resident census:123	K 000	THE SIGNING OF THIS PLAN OF CORRECTION IS NOT AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE TRUTH OF THE FACTS ALLEGED IN THIS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION. IN FACT, THIS PLAN OF CORRECTION IS SUBMITTED EXCLUSIVELY TO COMPLY WITH FEDERAL AND STATE LAW. THIS PLAN OF CORRECTION CONSTITUTES MY CREDIBLE ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES NOTED. 2018 NOV 15 PM 4:00	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 223	**K 232 Doors with Self-Closing Devices** **CFR(s): NFPA 101** **Specific Action to Correct the Deficiency:** The door to the dining room has been repaired on 10/22/18 to fully close. **How the facility identify other residents having the potential to be affected:** The smoke doors that prevent smoke and/or fire from passing from one smoke compartment to other areas of the facility were checked to ensure the doors fully close. There were no other smoke doors identified that did not properly close.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Bellantuono NHA
TITLE: ADMINISTRATOR
(X6) DATE: 11/15/18

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.

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: 07598 Highest scope and severity= E Total licensed beds:130 Total resident census:123	K 000	THE SIGNING OF THIS PLAN OF CORRECTION IS NOT AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE TRUTH OF THE FACTS ALLEGED IN THIS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION. IN FACT, THIS PLAN OF CORRECTION IS SUBMITTED EXCLUSIVELY TO COMPLY WITH FEDERAL AND STATE LAW. THIS PLAN OF CORRECTION CONSTITUTES MY CREDIBLE ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES NOTED. 2018 NOV 15 PM 4:00	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 223	**K 232 Doors with Self-Closing Devices** **CFR(s): NFPA 101** **Specific Action to Correct the Deficiency:** The door to the dining room has been repaired on 10/22/18 to fully close. **How the facility identify other residents having the potential to be affected:** The smoke doors that prevent smoke and/or fire from passing from one smoke compartment to other areas of the facility were checked to ensure the doors fully close. There were no other smoke doors identified that did not properly close.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jenna Bellantoni NHA | TITLE: ADMINISTRATOR | (X6) DATE: 11/15/18

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.

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K 223	Continued From page 1 failed to ensure that one of four sets of doors held open by magnets were able to be released from the magnetic holder and automatically close upon the activation of the smoke detectors or pull stations. Smoke doors prevent smoke and/or fire from passing from one smoke compartment to other areas of the facility, in the event of smoke and/or fire. The deficiency affected one out of five smoke compartments. Findings: On October 22, 2018, at 10:38 a.m., during the fire alarm test, the evaluator observed the maintenance supervisor test the smoke detector located by the dining room on the ground floor. At that time, the door to the dining room released but failed to fully close. The evaluator then observed the maintenance supervisor test a pull station at 10:40 a.m. The door to the dining room released but still failed to fully close. During an interview with the maintenance supervisor at 10:41 a.m., he stated he did not know what was preventing the door from fully closing upon activation of the fire alarm system. He further stated he would call the alarm company to repair the problem immediately. The deficiency was brought to the attention of the administrator, the director of nursing and the maintenance supervisor during the exit conference on October 22, 2018.	K 223	**Measures put in place to ensure deficient practice does not recur/systemic changes:** The Maintenance Supervisor will check all smoke doors monthly during preventative maintenance rounds. **Monitoring Performance to ensure that correction is achieved and sustained:** As part of the facility's Continuous Quality Improvement (CQI) program, the Maintenance Supervisor will make a report to the Quality Assessment and Assurance (QAA) committee monthly for the next three months regarding result of the monthly inspection of the smoke doors. The Administrator will monitor for compliance. **Corrective Action Completion:** November 15, 2018	11/15/18
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363	**K 363 Corridor - Doors** **CFR(s): NFPA 101** **Specific Action to Correct the Deficiency:** The corridor door to Shower Room 2A has been repaired on 11/09/18, to ensure the door is flush with the door frame.	

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K 363	Continued From page 2 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 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:	K 363	**How the facility identify other residents having the potential to be affected:** The Maintenance Supervisor checked all corridor doors. No other doors identified with the same deficiency. **Measures put in place to ensure deficient practice does not recur/systemic changes:** The Maintenance Supervisor will check the corridor doors to ensure that the door is flush with the door frame to prevent the passage of smoke to the hallway corridor during his monthly preventative maintenance rounds. **Monitoring Performance to ensure that correction is achieved and sustained:** As part of the facility's CQI program, the Maintenance Supervisor will make a report to the QAA committee monthly for the next three months regarding results of his monthly rounds. The Administrator will monitor for compliance. **Corrective Action Completion:** November 15, 2018	11/15/18

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K 363	Continued From page 3 Based on observation and interview, the facility failed to ensure one corridor door was flush to the top of the door frame so as to prevent the passage of smoke to the hallway corridor. In the event of a fire emergency, rapid closure of doors, without any impediments, is an essential component in the containment of smoke and/or fire. The deficiency affected one out of five smoke compartments. Findings: On October 22, 2018, at 1:14 p.m., during a life safety code tour of the facility, the evaluator observed the corridor door to shower room 2A had a gap between the top of the door and the door frame when the door was closed. The gap measured four inches by one half inch. During an interview, the maintenance supervisor stated he will adjust the door so that there would be no gaps to allow the passage of smoke into the hallway from the room. The deficiency was brought to the attention of the administrator, director of nursing, and the maintenance supervisor during the exit conference on October 22, 2018.	K 363		
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings	K 364	**K 364 Corridor - Openings** **CFR(s): NFPA 101** **Specific Action to Correct the Deficiency:** 1. The transfer grille/louver on the lower portion of the corridor door to the biohazard storage room has been repaired on 10/23/18 so as to provide the required and/or smoke protection in case of a fire emergency. 2. The transfer grille/louver on the lower portion of the corridor door to the Janitor Closet between Rooms 12 and 10 has been repaired on 10/23/18 so as to provide the required fire and/or smoke protection in case of a fire emergency. 3. The transfer grille/louver on the upper and lower portions of the corridor doors to the two residents bathrooms in the basement have been repaired on 10/23/18 so as to provide the required fire and/or smoke protection in case of a fire emergency.	

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K 364	Continued From page 4 are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the corridor doors to the biohazard storage room, janitor closet on the ground floor, and the two resident bathrooms in the basement, did not have a transfer grille/louver. A corridor door equipped with a transfer grille would not provide the required protection from fire and/or smoke during a fire emergency. The deficient practice affected 3 out of 5 smoke compartments. Findings: On October 22, 2018, during a life safety code tour of the facility, the evaluator and the maintenance supervisor observed the following: 1. At 1:14 p.m., the corridor door to the biohazard storage room next to Room 8 on the ground floor had a transfer grille/louver on the lower portion of the door measuring 18 inches in width by 12 inches in height. 2. At 1:27 p.m., the corridor door to the janitor closet between Rooms 12 and 10 on the ground floor had a transfer grille/louver on the lower	K 364	**How the facility identify other residents having the potential to be affected:** The Maintenance Supervisor conducted a facility rounds to identify other doors with a transfer grille/louver. No other doors were identified with transfer grill/louvers. **Measures put in place to ensure deficient practice does not recur/systemic changes:** The Maintenance Supervisor will check during monthly preventative maintenance rounds to ensure no deficient transfer grille/louvers are installed in the facility. **Monitoring Performance to ensure that correction is achieved and sustained:** As part of the facility's CQI program, the Maintenance Supervisor will make a report to the QAA committee monthly for the three months regarding results of his preventative rounds. The Administrator will monitor for compliance. **Corrective Action Completion:** November 15, 2018	11/15/18

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K 364	Continued From page 5 portion of the door measuring 18 inches in width by 12 inches in height. 3. At 2:18 p.m., the corridor doors to the two resident bathrooms in the basement had two transfer grille/louvers each on the upper and lower portions of the door measuring 18 inches in width by 12 inches in height. During an interview with the maintenance supervisor at the time of the observation, he stated that the doors would be repaired so as to provide the required fire and/or smoke protection in case of a fire emergency. The deficiency was brought to the attention of the administrator, the director of nursing, and the maintenance supervisor during the exit conference on October 22, 2018.	K 364		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping 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: Based on observation and interview, the facility failed to comply with the electrical wiring	K 511	**K 511 Utilities – Gas and Electric** **CFR(s): NFPA 101** **Specific Action to Correct the Deficiency:** The electrical outlets in residents' bathroom sinks have been replaced with *Ground-Fault Circuit Interrupter* (GFCI) protected outlets on 10/23/18. **How the facility identify other residents having the potential to be affected:** No other electrical outlets in residents' bathroom sinks that is not GFCI protected were identified.	

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K 511	Continued From page 6 requirements in accordance with NFPA 70, National Electric Code 2011 Edition. Article 210.8(B) Sinks. All 15A and 20A, 125V receptacles installed within 6 feet of the outside edger of a sink must be GFCI (Ground Fault Circuit Interrupter)-protected. Thirty four out of 44 residents' bathroom sinks with electrical outlets were not GFCI protected. A Ground Fault Circuit Interrupter is used to protect residents from electrical shock hazards when using electrical appliances near wet locations. The deficient practice affected four out of five smoke compartments. Findings: During a life safety code tour of the facility on October 22, 2018, from 1:10 p.m., to 2:05 p.m., in the presence of the maintenance supervisor, the evaluator observed 34 out of 44 residents' bathroom sinks (2, 3, 5, 7, 9, 11/13, 12/10, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26/28, 27, 29, 30/32, 31, 33, 34/36, 38, 39, 40, 41, 42, 45, and two resident bathroom sinks in the basement) had electrical outlets installed next to the wash basin sinks that were not GFCI protected. During an interview, the maintenance supervisor stated he would either replace the existing electrical outlets with GFCI protected ones or seal off the outlets. The deficiency was discussed with the administrator, the director of nurses, and the maintenance supervisor during the exit conference on October 22, 2018.	K 511	**Measures put in place to ensure deficient practice does not recur/systemic changes:** The Maintenance Supervisor will check electrical outlets in residents' bathroom sinks to ensure it is replaced with GFCI protected outlets when needed during his monthly preventative rounds. **Monitoring Performance to ensure that correction is achieved and sustained:** As part of the facility's CQI program, the Maintenance Supervisor will make a report to the QAA committee monthly for the next three months regarding result of his monthly preventative maintenance rounds. The Administrator will monitor for compliance. **Corrective Action Completion:** November 15, 2018	11/15/18
K 541	Rubbish Chutes, Incinerators, and Laundry Chu	K 541	**K 541 Rubbish Chutes, Incinerators, and Laundry Chute CFR(s): NFPA 101** **Specific Action to Correct the Deficiency:** The soiled resident gown wrapped around the sprinkler head with metal cage was removed on 10/22/18.	

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K 541 SS=D	Continued From page 7 CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the laundry chute so that the sprinkler head was not wrapped up with linen, hampering its ability to provide sprinkler protection during a fire. An automatic extinguishing protection system is an essential component to decreasing/eliminating the propagation of fire up a laundry chute. Findings:	K 541	**How the facility identify other residents having the potential to be affected:** The Maintenance Supervisor conducted a facility rounds to ensure that sprinkler heads are not hampered with any material. **Measures put in place to ensure deficient practice does not recur/systemic changes:** The Maintenance Supervisor will check during his monthly preventative maintenance rounds to ensure that sprinkler heads are not hampered with any materials. The Environmental Service Supervisor conducted an in-service with housekeeping and laundry staff on 10/23/18, regarding making sure that no linen is wrapped around the sprinkler head when throwing linen down the chute by visually checking before closing the laundry chute door. The Director of Staff Development conducted an in-service with nursing staff on 10/31/18, regarding making sure that no linen is wrapped around the sprinkler head when throwing linen down the chute by visually checking before closing the laundry chute door. **Monitoring Performance to ensure that correction is achieved and sustained:** As part of the facility's CQI program, the Maintenance Supervisor will make a report to the QAA committee monthly for the next three months regarding result of the monthly preventative maintenance rounds to ensure that sprinkler heads are not hampered. The Administrator will monitor for compliance. **Corrective Action Completion:** November 15, 2018	11/15/18

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K 541	Continued From page 8 During a life safety code tour of the facility on October 22, 2018, at 1:36 p.m., in the presence of the maintenance supervisor, the evaluator observed the sprinkler head located at the top of the linen chute had a resident gown wrapped around it. During an interview with the maintenance supervisor , he stated that the nursing staff have to be more careful when throwing linen down the chute so that the sprinkler head is not blocked. The deficient practice affected 2 out of five smoke compartments. The deficiency was discussed with the administrator, the director of nurses, and the maintenance supervisor during the exit conference on October 22, 2018.	K 541	**This page intentionally left blank**	

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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 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 07598 Census :130 Bed capacity:123 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000		

2018 NOV 15 PM 4:00

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jemma Bellantoni NHA | TITLE: ADMINISTRATOR | (X6) DATE: 11/15/18

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.