asid any 200

37kg (200) Sifesil / (arm		ERUTAN	DERSUPPLIER REPRESENTATIVES SIG	VORTECTORS OR PROV	ROTAROBA
SING WAY	-				ntion and interview, the facility		
		not properly close.			beonabive as fem fon at TV		
		were no other smoke doors identified that	•	1	8.2.2.2.81 ,7.2.2.2.81	18.2.2.2.81	
		checked to ensure the doors fully close. T				* Loss of power.	
		fire from passing from one sn compartment to other areas of the facility v			er system, if installed; and	* Automatic sprink	ŀ
[The smoke doors that prevent smoke an		ŀ	vatem: suq	smoke detection s	
l i		having the notential to be affected:			beniupen a to gninedo ent riguo	Trip Brigger and The Trip	ł
	झक	How the facility identify other resid			fire alarm system; and sctors designed to detect	" Kequileu inclue	į.
[]		there forms as as many up			iline facility upon activation of:	19 TO JASITITISM OF GT	
1.	nam	The door to the dining room has been repo	1		exporte eth troughout the smoke	closes all such dec	
1					With 7.2.1.8.2 that automatically	v Britigmoo eoiveb	j
[. 12	Spealife Action to Correct the Deficiency	l		less heid open by a release	nu .gostisog basols I	i
		CLK(8): NELV 101			self-closing and kept in the	916 Stucchine Retre	i.
		Devices			moke barrier, or hazardous	ay sive his in clood A fixe istrostrod to	
	2	K 232 Doors with Self-Closin			sasgeway, stairway enclosure,	Doors with Self-Clo	
					Soprag acies	NO NO WITH SECOND	}
	_			i		CFR(s): NFPA 101	0=88
	8		523	K:	Sevices Devices	Doors with Self-Cla	K 553
	t: 00					Total resident cens	
	Pa				130	sbed beansoil latoT	
	. 4				= _fuoAcc	Highest scope and	
	15				∃ ≡uffraves	hne arona taodaiti	
1	<u> </u>	DEMCIENCIES NOLED* CEEDIESS VITEGYLION ON CONNTIVACE NOB	j			07598	
	יולב"	THIS PLAN OF CORRECTION CONSTITUTES			epstruent of Public Health:] arit pritneserra9	
	3	COURT ALTH PEDERAL AND STATE LAW	1		۸- ا	Safety Code Surve	
1	i or	COMPECTION IS SUBSTITIED EXCEUSIVIELY.	l		Sild eth grinub dilise Holi		
· 1	ASSET	IN THIS STATEMENT OP DEPICIENCIES AND P			ent to agnitum ent atnes	ergen griwollof enT	
		SVCIPLA OS LEE LEGLE OS LEE SVCL8 VITE			4		
		KOL YN YDWISSION OB YGBERHENL BA LE			other applicable codes.	Occupancies, and	
	""	THE SIGNING OF THIS PLAN OF CORRECTION			Existing Health Care	Right Change 19	
i i					IVEYED UNDER 42 CFR Part Sty Code NFPA 101, 2012	1 1132 18CHILÀ AASS 201	
	l				tred 930 CA rober: beyen-	and a second	
			000	14		INITIAL COMMEN	K 000
			001	<i>)</i>	1		
		DELICIENCA					
DATE		CROSS-REPERENCED TO THE APPROPT		DAT	BC (DENTIFYING INFORMATION)	REGULATORY OR L	XITERA DAT
(SIG)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	*	OI 취료자위	TEMENT OF DEFICIENCES	ATS YRAMMUS	Q1 (bX)
	•	INDIO CITY, CA 91604	LS		,	L CARE CENTER	AIN3480
AA1 VENTURA BLVD					GSTUSŲ SGYU	A (G3G11)	
	REET ANDRESS, CITY, STATE, ZIP CODE					ROVIDER OR SUPPLIER	HAME OF F
81/02/23	2/01			B. WING	707 888		
רבובו	OH - MAIN BUILDING OH		D EN:	A BUILD	IDENTIFICATION NUMBER:	F CORRECTION	O NASH GWA
	CONSTRUCTION (23) DATE SURVEY		2.JqTT.	EFICIENCIES (X1) PROVIDERSUPPLIERICLIA (X2) MULTIP		OF DEFICIENCIES	STATEMENT
1660-8660		10 865L0 B1		2/-1	& MEDICAID SERVICES		
APPROVED APPROVED				11-1	AND HUMAN SERVICES	MENT OF HEALTH	TAA930

program participation. Any deficiency statement ending with an sateriek (**) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sates are stated above are disclosable 80 days other sates provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings and plans of conection are disclosable 14 deficiently the date these documents are made available to the facility. If deficiencies are cited, an approved plan of conection is negligible to continued days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of conection is negligible to continued days following the date these documents are made available to the facility.

31151111

PRINTED: 11/05/2018

ROTHSTEMINION

MHA

from petterina

PRINTED: 11/05/2018 FORM APPROVED OMB_NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		555707	B. WING _		10/22/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	X5) PLETION PATE
K 000	INITIAL COMMEN	rs	K 00	00		
K 223 SS=D	483.70(a), Life Safe Edition, Chapter 19 Occupancies, and of The following representation of Pub Safety Code Survey Representing the D07598 Highest scope and Total licensed beds Total resident cens Doors with Self-Clo	epartment of Public Health: severity= E ::130 us:123	K 22	THE SIGNING OF THIS PLAN OF CORRECTION NOT AN ADMISSION OR AGREEMENT BY THE FACILITY OF THE TRUTH OF THE FACTS ALL IN THIS STATEMENT OF DEFICIENCIES AND OF CORRECTION. IN FACT, THIS PLAN OF CORRECTION IS SUBMITTED EXCLUSIVELY COMPLY WITH FEDERAL AND STATE LAND THIS PLAN OF CORRECTION CONSTITUTES CREDIBLE ALLEGATION OF COMPLIANCE FOR DEFICIENCIES NOTED.	HIS EGED PLAN F TO V.	
	or horizontal exit, s area enclosure are closed position, undevice complying v closes all such doo compartment or en * Required manual * Local smoke dete smoke passing thre smoke detection sy * Automatic sprinkl * Loss of power. 18.2.2.2.7, 18.2.2.2 This REQUIREME by: Based on observa	ssageway, stairway enclosure, moke barrier, or hazardous self-closing and kept in the less held open by a release with 7.2.1.8.2 that automatically are throughout the smoke tire facility upon activation of: fire alarm system; and ectors designed to detect ough the opening or a required extem; and er system, if installed; and 2.8, 19.2.2.2.7, 19.2.2.2.8 NT is not met as evidenced tion and interview, the facility		K 232 Doors with Self-Closin Devices CFR(s): NFPA 101 Specific Action to Correct the Deficience The door to the dining room has been repon 10/22/18 to fully close. How the facility identify other residuaving the potential to be affected: The smoke doors that prevent smoke a fire from passing from one strompartment to other areas of the facility checked to ensure the doors fully close. Twere no other smoke doors identified the not properly close.	aired dents nd/or noke were There t did	ATE
LABORATOR	V DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) D	MIC

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.

ADMINISTRATOR

NHA

PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	555707	B. WING	STREET ADDRESS, CITY, STATE, ZIP		10/22/2018	
	L CARE CENTER			11441 VENTURA BLVD STUDIO CITY, CA 91604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 223 K 363 SS=D	open by magnets we the magnetic holder the activation of the stations. Smoke do from passing from other areas of the frand/or fire. The defision of the smoke compartments of the frand/or fire. The defision of the smoke compartments of the france super located by the dining and the france super located by the dining of the evaluator then supervisor test a property of the dining of the france of the france of the further stated in the further stated in the france super conference on Oct.	at one of four sets of doors held were able to be released from a rand automatically close upon a smoke detectors or pull cors prevent smoke and/or fire one smoke compartment to acility, in the event of smoke ficiency affected one out of five ints. 18, at 10:38 a.m., during the evaluator observed the visor test the smoke detector of room on the ground floor. Or to the dining room released ose. observed the maintenance call station at 10:40 a.m. The oom released but still failed to with the maintenance a.m., he stated he did not eventing the door from fully ation of the fire alarm system. It is brought to the attention of the director of nursing and the rvisor during the exit ober 22, 2018.	K 2	The Maintenance Supervisor smoke doors monthly during maintenance rounds. Monitoring Performance to correction is achieved and sus. As part of the facility's Cont Improvement (CQI) program, the Supervisor will make a report Assessment and Assurance (Que monthly for the next three moresult of the monthly inspection doors. The Administrator with compliance. Corrective Action Completion November 15, 2018 K 363 Corridor - Door CFR(s): NFPA 101 Specific Action to Correct the The corridor door to Shower been repaired on 11/09/18, to is flush with the door frame.	will check all g preventative ensure that tained: inuous Quality ne Maintenance to the Quality AA) committee onths regarding n of the smoke ill monitor for the smoke ill monitor for the tained: EDeficiency: Room 2A has	1/15/18	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CA920000078

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 A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		555707	B. WING			10/2	22/2018	
IMPERIAL CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	1 S	TREET ADDRESS, CITY, STATE, ZIP CODE 1441 VENTURA BLVD TUDIO CITY, CA 91604 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE	
K 363	Corridor - Doors Doors protecting corequired enclosure: hazardous areas reand are made of 1 wood or other mate at least 20 minutes smoke compartme the passage of smote to rooms containing materials have pose latches are prohibit requirements do not do not contain flam Clearance between covering is not exc complying with 7.2. with a device capa when a force of 5 li impediment to the devices that releas pulled are permitte of unlimited height meeting 19.3.6.3.6 shall be labeled an materials in compli smoke compartme window assemblies sprinklered compa restrictions in area frames in window a 19.3.6.3, 42 CFR f and 485 Show in REMARK protection ratings, etc.	prridor openings in other than a sof vertical openings, exits, or esist the passage of smoke 3/4 inch solid-bonded core erial capable of resisting fire for . Doors in fully sprinklered into are only required to resist oke. Corridor doors and doors of flammable or combustible itive latching hardware. Roller and by CMS regulation. These of apply to auxiliary spaces that imable or combustible material. In bottom of door and floor eeding 1 inch. Powered doors 1.9 are permissible if provided to be of keeping the door closed of is applied. There is no closing of the doors. Hold open e when the door is pushed or d. Nonrated protective plates are permitted. Door frames d made of steel or other ance with 8.3, unless the ent is sprinklered. Fixed fire is are allowed per 8.3. In retments there are no or fire resistance of glass or		363	How the facility identify other resibaving the potential to be affected: The Maintenance Supervisor checke corridor doors. No other doors identified the same deficiency. Measures put in place to ensure deficiency. The Maintenance Supervisor will checker corridor doors to ensure that the door is with the door frame to prevent the passismoke to the hallway corridor during monthly preventative maintenance round. Monitoring Performance to ensure correction is achieved and sustained: As part of the facility's CQI program Maintenance Supervisor will make a repette QAA committee monthly for the three months regarding results of his months. The Administrator will monit compliance. Corrective Action Completion: November 15, 2018	d all d with icient es: k the flush age of g his s. that n, the port to e next onthly	1/15/18	

Facility ID: CA920000078

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		555707	B. WING	B. WING		10/22/2018	
	PROVIDER OR SUPPLIER			11	IREET ADDRESS, CITY, STATE, ZIP CODE 1441 VENTURA BLVD TUDIO CITY, CA 91604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 364 SS=E	failed to ensure one top of the door fram passage of smoke event of a fire eme without any impedia component in the ofire. The deficiency compartments. Findings: On October 22, 20 safety code tour of observed the corrich had a gap between door frame when the measured four incharacter of the deficiency was administrator, directly be no gaps to allow the hallway from the the deficiency was administrator, directly maintenance supeconference on Oct Corridor - Opening CFR(s): NFPA 101 Corridor - Opening Transfer grilles are doors. Auxiliary spread to have louvers or In other than smokens.	tion and interview, the facility a corridor door was flush to the ne so as to prevent the to the hallway corridor. In the regency, rapid closure of doors, ments, is an essential containment of smoke and/or affected one out of five smoke affected one out of five smoke the facility, the evaluator for door to shower room 2A the top of the door and the ne door was closed. The gap hes by one half inch. If the maintenance supervisor the door so that there would we the passage of smoke into the corroom. It brought to the attention of the corroor during the exit ober 22, 2018. It is not used in corridor walls or paces that do not contain outstible materials are permitted.	κ:	364	K 364 Corridor - Openings CFR(s): NFPA 101 Specific Action to Correct the Deficien 1. The transfer grille/louver on the portion of the corridor door to the biol storage room has been repaired on 10/23 as to provide the required and/or protection in case of a fire emergency. 2. The transfer grille/louver on the portion of the corridor door to the Closet between Rooms 12 and 10 has repaired on 10/23/18 so as to provirequired fire and/or smoke protection in of a fire emergency. 3. The transfer grille/louver on the upplower portions of the corridor doors to tresidents bathrooms in the basement been repaired on 10/23/18 so as to provirequired fire and/or smoke protection in of a fire emergency.	lower hazard 1/18 so smoke lower Janitor s been de the in case per and he two t have ide the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		555707	B. WING			10/22/2018	
IMPERIA (X4) ID	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF	1º S	TREET ADDRESS, CITY, STATE, ZIP CODE 1441 VENTURA BLVD STUDIO CITY, CA 91604 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRODEFICIENCY)		DATE
K 364	are permitted in visithe openings per roinches and are at of floor to ceiling. In sper room do not ex Vision panels in cofixed window asserfully sprinklered sm no restrictions in the glass and frames.) 18.3.6.5.1, 19.3.6.5. This REQUIREME by: Based on observationation from the basement, did grille/louver. A cortransfer grille would protection from fire emergency. The dof 5 smoke comparation from the facility, maintenance super 1. At 1:14 p.m., the storage room next had a transfer grille the door measurin inches in height. 2. At 1:27 p.m., the closet between Room in the sin height.	sion panels or doors, provided from do not exceed 20 square for below half the distance from prinklered rooms, the openings acced 80 square inches. Tridor walls or doors shall be inables in approved frames. (In noke compartments, there are see area and fire resistance of 5.2, 8.3 NT is not met as evidenced attion and interview, the facility at the corridor doors to the room, janitor closet on the he two resident bathrooms in not have a transfer ridor door equipped with a door provide the required and/or smoke during a fire efficient practice affected 3 out	K	364	How the facility identify other rhaving the potential to be affected: The Maintenance Supervisor cond facility rounds to identify other door transfer grille/louver. No other doo identified with transfer grill/louvers. Measures put in place to ensure depractice does not recur/systemic chate. The Maintenance Supervisor will check monthly preventative maintenance recensure no deficient transfer grille/lou installed in the facility. Monitoring Performance to ensure correction is achieved and sustained: As part of the facility's CQI progress Maintenance Supervisor will make a result the QAA committee monthly for the months regarding results of his prevent of the prevent of	eficient nges: k during unds to vers are that am, the eport to the three entative	11/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		555707	B. WING			10/22/2018	
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 1441 VENTURA BLVD TUDIO CITY, CA 91604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 364	portion of the door by 12 inches in height 3. At 2:18 p.m., the resident bathrooms transfer grille/louve lower portions of the width by 12 inches. During an interview supervisor at the tile stated that the door provide the require in case of a fire em. The deficiency was administrator, the comministrator, the comministrator of the require in case of a fire em. The deficiency was administrator, the comministrator of the conference on Octutilities - Gas and CFR(s): NFPA 101. Utilities - Gas and Equipment using gromplies with NFP electrical wiring an NFPA 70, National installations can compare to life. 18.5.1.1, 19.5.1.1, This REQUIREME by: Based on observations.	measuring 18 inches in width ght. corridor doors to the two in the basement had two irs each on the upper and e door measuring 18 inches in in height. with the maintenance me of the observation, he res would be repaired so as to dire and/or smoke protection tergency. brought to the attention of the director of nursing, and the roisor during the exit ober 22, 2018. Electric Electric Electric Electric Sor related gas piping A 54, National Fuel Gas Code, dequipment complies with Electric Code. Existing ontinue in service provided no		511	K 511 Utilities – Gas and Electric CFR(s): NFPA 101 Specific Action to Correct the Deficien The electrical outlets in residents' bat sinks have been replaced with Ground Circuit Interrupter (GFCI) protected on 10/23/18. How the facility identify other reshaving the potential to be affected: No other electrical outlets in residents bathroom sinks that is not GFCI prowere identified.	hroom I-Fault outlets idents	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		555707	B. WING _		10	/22/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 11441 VENTURA BLVD STUDIO CITY, CA 91604	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 511	National Electric Co 210.8(B) Sinks. All receptacles installe edger of a sink muci Circuit Interrupter)-residents' bathroom were not GFCI produterrupter is used electrical shock has appliances near we practice affected for compartments. Findings: During a life safety October 22, 2018, the presence of the evaluator observed bathroom sinks (2, 16, 17, 18, 19, 20, 29, 30/32, 31, 33, 3 and two resident be basement) had elethe wash basin sin protected. During an interview stated he would eit electrical outlets woff the outlets. The deficiency was administrator, the maintenance superconference on October 210.	cordance with NFPA 70, ode 2011 Edition. Article 15A and 20A, 125V d within 6 feet of the outside at be GFCI (Ground Fault protected. Thirty four out of 44 in sinks with electrical outlets tected. A Ground Fault Circuit to protect residents from zards when using electrical et locations. The deficient our out of five smoke code tour of the facility on from 1:10 p.m., to 2:05 p.m., in a maintenance supervisor, the 134 out of 44 residents' 3, 5, 7, 9, 11/13, 12/10, 14, 15, 21, 22, 23, 24, 25, 26/28, 27, 34/36, 38, 39, 40, 41, 42, 45, athroom sinks in the ctrical outlets installed next to ks that were not GFCI w, the maintenance supervisor ther replace the existing ith GFCI protected ones or seal of discussed with the director of nurses, and the rvisor during the exit ober 22, 2018.		The Maintenance Supervisor we electrical outlets in residents' baths to ensure it is replaced with GFC outlets when needed during his preventative rounds. Monitoring Performance to encorrection is achieved and sustain. As part of the facility's CQI promaintenance Supervisor will make the QAA committee monthly for three months regarding result of his preventative maintenance round Administrator will monitor for compactive Action Completion: November 15, 2018 K 541 Rubbish Chutes, Incinerators, and Laundry CFR(s): NFPA 101 Specific Action to Correct the Deep The soiled resident gown wrapped sprinkler head with metal cage we on 10/22/18.	changes: vill check room sinks I protected s monthly sure that ed: ogram, the a report to r the next is monthly s. The oliance.	11/15/18
K 541	Rubbish Chutes, I	ncinerators, and Laundry Chu	K 54	} 1		

PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1		E CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED	
		555707	B. WING			10/2	22/2018
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 1441 VENTURA BLVD TUDIO CITY, CA 91604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 541 SS=D	Rubbish Chutes, In Chutes 2012 EXISTING (1) Any existing line pneumatic rubbish directly onto any coresistive construction shall be provided water a fire protection rate shall comply with 9 (2) Any rubbish chup neumatic rubbish provided with autor in accordance with (3) Any trash chuter collection room user protected in accordance with 19 (4) Existing fuel-feed by fire resistive corruse. 19.5.4, 9.5, 8.4, NET his REQUIREMED by: Based on observational first sprinkler head was hampering its ability protection during a extinguishing protection manual resistive component to decide the second	en and trash chute, including and linen systems, that opens orridor shall be sealed by fire on to prevent further use or with a fire door assembly having ing of 1-hour. All new chutes 1.5. Lute or linen chute, including and linen systems, shall be matic extinguishing protection 9.7. It is shall discharge into a trash and for no other purpose and dance with 8.4. (Existing mitted to discharge into same of by automatic sprinklers in 19.3.5.9 or 19.3.5.7.) It incinerators shall be sealed instruction to prevent further	K	541	How the facility identify other resibaving the potential to be affected: The Maintenance Supervisor conduct facility rounds to ensure that sprinkler are not hampered with any material. Measures put in place to ensure deferractice does not recur/systemic change. The Maintenance Supervisor will check this monthly preventative maintenance resonance to ensure that sprinkler heads are hampered with any materials. The Environmental Service Superconducted an in-service with houseked and laundry staff on 10/23/18, regardless are the sprinkler head when throwing linen the chute by visually checking before the laundry chute door. The Director of Staff Development condant in-service with nursing staff on 10/10 regarding making sure that no line wrapped around the sprinkler head throwing linen down the chute by visually checking before closing the laundry door. Monitoring Performance to ensure correction is achieved and sustained: As part of the facility's CQI program Maintenance Supervisor will make a repthe QAA committee monthly for the three months regarding result of the more preventative maintenance rounds to that sprinkler heads are not hampered. Administrator will monitor for compliance Corrective Action Completion: November 15, 2018	ted a heads icient es: during ounds ervisor eeping arding round down losing lucted 31/18, en is when sually chute that that n, the port to enext onthly ensure The	11/15/18

Event ID: B70021

Facility ID: CA920000078

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		555707	B. WING_			10/2	22/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, 11441 VENTURA E STUDIO CITY, C			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CO	DER'S PLAN OF CORRECTI DRRECTIVE ACTION SHOUI FERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 541	October 22, 2018, of the maintenance observed the sprint the linen chute had around it. During an interview supervisor, he stat to be more careful chute so that the significant pract smoke compartme. The deficiency was administrator, the officiency was administrator.	code tour of the facility on at 1:36 p.m., in the presence expervisor, the evaluator kler head located at the top of a resident gown wrapped with the maintenance ted that the nursing staff have when throwing linen down the prinkler head is not blocked. ice affected 2 out of five ints.	K 54	This pa	ge intentionally	left	

PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		555707	B. WING	B. WING		10/22/2018	
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 11441 VENTURA BLVD STUDIO CITY, CA 91604	•	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	The following reflectalifornia Department Emergency Prepare The findings are in Federal Regulation for Long Term Care Representing the CHealth: 07598 Census:130 Bed capacity:123 The facility is in subsections and prepared to the capacity of the capacit	cts the findings of the ent of Public Health, during an edness recertification survey. accordance with 42 Code of s (CFR) 483.73, Requirement e (LTC) Facilities. California Department of Public estantial compliance with 42 and Term Care (LTC) Facilities.	E	000		70 1:07 15 PH 4: 00	
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

ADMINISTRATOR

NHA