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

7/6/15 #16279 POC ACCEPTABLE

PRINTED: 06/03/2015
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
	055344	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA CLAREMONT HEALTH	590 S. INDIAN HILL BLVD. CLAREMONT, CA 91711

(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, 2000 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: Evaluator #: 16279, REHS, HFE I Resident census: 95 Bed capacity: 99 Highest Scope & Severity: E	K 000	**Country Villa Claremont** submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

2015 JUN 16 AM 9:27
LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

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

7/6/15

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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors positively close and latch. 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 door to the ice machine room did not positively close and properly latch. Findings: On May 20, 2015, between 12:50 p.m. to 3:25 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code tour of the facility. At 2:40 p.m., the evaluator observed that the door to the facility's ice machine room did not positively close and properly latch, when closed. Upon closer observation, it was noticed that the door's top hinge was broken. At 2:41 p.m., the maintenance supervisor informed the evaluator that he would immediately repair this door to positively close and properly latch. The deficient practice affected one of two smoke compartments. On May 20, 2015, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 018	**K018** No residents were affected by the findings. The maintenance supervisor immediately repaired the door to the facility's ice machine room. The broken hinge was replaced and the door now positively closes and properly latches. Correction was done on 5/21/15 Maintenance supervisor evaluated all facility doors to ensure that they positively close and latch. All doors currently close and latch properly. in-service done on 6/9/15 for all staff to ensure that any equipment that is observed to be broken or not working properly be documented in the maintenance log. Maintenance supervisor or designee to check the maintenance log on a daily basis for any maintenance issues logged in. Administrator and maintenance supervisor will conduct random checks to ensure that all doors positively close and latch. The administrator and/ or designee will provide a summary of trend and analysis to the CQI steering committee on the quarterly meeting for review and recommendations.	5/21/15

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K 025 K 025 SS=D	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a fire resistance rating of at least one-half hour by having penetrations through one smoke barrier wall. A penetration on a smoke barrier wall may compromise the integrity of the smoke compartments, thereby allowing smoke and/or fire to pass between the smoke compartments. Findings: On May 20, 2015, between 12:10 p.m. to 3:25 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code tour of the facility. At 12:28 p.m., the evaluator observed an 18-inch by 24-inch square penetration that extended through the smoke barrier, above the medical records office.	K 025 K 025	**K025** No residents were affected by the findings. The maintenance supervisor repaired the square penetration above the medical records office using fire resistant Gypsum Sheathing and fire barrier sealant. Correction done on 5/21/15. All other rooms with smoke barrier walls were evaluated and no corrections were necessary. Administrator and maintenance supervisor will conduct random checks to ensure that there are no penetrations on any smoke barrier walls. The administrator and/ or designee will provide a summary of trend and analysis to the CQI steering committee on the quarterly meeting for review and recommendations.	5/21/15

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K 025	Continued From page 3 During this LSC tour, the maintenance supervisor informed the evaluator that he would seal this penetration with an approved fire rated material (or door), as soon as possible. The deficient practice affected one of two smoke compartments. On May 20, 2015, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 025	**K029** No residents were affected by the findings The maintenance supervisor evaluated and added a surface mounted door closure to the medical records office door. Correction done on 6/11/15 on 6/11/15 the maintenance supervisor repaired and sealed the penetrations in the boiler room.	6/11/15
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous areas were maintained with a one hour fire rated construction, by failing to seal the penetrations and/or maintaining the doors with self-closing devices at two areas. In the event of a fire, the separation of these rooms would not be achieved, which would allow smoke and/or fire to travel	K 029	The maintenance supervisor evaluated all other rooms and spaces larger than 50 sq ft. used for storage of combustible supplies and equipment to ensure that a mounted door closure is present. The maintenance supervisor insepected interior finish of the entire building to ensure that there are no other penetrations on walls, ceilings, doors and exposed surfaces. The maintenance supervisor will conduct weekly rounds to ensure that there are no penetrations on walls, ceilings, doors and exposed surfaces. The administrator and/ or designee will provide a summary of trend and analysis to the CQI steering committee on the quarterly meeting for review and recommendations.	

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K 029	Continued From page 4 from one area to another. Findings: On May 20, 2015, between 12:10 p.m. to 3:25 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code tour of the facility. During the LSC tour, the evaluator observed the following: 1. At 12:37 p.m., the evaluator observed that the medical records office had a large amount of combustible material, which consisted of paper products and the medical records office door did not have a self-closing device, to automatically close and latch the door. During a brief interview, the maintenance supervisor mentioned that the square footage of the medical records office was determined to be 216 square feet (sq. ft.). (According to NFPA 101, Life Safety Code, 2000 Edition, 19.3.2.1, all hazardous areas are rooms and spaces larger than 50 sq. ft., used for storage of combustible supplies and equipment in quantities deemed hazardous by the Authority Having Jurisdiction, and shall have doors that are self-closing.) 2. At 2:45 p.m., the evaluator observed the boiler room which housed two gas fueled water heaters, had two 14-inch penetrations with two 12-inch exhaust tubing that extended through the ceiling. During this LSC tour, the maintenance supervisor informed the evaluator that he would provide a self-closing device to the medical records office door, and seal the penetrations with an approved fire rated sealant, as soon as possible. The deficient practice affected two of two smoke	K 029		

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K 029	Continued From page 5 compartments. On May 20, 2015, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one of six exit access was arranged so that the exit was readily accessible at all times. This South side access pathway was blocked and it also had a rough and uneven surface which had the potential to delay evacuation, in the case of a fire.. Findings: On May 20, 2015, at 12:05 p.m., a review of the facility's evacuation plan showed that there were six evacuation exits. One exit was at the front of the facility (at the lobby entrance), one exit was facing the South side, two exits were facing the East side, one was exit facing the North side, and one exit was facing the West side. On May 20, 2015, between 12:10 p.m. to 3:25 p.m., the evaluator and the maintenance	K 038	**K038** No residents were affected by the findings. The administrator contacted a licensed contractor to construct new concrete egress walkway adjacent to HVAC unit and to extend existing walkway to sidewalk adjacent to front building. Architectural plans are being worked on and will be submitted for city approval. The administrator and/ or designee will provide a summary of trend and analysis to the CQI steering committee on the quarterly meeting for review and recommendations.	8/31/15

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K 038	Continued From page 6 supervisor conducted a Life Safety Code tour of the facility. At 12:50 p.m., it was observed that the South side evacuation exit had a 4-foot wide cement pathway that went along the side of the building,and extending to the front and the back of the building. This 4-foot wide pathway was blocked by a 4-foot by 4-foot air conditioning unit (20 feet to the west of this exit). As the pathway continued to the front (west side) of the building, it could be seen that the cement pathway ended outside of Room 1. The rest of the 50 foot egress was an uneven, bumpy grassy surface, which led to the front parking area. At 12:52 p.m., an interview was conducted with the maintenance supervisor and the administrator regarding this uneven and bumpy egress. The maintenance supervisor was informed that if residents in wheelchairs, gurneys or beds, had to exit the facility, due to a fire emergency, the blocked pathway would delay a safe evacuation, and uneven egress would prevent a quick and safe evacuation. The maintenance supervisor stated he was unaware of this blocked and uneven egress, and that he would correct this, immediately. The deficient practice did not directly affect any of the smoke compartments, but did affect one of two smoke compartments. On May 20, 2015, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 038		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		

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K 069 SS=D	Continued From page 7 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain commercial cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. One of seven grease filters, in the kitchen exhaust system, did not prevent accumulation of grease from building up in the exhaust system. This filter could increase the possibility of a fire hazard inside the exhaust system. Findings: On May 20, 2015, between 12:10 p.m. to 3:25 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code tour of the facility. At 12:40 p.m., the evaluator observed that the kitchen exhaust system had a 3-inch separation, due to a smaller size grease filter at one end of the seven grease filters. This separation could allow grease particles to enter the exhaust system, accumulate grease inside the exhaust system and could cause a fire. At 12:43 p.m., the maintenance supervisor informed the evaluator that he would replace this grease filter with a proper-fitting grease filter, immediately. The deficient practice affected one of two smoke compartments.	K 069	**K069** No residents were affected by the findings. On 6/11/15 The maintenance supervisor installed a proper fitting grease filter eliminating any space and to prevent any particles from entering the exhaust system. Dietary supervisor will conduct random checks to ensure that grease filters are properly fitted and that there are no gaps to prevent grease particles from entering the exhaust system. Any findings by the dietary supervisor will be reported to the maintenance supervisor. The administrator and/ or designee will provide a summary of trend and analysis to the CQI steering committee on the quarterly meeting for review and recommendations.	6/11/15

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K 069	Continued From page 8 On May 20, 2015, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 069		
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to post no smoking signs in areas where oxygen tanks are stored in accordance with 19.3.2.4 NFPA 99 8.6.4.2. Areas where oxygen tanks are being stored without "No Smoking" signs may increase the risk for fire emergencies. Findings: On May 20, 2015, between 12:10 p.m. to 3:25 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code tour of the facility. At 2:55 p.m., the evaluator observed a "crash" cart (which was not in use), with a 25 cubic foot oxygen tank, inside Station 1's utility room. Further observation showed that a "No Smoking" sign was not posted, outside of this room. At 2:57 p.m., the evaluator conducted an interview with the director of nursing regarding the missing "No Smoking" sign. The director of	K 141	**K141** No residents were affected by the findings. On 5/20/15 The maintenance supervisor immediately posted a "no smoking" sign outside of station 1's utility room. All rooms throughout the building containing oxygen tanks have been posted with "no smoking" signs. DON and DSD will inspect all rooms containing oxygen tanks on a weekly basis to ensure that "no smoking" signs are posted. The administrator and/ or designee will provide a summary of trend and analysis to the CQI steering committee on the quarterly meeting for review and recommendations.	5/20/15

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K 141	Continued From page 9 nursing stated that a "No Smoking" sign should be posted at this area and that a sign would be posted, immediately. At 3:30 p.m., the evaluator reviewed the facility's 1994 oxygen administration policy and procedure. This policy stated to post a "No Smoking" sign outside any areas where full and/or empty oxygen tanks are stored. The deficient practice affected one of two smoke compartments. On May 20, 2015, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 141		