P.O.C. Acceptance w/ addendum (P.6) 9/14

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

PRINTED: 08/26/2011
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
	055760	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA CONVALESCENT HOME	415 SOUTH GARFIELD ALHAMBRA, CA 91801

(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: CMS #04917 Census: 89 Highest scope and severity= D Exit date: July 20, 2011	K 000		
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	***K 018 NFPA 101 Life Safety Code Standard – Doors Obstructed – Activity/Dining Rooms.*** a) Corrective action for residents affected by deficiency: The residents and tables were removed when deficiency was brought to our attention. The Administrator explained to Activities and Nursing staff that the doors were to remain un-obstructed. b) Corrective action which may affect others residents: A sign was posted on each of the doors by the Maintenance Supervisor as a reminder to staff. The DSD reviewed the policy with the Nursing staff.	

SEP 21 2011 2:- JUL 2011

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

Barbara Ringer - Administrator

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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K 018	Continued From page 1	K 018		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that the corridor door leading to "Magnolia Room" and the "Garden Room" were not able to resist the passage of smoke, by having the door impeded from closing freely and have the ability to positively latch. The evaluator observed that equipment such as a resident dining table, and resident wheel chair, impeded the doors from closing. In the event of a fire emergency, rapid closure with a means suitable for keeping the door closed without any impediments or penetrations, and the ability for the doors to positively latch are essential component in the containment of smoke and/or fire. At the time the facility bed census was 89, and the licensed bed capacity was 97.

Findings:

On July 19, 2011, between 10:20 a.m. and 11:15 a.m., and between 1:45 p.m. and 3:00 p.m., the evaluator in the presence of the maintenance supervisor conducted a Life and Safety Code (LSC) tour of the facility and observed the following:

a. One the same date, at 2:10 p.m., one of two doors to the Magnolia Room (resident dining/ television room) was not able to resist the passage of smoke by having the door impeded from closing freely and having the ability to positively latch. While residents were observed watching television in the Magnolia Room, one of

c) Systemic Changes: The Activities Staff will check daily to verify that the doors are un-obstructed. The Maintenance staff will also Check daily during routine rounds to make sure the door is un-obstructed

d) Monitoring: The Administrator will monitor for compliance by doing random checks. The Safety Committee will review for compliance at least monthly.

e) The facility will be in substantial compliance by 9/2/11

9/2/11

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K 016	Continued From page 2 two doors was impeded from closing due to the resident's dining table was placed in front of, and against, one of the doors to the Magnolia Room, obstructing the door from readily closing. b. One the same date, at 3:05 p.m., One of two doors to the Garden Room (resident lounge/ television room) was not able to resist the passage of smoke by having the door impeded from closing freely and having the ability to positively latch. While residents were observed watching television in the Garden Room, one of two doors was impeded from closing due to a resident, who was sitting in a wheelchair, was placed in front of one of the doors to the Garden Room, obstructing the door from readily closing. At the same time, during an interview, the maintenance supervisor stated he would make the necessary adjustments to the Magnolia Room and Garden Room, and any other room, to ensure that the doors would not be obstructed; and, that the doors would resist the passage of smoke, and have the ability to close freely and positively latch and close. He further stated he would ensure that housekeeping staff would be in-serviced, including in-services to be done by the Director of Staff Development. The deficiency affected two of 4 smoke compartments. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on July 20, 2011.	K 016		
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those	K 054	***K 054 NFPA 101 Life Safety Code Standard – 1 Smoke Detector not documented for routine services- but working.***	

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K 054	Continued From page 3 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 one of 29 smoke detectors released the electro-magnetically held cross-corridor doors and activate an audible alarm. Smoke detectors that do not release the electro-magnetically held cross-corridor doors would fail to close upon the activation of the fire alarm system and would therefore allow smoke and/or fire to pass from one smoke compartment to other areas of the facility. At the time of survey, the facility census was 89 and the licensed capacity was 97. Findings: On July 14, 2011, between 1:00 p.m. to 3:30 p.m., the Evaluator observed the maintenance supervisor during the Life Safety Code (LSC) survey of the facility, test the facility's fire alarm system in the Lodge Building that included the testing of the 21 smoke detectors and 6 pull stations. On the same date, at 2:40 p.m., the Evaluator observed that one smoke detector, identified as "21," located in the facility's basement activated the audible alarm and released the electro-magnetically held cross-corridor doors when tested. At 2:44 p.m., a pull station, identified as "6," located in the facility's basement activated the audible alarm and released the	K 054	a) Corrective action for residents affected by deficiency: The Maintenance Supervisor added the smoke detector to the routine monitoring form. b) Corrective action which may affect others residents. The administrator re-typed the monitoring form to include instructions and inclusion of all smoke detectors. c) Systemic Changes: The Maintenance Supervisor will monitor all smoke detectors including the one missed and document accordingly. d) Monitoring: The Safety Committee will review at least monthly for compliance by checking documentation. e) The facility will be in substantial compliance by 9/2/11	9/2/11

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K 054	Continued From page 4 electro-magnetically held cross-corridor doors when tested. On July 20, 2011, between 9:30 a.m. and 11:45 a.m., during a review of the facility's fire alarm system documents required for fire inspection, in the presence of the administrator and the maintenance supervisor, the Evaluator found no documentation on the "Alhambra Convalescent Home Monitoring List" that indicated a fire alarm test was conducted on all 21 smoke detectors. On July 20, 2011, at 11:00 a.m., during an interview, the maintenance supervisor stated he would ensure that all 21 smoke detectors were fire alarm tested and that the "Alhambra Convalescent Home Monitoring List" would include documentation that a fire alarm test was routinely conducted on all 21 smoke detectors. The deficient practice affected one of 4 smoke compartments. The deficiency was brought to the attention of the Administrator, and the Maintenance Supervisor, during the exit conference on July 20, 2011.	K 054		
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: NFPA 96, 1998 Edition: Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 8-2 Inspection. An inspection and servicing of the	K 069	K 069 NFPA 101 Life Safety Code Standard – 6 month Service of Kitchen Hood a) Corrective action for residents affected by deficiency: The Maintenance supervisor was made aware of the issue and reminded by the Administrator to stick to the schedule regardless of compliance from outside services.	

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K 069	Continued From page 5 fire-extinguishing system shall be made at least every 6 months by properly trained qualified persons. Based on observation, interview, and record review, the facility failed to ensure that the cooking facilities were protected in accordance with NFPA 96, by failing to provide documented evidence that an inspection and servicing of the fire-extinguishing system was conducted every six months by a qualified person. The six-month service of the kitchen fire-extinguishing system helps prevent accumulation of grease and other fire active materials from building up in the fire extinguishing system thereby, helping to decrease the potential for a fire hazard in the hood and flue in kitchen. At the time of the survey, the facility's census was 87 and the licensed capacity was 97 beds. Findings: On July 20, 2011, between 9:30 a.m. and 11:45 a.m., during a review of the facility's life safety code documents required for Life safety Code LSC inspection, in the presence of the administrator and the maintenance supervisor, the Evaluator was provided the facility's kitchen equipment service records which revealed that the kitchen hood system was serviced on August 16, 2010, and May 23, 2011, nine months later. On July 20, 2011, at 11:30 a.m., during an interview with the maintenance supervisor revealed that he failed to contact the kitchen equipment service company to ensure that an inspection and servicing of the fire-extinguishing	K 069	b) Corrective action which may affect others residents: The administrator reviewed with Maintenance Supervisor as monitoring and verifying timely when outside services representatives were to come in and to report any non compliance to the Administrator ASAP. c) Systemic Changes: The Administrator has a copy of the scheduled due dates for outside services and will work with Maintenance Supervisor to secure services if any provider is not timely. d) Monitoring: The Administrator will monitor the schedule and verify with the Maintenance Supervisor when outside services are due - Double Check process. e) The facility will be in substantial compliance by 9/2/11. 9/2/11	

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K 069	Continued From page 6 system was conducted every six months by a qualified person. By the end of the survey, the facility had failed to provide documented evidence to the evaluator that the kitchen hood system was serviced at least every 6 months. The deficient practice affected one of 4 smoke compartments. The deficiency was brought to the attention of the administrator and the maintenance supervisor, during an exit conference on July 20, 2011.	K 069		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 101 Life Safety Code 2000 Edition; chapter 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or a key from the egress side. Based on observation and interview, the facility failed to ensure that 2 access doors to exit corridor was readily accessible at all times by ensuring that the lock-set on the door on the egress side of the door did not require two releasing operations to unlock and unlatch the door. In the event of an evacuation, fire or smoke emergency, readily accessible exit door access all all times, that does not require the use of a key, tool, or special knowledge or effort of	K 130	K 130 NFPA 101 Miscellaneous – Other LSC Deficiency Not on 2786 – Extra Locks on 2 Office Doors. a) Corrective action for residents affected by deficiency: The Maintenance Supervisor removed the extra locks before the surveyors exited the survey. b) Corrective action which may affect others residents: The Maintenance Supervisor is aware of the regulations, checked all locks in the building to verify no other doors had double locks. None did. c) Systemic Changes: Policy was written to address the locking of doors and placed in the Maintenance Manual. d) Monitoring: The Safety Committee will review at least monthly to verify that there is	

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K 130	Continued From page 7 operation from the egress side is imperative for the rapid and expeditious egress of residents and staff members from the building to an area of safety. At the time of the survey, the facility's census was 89 and the licensed bed capacity was 97. Findings: On July 19, 2011, between 10:20 a.m. and 11:15 a.m., and between 1:45 p.m. and 3:00 p.m., the evaluator in the presence of the maintenance supervisor conducted a Life and Safety Code (LSC) tour of the facility and observed that 2 access doors to the exit corridor had greater than one action in the interior knob lock-set on the door that resulted in additional effort from the egress side to unlock and unlatch the door. The 2 doors were observed at the Director of Nurse's office door, and the Maintenance Supervisor's office door. The maintenance supervisor stated that the 2 access doors to the exit corridor that had more than one action in the interior knob access doors would be corrected so as to provide one action in the interior door knob to open the doors for all both doors. The deficiency affected 1 of 4 smoke compartments. The deficiency was brought to the attention of the administrator during the exit conference on July 20, 2011.	K 130	compliance. The Administrator will do random checks to verify compliance. e) The facility will be in substantial compliance by 9/2/11.	9/2/11