#### p.o.c. AccepTMCo PRINTED: 08/26/2011 DEPARTMENT OF HEALTH AND HUMA SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB\_NO. 0938-0391 (X1) PROVIDER/BUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUC (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 8. WING 055760 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 415 SOUTH GARFIELD ALHAMBRA CONVALESCENT HOME ALHAMBRA, CA 91801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID m (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REQULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 i INITIAL COMMENTS K 000 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 **C**.53 Census: 89 Highest scope and severity= D Exit date: July 20, 2011 K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018 NFPA 101 Life Safety Code SS=D Standard - Doors Obstructed -Doors protecting corridor openings in other than Activity/Dining Rooms. required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as a) Corrective action for residents affected by those constructed of 1% inch solid-bonded core deficiency: The residents and tables were wood, or capable of resisting fire for at least 20 removed when deficiency was brought to minutes. Doors in sprinklered buildings are only our attention. The Administrator explained required to resist the passage of smoke. There is to Activities and Nursing staff that the doors no impediment to the closing of the doors. Doors are provided with a means suitable for keeping were to remain un-obstructed. the door closed. Dutch doors meeting 19.3.6.3.6 b) Corrective action which may affect are permitted. 19.3.6.3 others residents: A sign was posted on each of the doors by the Maintenance Supervisor Roller latches are prohibited by CMS regulations as a reminder to staff. The DSD reviewed in all health care facilities.

BORATORY DIFECTOR'S OR PROVIDENGUPPLIER REPRESENTATIVE'S SIGNATURE

TITI.E

the policy with the Nursing staff.

(X6) DATE

y deficiency statement ending with an asterisk (figenotes 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 is 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.

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

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	PLE CONSTRUCTION  G 01 - MAIN BUILDING 01	(X3) DATE ! COMPL	
		055760	B. WING_	**************************************	07/3	20/2011
	ROVIDER OR SUPPLIEI IRA CONVALESCE		4	REET ADDRESS, CITY, STATE, ZIP COD 115 SOUTH GARFIELD ALHAMBRA, CA 91801	·········	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
K 018	Continued From	page 1	K 018			THE
	Based on observabled to ensure the "Magnolia Room" not able to resist having the door in have the ability to observed that equaling table, and the doors from observed that equaling table, and the doors from observed that equaling the doors from observed that equaling the doors to position of the fire. At the time the licensed of the licensed of the licensed of the licensed of the following:  a. One the same doors to the Magnory to the Ma	is not met as evidenced by: vation and interview, the facility hat the corridor door leading to 'and the "Garden Room" were the passage of smoke, by mpeded from closing freely and positively latch. The evaluator uipment such as a resident resident wheel chair, impeded osing. In the event of a fire I closure with a means suitable cor closed without any penetrations, and the ability for tively latch are essential containment of smoke and/or me facility bed census was 89, bed capacity was 97.  I between 10:20 a.m. and 11:15 on 1:45 p.m. and 3:00 p.m., the presence of the maintenance rected a Life and Safety Code facility and observed the  date, at 2:10 p.m., one of two molia Room (resident dining/ was not able to resist the te by having the door impeded ly and having the ability to While residents were observed		c) Systemic Changes: The Acti will check daily to verify that the un-obstructed. The Maintenance also Check daily during routine make sure the door is un-obstructed.  d) Monitoring: The Administration monitor for compliance by doing checks. The Safety Committee of for compliance at least monthly.  e) The facility will be in substate compliance by 9/2/11	e doors are e staff will rounds to sted  tor will g random will review	90

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

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

54D1 22-64 C	TOTAL CINA	SPILENTS : SE FINNERS CAPERS 33 MESSERVERS P.	A BU	LDING	01 - MAIN BUILDING 01	JOHN LE	- 1 Bu. Suf		
		055760	5. WII	NG		07/2	0/2011		
NAME OF PROVIDER OR SUPPLIER ALHAMBRA CONVALESCENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 416 SOUTH GARFIELD ALHAMBRA, CA 91801						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APP	OULD BE	(X5) COMPLETION DATE		
K 016 K 054 SS=C	resident's dining tal against, one of the obstructing the doo b. One the same dadoors to the Gardentelevision room) wapassage of smoke from closing freely positively latch. Why watching television two doors was imperesident, who was suplaced in front of or Room, obstructing. At the same time, of maintenance super the necessary adjuinant Garden Room, ensure that the doors smoke, and have the positively latch and would ensure that in-serviced, including the Director of Staff.  The deficiency affer compartments.  The deficiency was administrator and the during the exit confine NFPA 101 LIFE SAME.	aded from closing due to the ole was placed in front of, and doors to the Magnolia Room, or from readily closing.  ate, at 3:05 p.m., One of two in Room (resident lounge/ is not able to resist the by having the door impeded and having the ability to ille residents were observed in the Garden Room, one of eded from closing due to a sitting in a wheelchair, was no of the door from readily closing.  Auring an interview, the visor stated he would make streents to the Magnolia Room and any other room, to ins would not be obstructed; would resist the passage of the ability to close freely and close. He further stated he housekeeping staff would be ing in-services to be done by		018	K 054 NFPA 101 Life Safety Co Standard — I Smoke Detector no documented for routine services working.	et .			

# DEPARTMENT OF HEALTH AND HUMA. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

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ND TENN D	r correction	IDEN (ILINA) INN NOMBER	A BUILI	DING	01 - MAIN BUILDING 01	VVMIFEE	YEN .
		055760	B, WINK	À		07/2	0/2011
	ROVIDER OR SUPPLIER RA CONVALESCENT	HOME	**************************************	415 S	ADDRESS, CITY, STATE, ZIP CODE COUTH GARFIELD AMBRA, CA 91801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ALLEAN MONTH VAN TO THE TITLE	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(%5) COMPLETION DATE
K 054	maintained, inspect with the manufactur. This STANDARD is Based on observat failed to ensure that released the electrocross-corridor doors alarm. Smoke detected electro-magnetically would fail to close u alarm system and wand/or fire to pass for the facility census was 97.  Findings:  On July 14, 2011, bp.m., the Evaluator supervisor during the survey of the facility system in the Lodge testing of the 21 sm stations.  On the same date, a observed that one is "21," located in the the audible alarm an electro-magnetically when tested. At 2:4	ed and tested in accordance er's specifications. 9.6.1.3  Is not met as evidenced by: ion and interview, the facility one of 29 smoke detectors imagnetically held and activate an audible ctors that do not release the held cross-corridor doors pon the activation of the fire would therefore allow smoke rom one smoke compartment of facility. At the time of survey, was 89 and the licensed  etween 1:00 p.m. to 3:30 observed the maintenance in Life Safety Code (LSC) is, test the facility's fire alarm is Building that included the loke detectors and 6 pull in the process of the pull in the process of the pull station, identified as facility's basement activated in the facility's basement activated in facility in fa	KO	a da	Corrective action for residents a efficiency: The Maintenance Sunded the smoke detector to the romanitoring form.  Corrective action which may alwhers residents. The administrator he monitoring form to include insund inclusion of all smoke detectors) Systemic Changes: The Mainten Supervisor will monitor all smoke including the one missed and documentation.  Monitoring: The Safety Commercial at least monthly for complichecking documentation.  The facility will be in substantic compliance by 9/2/11	pervisor utine  ffect re-typed structions rs.  nance detectors ument  nittee will iance by	aplu

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

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N A. BU		PLE CONSTRUCTION  O1 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		055760	B. WII	4G		07/2	)/2011
	ROVIDER OR SUPPLIES			41	EET ADDRESS, CITY, STATE, ZIP CODE IS SOUTH GARFIELD LHAMBRA, CA 91801		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	3	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
K 054	when tested.  On July 20, 2011 a.m., during a reversity as the presence of the maintenance supdocumentation of thome Monitoring test was conducted.  On July 20, 2011 interview, the maintenance that would ensure that fire alarm tested. Convalescent Houseld document routinely conducted. The deficient pracompartments.  The deficiency will administrator, and during the exit conversity and the exit conversity. The deficiency will administrator, and during the exit conversity and the exit conversity. This STANDARD NFPA 96, 1998. Control and Fire Cooking Operation.	ally held cross-corridor doors  between 9:30 a.m. and 11:45 view of the facility's fire alarm its required for fire inspection, in he administrator and the rervisor, the Evaluator found no in the "Alhambra Convalescent List" that indicated a fire alarm ed on all 21 smoke detectors.  at 11:00 a.m., during an intenance supervisor stated he it all 21 smoke detectors were and that the "Alhambra ime Monitoring List" would station that a fire alarm test was red on all 21 smoke detectors.  ctice affected one of 4 smoke  as brought to the attention of the ind the Maintenance Supervisor, inference on July 20, 2011. SAFETY CODE STANDARD  are protected in accordance 3.2.6, NFPA 96  b is not met as evidenced by: Edition: Standard for Ventilation Protection of Commercial ons		054	K 069 NFPA 101 Life Safety C  - 6 month Service of Kitchen H  a) Corrective action for resident deficiency: The Maintenance swas made aware of the issue and by the Administrator to stick to regardless of compliance from services.	ood <u>s affected by</u> upervisor d reminded the scheduk	
	An inspection and	a servicing of the		]			

#### DEPARTMENT OF HEALTH AND HUM: 'SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 B. WING 055760 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 415 SOUTH GARFIELD ALHAMBRA CONVALESCENT HOME ALHAMBRA, CA 91801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 10 COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Continued From page 5 K 069 fire-extinguishing system shall be made at least every 6 months by properly trained qualified persons. b) Corrective action which may affect others residents: The administrator reviewed with Based on observation, interview, and record Maintenance Supervisor as monitoring and review, the facility falled to ensure that the verifying timely when outside services cooking facilities were protected in accordance representatives were to come in and to with NFPA 96, by failing to provide documented report any non compliance to the evidence that an inspection and servicing of the Administrator ASAP. fire-extinguishing system was conducted every six months by a qualified person. c) Systemic Changes: The Administrator has a copy of the scheduled due dates for The six-month service of the kitchen outside services and will work with fire-extinguishing system helps prevent Maintenance Supervisor to secure services if accumulation of grease and other fire active materials from building up in the fire extinguishing any provider is not timely. system thereby, helping to decrease the potential for a fire hazard in the hood and flue in kitchen. At d) Monitoring: The Administrator will the time of the survey, the facility's census was monitor the schedule and verify with the 87 and the licensed capacity was 97 beds. Maintenance Supervisor when outside services are due - Double Check process. Findings: e) The facility will be in substantial On July 20, 2011, between 9:30 a.m. and 11:45 compliance by 9/2/11. 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

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

PRINTED: 08/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION  G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		058760	B. WI	NG		07/21	)/2011
	ROWDER OR SUPPLIER BRA CONVALESCEN	T HOME		4	REET ADDRESS, CITY, STATE, ZIP CODE 16 SOUTH GARFIELD LLHAMBRA, CA. 91801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ITEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF YAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPOPULATION OF THE APPOPU	DUILD BE	COX) HOTTLEHECO TAGE
K 069	every 6 months by persons.  Based on observat review, the facility i	ystem shall be made at least properly trained qualified ion. interview, and record alled to ensure that the	K	069	K 130 NFPA 101 Miscellameous — LSC Deficiency Not on 2786 — Ex on 2 Office Doors.	tra Locks	
	with NFPA 96, by for evidence that an in	ere protected in accordance alling to provide documented spection and servicing of the ystem was conducted every allified person.			deficiency: The Maintenance Superemoved the extra locks before the exited the survey.  b) Corrective action which may af	ervisor surveyors <u>Tect others</u>	
	accumulation of grammaterials from bulk system thereby, he	ystem helps prevent ease and other fire active ding up in the fire extinguishing lping to decrease the potential			residents: The Maintenance Super aware of the regulations, checked in the building to verify no other d double locks. None did.  c) Systemic Changes: Policy was	all locks locers had	
	the time of the sun	the hood and flue in kitchen. At least the facility's census was a capacity was 97 beds.			address the locking of doors and p the Maintenance Manual.		
	Findings:				d) Monitoring: The Safety Commercial and a least monthly to verify the compliance. The Administrator with the compliance of the compliance.	lust there is	
	a.m., during a revie code documents re	011, between 9:30 a.m. and 11:45 I review of the facility's life safety Into required for Life safety Code			random checks to verify complian	ce.	
	the Evaluator was equipment service the kitchen hood s	the presence of the he maintenance supervisor, provided the facility's kitchen records which revealed that ystem was serviced on August 23, 2011, nine months later.			e) The facility will be in substantic compliance by 9/2/11.	" (W	MII
	interview with the newealed that he far equipment service	at 11:30 a.m., during an naintenance supervisor led to contact the kitchen company to ensure that an vicing of the fire-extinguishing					

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

Event ID: 04M921

Facility ID: CA950000101

If continuation sheet Page 6 of 8

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

PRINTED: 08/26/2011 FORM APPROVED OMB NO 0938-0391

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUI	LDING	***	(X3) DATE SURVEY COMPLETED		
		055760	B. WIN	IG		07/2	0/2011	
NAME OF PROVIDER OR SUPPLIER ALHAMBRA CONVALESCENT HOME				415	T ADDRESS, CITY, STATE, ZIP CODE SOUTH GARFIELD JAMBRA, CA 91801			
(X4) ID PREFIX TAG				X į	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 069 K 130 SS=D	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. NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786		K 069 K 130		K 130 NFPA 101 Miscellaneous LSC Deficiency Not on 2786 — E on 2 Office Doors. a) Corrective action for residents deficiency: The Maintenance Su	affected by pervisor		
	NFPA 101 Life Sar chapter 19.2.2.2.4 Doors within a requipe equipped with a the use of a tool or Based on observatifailed to ensure that corridor was readily ensuring that the longress side of the creleasing operation door. In the event	s not met as evidenced by: fety Code 2000 Edition; fired means of egress shall not latch or a lock that requires a key from the egress side. fon and interview, the facility access doors to exit accessible at all times by ck-set on the door on the floor did not require two s to unlock and unlatch the of an evacuation, fire or smoke accessible exit door access		The state of the s	removed the extra locks before the exited the survey.  b) Corrective action which may residents: The Maintenance Supaware of the regulations, checker in the building to verify no other double locks. None did. c) Systemic Changes: Policy was address the locking of doors and the Maintenance Manual. d) Monitoring: The Safety Comreview at least monthly to verify	affect others ervisor is d all locks doors had s written to placed in	A A A CONTRACTOR OF THE PROPERTY OF THE PROPER	

all all times, that does not require the use of a key, tool, or special knowledge or effort of

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 08/26/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER  ALHAMBRA CONVALESCENT HOME    COAI, ID   COAI,	IND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:		ILDING	01 - MAIN BUILDING 01	COMPLE	. FED			
ALHAMBRA CONVALESCENT HOME    Main   Discrete   Summary Statement of Deficiencies   (EACH Deficiency Must be PRECEDED by Full REGULATORY OR LSC IDENTIFYING INFORMATION)   DISCREDIA   (EACH DOSRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE			055760	B, WII	NG		07/2	0/2011			
FRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 145 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.  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 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 will do random checks to verify compliance.  (EACH-CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  K 130  Continued From page 7  Operation from the egress side is imperative for the residents and staff members from the administrator will do random checks to verify compliance.  e) The facility will be in substantial compliance.  e) The Administrator will do random checks to verify compliance.  e) The Administrator will do random checks to verify compliance.  e) The Administrator will do random checks to verify compliance.  e) The facility will be in sub					STREET ADDRESS, CITY, STATE, ZIP CODE 415 SOUTH GARFIELD						
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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION			
		operation from the the rapid and expect staff members from safety. At the time census was 89 and 97.  Findings:  On July 19, 2011, ba.m., and between evaluator in the presupervisor conduct (LSC) tour of the faccess doors to the one action in the indoor that resulted in egress side to unlo doors were observed office door.  The maintenance saccess doors to the office door.  The maintenance saccess doors to the than one action in the would be corrected the interior door known both doors.  The deficiency affections administrator during the safety was administrator during the safety.	egress side is imperative for ditious egress of residents and in the building to an area of of the survey, the facility's the licensed bed capacity was between 10:20 a.m. and 11:15 1:45 p.m. and 3:00 p.m., the sence of the maintenance ed a Life and Safety Code will and observed that 2 exit corridor had greater than terior knob lock-set on the madditional effort from the ck and unlatch the door. The 2 ed at the Director of Nurse's Maintenance Supervisor's supervisor stated that the 2 exit corridor that had more the interior knob access doors so as to provide one action in ob to open the doors for all octed 1 of 4 smoke	K		random checks to verify compliance  e) The facility will be in substantial	e.	9/2/11			