P.O.C. Acceptance 8/22/11 V. Sanjaur

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A134	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK MEDICAL CENTER	2030 N. GAREY AVE. POMONA, CA 91767

(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: 16279 Highest Scope & Severity: E	K 000		
K 018 SS=E	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	1.) Rooms 38 and 46 have been refitted with proper latches and closing devices designed for rapid closure. 2.) All doors in the facility have been checked for rapid closing and latching to prevent health hazards in case of fire or disaster. 3.) Maintenance Director will conduct monthly checks of all facility doors for proper closure and latching. 4.) Quality Assurance committee to review quarterly. Administrator to supervise compliance with this plan of correction. 5.) Compliance in effect 6/16/11.	6/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rosemary Gibbs TITLE: Administrator (X6) DATE: 8/19/11

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	K 018		

This STANDARD is not met as evidenced by:
Please use the final draft of the Mesa Glen K-18 report as an example for editing the survey report below.

Based on observation and interview, the facility failed to ensure two corridor doors to positively closed 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 doors to Rooms 38 and 46 did not positively close and properly latch. At the time of survey, the facility census was 95 and the licensed capacity was 95.

Findings:

On June 25, 2011, between 8:55 a.m. and 11:50 a.m., the evaluator in the presence of the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility and observed doors that did not positively close and latch at the following locations:

1. At 10:53 a.m., the evaluator observed that the door to Room 38 door did not positively close and properly latch, when closed. This room had two residents inside.

2. At 10:59 a.m., the evaluator observed that the door to Room 46 door did not positively close and properly latch, when closed. This room had two residents inside.

During this LSC tour, the maintenance supervisor stated that he would repair these doors to positively close and properly latch, at once.

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K 018	Continued From page 2 The deficient practice affected one of eight smoke compartments. On June 25, 2011, and June 26, 2011, the above finding was acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 018		
K 029 SS=D	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 use areas were maintained with a one hour fire rated construction by having a self-closing device on one oxygen (O2) storage room door. In the event of a fire, the separation of the O2 storage room would not be achieved, because the door would allow smoke and/or fire to travel from one smoke compartment to another. At the time of survey, the facility census was 95 and the licensed capacity was 95. Findings:	K 029	1.) The oxygen room will have a self closing device to prevent potential danger to residents and staff in case of fire or disaster. 2.) All facility doors will be one hour fire rated construction and self closing. 3.) Maintenance Director will assure that all doors meet this standard with regular checks of doors for closing and repair. 4.) Quality Assurance committee to meet quartely to review procedure. Administrator to supervise compliance. 5.) Compliance in effect	6/29/11

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K 029	Continued From page 3 On June 25, 2011, between 8:55 a.m. and 11:50 a.m., the evaluator in the presence of the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 11:05 a.m., the evaluator observed one O2 storage room across from the East Unit nurses' station, which housed one small (25 cubic feet) O2 tank. The evaluator observed that the O2 storage room door did not have a self-closing device to automatically close and maintain the door in the latched position. During this LSC tour, the maintenance supervisor stated that he would provide a self-closing device to automatically close and maintain the door in the latched position, as soon as possible. The deficient practice affected one of eight smoke compartments. On June 25, 2011, and June 26, 2011, the above finding was acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 029		
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13, 1999 Edition; 5-5.6 The clearance between the deflector and the top of the storage area shall be 18 inches (457 millimeter) or greater.	K 130	1.) Storage room, clean linen closet, therapy rooms and room 38 will maintain a clear space of 18 inches from the sprinkler head of the fire sprinkler system. 2.) All storage areas, rooms and closets will maintain a clear space of 18 inches from the sprinkler head of the fire sprinkler system. 3.) Maintenance to do a monthly check of all closets, rooms and storage areas to	

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K 130 Continued From page 4

This requirement is not met as evidenced by:

Based on observation and interview, the facility failed to ensure and maintain unobstructed areas around the sprinkler deflector above storage areas throughout the facility. Unobstructed areas below the sprinkler deflectors at storage areas will ensure an expeditious and effective response of water dispersion from the fire sprinklers and will ensure that the sprinklers will function as designed, during fire emergencies. At the time of survey, the facility census was 95 and the licensed capacity was 95.

Findings:

On June 25, 2011, between 8:55 a.m. and 11:50 a.m., the evaluator in the presence of the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility and observed areas where the sprinkler deflectors were obstructed by objects that may hinder the effective response of the fire sprinkler heads in case of a fire emergency. The sprinkler deflectors were obstructed and did not have 18-inch clearances from the sprinkler head and the nearest object. These obstructed sprinkler deflectors were noted at the following areas:

1. At 11:05 a.m., the evaluator observed six pillows on the top shelf inside the clean linen closet near Room 48. These pillows were 1 inch away from the deflector.

2. At 11:15 a.m., the evaluator observed eight toilet paper rolls on the top shelf inside the janitor's closet next to the dirty linen room. These

K 130 to assure compliance.
4.) Quarterly Quality Assurance committee will meet to review procedure. Administrator to assure standard and compliance are being met.
5.) Full compliance in effect 6/26/1

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K 130	Continued From page 5 toilet paper tools were 6 inches away from the deflector. 3. At 11:35 a.m., the evaluator observed two blankets on the top shelf inside the clean linen closet at the basement. These blankets were 8 inches from the deflector. 4. At 11:45 a.m., the evaluator observed four binders on the top shelf inside the therapy room closet at the basement. These binders were 10 inches away from the deflector. During this LSC tour, the maintenance supervisor stated that he would correct these areas to ensure that all sprinkler deflectors would have 18-inch minimum clearance from the nearest objects, at once. The deficient practice affected three of eight smoke compartments. On June 25, 2011, and June 26, 2011, the above finding was acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 130		