POC ACCEPTABLE 5/31/17 #16279

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555085	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT MANOR CARE CENTER	621 W BONITA AVE 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 NFPA 101, Life Safety Code Handbook, 2012 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: 48 Bed capacity: 59 Highest Scope & Severity: D	K 000	2017 MAY 24 AM 9:00 This Plan of Correction constitutes our Credible Allegation of Compliance for the deficiencies noted. Our facility will be in substantial compliance with all corrective action by **05/30/17**	LOS ANGELES COUNTY DEPT HEALTH FACILITIES DIVISION
K 346 SS=C	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the fire alarm system is out of service for more than 4 hours in a 24-hour period. In the event the fire alarm system is out of service, a fire watch policy will assist with the appropriate emergency procedures to be implemented within the proper timeframe.	K 346	**K 346 – NFPA 101 Fire Alarm System – Out of Service** *Corrective Action for Affected Residents:* Fire Watch policies and procedures have been corrected and specify 4 hours in a 24 hour period. The Fire Watch policy will soon be in effect. *Systemic Change to Prevent Recurrence:* The Director of Environmental Services will contact the facility's Fire Training Official, Manny Rosales, to update Fire Watch policies.	5/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMIN.	5/22/17

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 346	Continued From page 1 Findings: On April 30, 2017, at 7:45 a.m., a review of the facility's fire watch policy and procedure was conducted. It was noticed that this policy did not indicate that the facility will begin a fire watch when the facility's fire alarm system is out of service for more than 4 hours. On April 30, 2017, at 11:10 a.m., an interview was conducted with the director of nursing and the maintenance supervisor regarding these fire watch policy and procedure. It was pointed out that there were no detailed procedures, regarding the fire watch being implemented after the fire alarm system is out of service for more than 4 hours in a 24-hour period. The director of nursing stated that she was aware of the 4 hour timeframe and that the fire watch policy would be revised to meet the requirement, as soon as possible. The deficient practice affected five of five smoke compartments. On April 30, 2017, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K.346	*Monitoring and Evaluation of Plan*: The Director of Environmental Services will provide an in-service and meet with the Fire Training Official to keep Fire Watch policies and procedures updated. Policies will be reviewed and discussed during monthly Quality Assurance meetings with the interdisciplinary team and any follow up actions will be executed as necessary. *Corrective Action Completion Date*: May 30, 2017	5/30/17
K 354 SS=C	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire	K 354	**K 354 – NFPA 101 Sprinkler System – Out of Service** *Corrective Action for Affected Residents:* Fire Watch policies and procedures have been corrected and specify 10 hours in a 24 hour period for the Fire Watch policy to go into effect.	5/30/17

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

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K 354	Continued From page 2 department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. In the event the automatic sprinkler system is out of service, a fire watch policy will assist with the appropriate emergency procedures to be implemented within the proper timeframe. Findings: On April 30, 2017, at 7:45 a.m., a review of the facility's fire watch policy and procedure was conducted. It was noticed that this policy did not indicate that the facility will begin a fire watch when the facility's automatic sprinkler system is out of service for more than 10 hours (as indicated in NFPA 25, Standard for the Inspection, Testing and Maintenance of the Water-Based Fire Protection Systems). On April 21, 2017, at 2:28 p.m., an interview was conducted with the director of nursing and the maintenance supervisor regarding these fire watch policy and procedure. It was pointed out that there were no detailed procedures, regarding the fire watch being implemented after the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. The	K 354	*Systemic Change to Prevent Recurrence:* The Director of Environmental Services will contact the facility's Fire Training Official, Manny Rosales, to update the Fire Watch policies. *Monitoring and Evaluation of Plan:* The Director of Environmental Services will provide an in-service and meet with the Fire Training Official to keep the Fire Watch policies and procedures updated. Policies will be reviewed and discussed during monthly Quality Assurance meetings with the interdisciplinary team and any follow up actions will be executed as necessary. *Corrective Action Completion Date:* May 30, 2017	5/30/17

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K 354	Continued From page 3 director of nursing stated that she was aware of the 10 hour timeframe and the fire watch policy would be revised to meet the requirement, as soon as possible. The deficient practice affected five of five smoke compartments. On April 30, 2017, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 354		
K 355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to inspect and maintain the portable fire extinguishers to be serviced on an annual basis. One of 11 portable fire extinguishers was not maintained on an annual basis. The timely service and maintenance of portable fire extinguishers may ensure they will perform properly, during a fire emergency. Findings: On April 30, 2017, between 8:30 a.m. and 11:05 a.m., the evaluator and maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, it was observed 11 wall-mounted portable fire extinguishers throughout the facility.	K 355	**K 355 – NFPA 101 Portable Fire Extinguishers** *Corrective Action for Affected Residents:* The Director of Environmental Services immediately replaced the portable fire extinguisher with fully service maintained portable fire extinguisher. *Identifying Other Potential Residents:* The Director of Environmental Services and Maintenance staff will complete monthly checks to assure that all portable fire extinguishers are maintained. *Systemic Change to Prevent Recurrence:* The Director of Environmental Services and Maintenance department staff will complete monthly checks to assure that all portable fire extinguishers are maintained.	4/30/17

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K 355	Continued From page 4 At 10:03 a.m., it was observed that there was a wall mounted portable fire extinguisher, inside the facility's beauty salon. Closer observation showed that this portable fire extinguisher's service tag was last serviced, in October 31, 2015 (over 18 months earlier). During this LSC tour, the maintenance supervisor stated that all the fire extinguishers had been serviced, in January 2017. He added that this portable fire extinguisher was probably missed and that he would have it replaced, immediately. The deficient practice affected one of five smoke compartments. On April 30, 2017, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 355	*Monitoring and Evaluation of Plan*: The Director of Environmental Services and Maintenance staff will conduct monthly checks on all fire extinguishers to assure that all are properly maintained. Any negative devices will be replaced immediately and these findings will be discussed during monthly Quality Assurance meetings with the interdisciplinary team. Any follow up actions concluded from the meeting will be executed as necessary. *Corrective Action Completion Date*: April 30, 2017	4/30/17
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on	K 363	**K 363 – NFPA 101 Corridor - Doors** *Corrective Action for Affected Residents:* The Director of Environmental Services immediately repaired latch on door. *Identifying other Potential Residents:* The Director of Environmental Services and Maintenance staff will make monthly checks to all doors to assure they are working properly. *Systemic Change to Prevent Recurrence:* The Director of Environmental Services and Maintenance staff will make monthly checks to all doors to assure they are working properly.	4/30/17

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K 363	Continued From page 5 corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 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 facility's activity room double doors did not positively close and properly latch. Findings: On April 30, 2017, between 8:30 a.m. and 11:05 a.m., the evaluator and maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 10:06 a.m., it was observed that the activity room had double doors and these double doors did not positively close and properly latch, when	K 363	*Monitoring and Evaluation of Plan*: The Director of Environmental services and Maintenance staff will conduct random checks on all doors to assure they are all working properly. Any negative findings will be repaired by either Maintenance staff or outside vendors and these findings will be discussed during the monthly Quality Assurance meeting with follow-up, if necessary. *Corrective Action Completion Date*: April 30, 2017	4/30/17

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K 363	Continued From page 6 the doors were closed. Sixteen residents were inside this room observing a television program. During this LSC tour, the maintenance supervisor stated that he would repair these doors to positively close and properly latch, immediately. The deficient practice affected one of five smoke compartments. On April 30, 2017, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 363		