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	055873	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CONV HOSP OF LA MESA, LP	8665 LA MESA BLVD. LA MESA, CA 91942

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1968 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SINGLE STORY AND BASEMENT/GARAGE, TYPE (V) (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 29566. Census: 106	K 000	**This Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of related Life and Safety Code regulations and is intended to serve as credible allegation of our intent to correct the isolated practices identified as deficient.** **K 029 NFPA 101 LIFE SAFETY CODE STANDARD** **Scope & Severity: "D"- Isolated** **Specific Action and/or measures to correct the deficiency:** On 1/30/13, door closers for the janitor storage room and electrical room were immediately installed. **Staff responsible for the corrective action:**	
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	K 029	The Maintenance Supervisor or designee and the Administrator **Systemic Change Implementation and Performance and Compliance Monitoring and POC Evaluation:** 1. During daily maintenance rounds, the Maintenance Supervisor shall inspect all hazardous area doors to ensure that these doors are equipped with appropriate door closers to facilitate self-closing as required. Any identified non-compliance shall be immediately corrected.	[redacted]

[redacted]

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

[redacted]

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to protect the corridor from hazardous areas as evidenced by the janitor closet and electrical room not equipped with self-closing device. This affected 2 of 3 smoke compartments. This could result in the spread of smoke and fire and increase the risk of injury to residents, visitors and staff in the event of a fire. National Fire Prevention Association 101, Life Safety Code 2000 Edition: 19.3.2.1 Hazardous Areas. Any Hazardous area shall be safe guarded by a fire barrier having a 1 -hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke -resisting partitions and doors. The doors shall be self-closing or automatic closing. Hazardous shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Cental/bulk laundries larger than 100 square ft (9.3 square m) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 square ft (4.6 square m), including repair shops, used for	K 029	2. Compliance reports which include immediate corrective actions taken shall be reported to the monthly Safety Committee and to the quarterly Quality Assurance Committee for further recommendations and/or pertinent Quality Improvement actions. **Completion date: 2/30/13 and ongoing**	

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K 029	Continued From page 2 storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have non-rated, factory-or field -applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. Findings: During a tour of the facility with the Maintenance Director on 1/30/13, the hazardous areas doors were observed. 1. At 3:50 p.m., the janitor storage room was not equipped with a self-closing device. The janitor storage room stored shelves of paper-products and other combustible supplies. 2. At 4:20 p.m., the eletrical room by Rom 307(sub-acute) was not equipped with a self-closing device.	K 029		[redacted]
K 048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to instruct their staff on their role to protect their residents in the event of an emergency. This	K 048	**K 048 NFPA 101 LIFE SAFETY CODE STANDARD** **Scope & Severity: "D"- Isolated** **Specific Action and/or measures to correct the deficiency:** On 1/30/12 and ongoing, affected staff were immediately re-educated regarding the sprinkler anti-tamper system and its location, use, or purpose. Staff were re-educated that in the event that the sprinkler system buzzed, they are to immediately call the Maintenance Supervisor/designee and/or the Administrator/designee. **Staff responsible for the corrective action:** Director of Staff Development, Maintenance Supervisor, and Administrator.	

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K 048	Continued From page 3 was evidenced by the staff's lack of familiarity with their duties when the sprinkler system was tampered. This could result in failure to notify maintenance of problems with the sprinkler system. NFPA 101, Life Safety Code, 2000 Edition 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. Findings: During the facility tour with the Maintenance Director on 1/30/13, the facility automatic sprinkler system tamper alarm was tested, and the staff were interviewed to determine their knowledge of the tamper alarm. At 3:17 p.m., the tamper switch was activated and the alarm sounded at the Nurse's Station. Three of Three staff members could not relate what action they were to take when the tamper alarm was activated at the nurse station.	K 048	**Systemic Change Implementation and Performance and Compliance Monitoring and POC Evaluation:** 1. Quarterly during drills, the Maintenance Supervisor shall activate the tamper switch and observe and ask staff on what their roles are when the alarm is sounded. Any staff identified to be unfamiliar with the sprinkler system shall receive immediate on-site re-education. 2. Compliance reports shall be reported to the monthly Safety Committee and to the quarterly Quality Assurance Committee for further recommendations and/or pertinent Quality Improvement actions. **Completion date: 2/30/13 and ongoing**	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to	K 062		

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K 062	Continued From page 4 maintain their automatic sprinkler system as evidenced by Fire Department Connections (FDC) failed to rotate smoothly. This affected 3 of 3 smoke compartments. This could potentially cause delay for fire-fighters in extinguishing a fire due to the faulty swivels at the facility and possible harm to residents and staff, in the event of a fire. NFPA 25, Inspection, Testing and Maintence of Water Based Fire Protection System. 1998 Edition 9-7.1 Fire Department Connections shall be inspected quarterly. The inspection shall verify the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly. Findings: During a tour of the facility with the maintenance director on 1/30/13, the FDC in the front parking lot was observed. At 3:25 p.m., one of one FDC, in the front parking lot of the facility, the couplings or swivels failed to rotate.	K 062	**K 062 NFPA 101 LIFE SAFETY CODE STANDARD** **Scope & Severity: "D"- Isolated** **Specific Action and/or measures to correct the deficiency:** On 1/30/13, the swivels for the parking lot FDC were replaced. **Staff responsible for the corrective action:** Maintenance Supervisor or designee **Systemic Change Implementation and Performance and Compliance Monitoring and POC Evaluation:** 1. Monthly, the Maintenance Supervisor shall inspect the FDC and ensure that the couplings or swivels are rotating appropriately. Any identified non-compliance shall be immediately corrected. 2. Compliance reports which include immediate corrective actions taken shall be reported to the quarterly Quality Assurance Committee for further recommendations and/or pertinent Quality Improvement actions. **Completion date: 2/30/1313 and ongoing**	[redacted]
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076	Continued From page 5 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain oxygen storage area. This was evidenced by storing of full and empty oxygen cylinders in the same crate, oxygen storage room was not equipped with a self-closure device. This affected 1 of 3 smoke compartments. This could cause a delay in an emergency for the resident and could cause a potential risk of injury to residents in an emergency. National Fire Protection Association Health Care Facilities -99 , 1999 Edition- 4-3.5.2.2 (b) (1) Storage shall be planned so that cylinders can be use in the order in which they are received from the supplier. (2) If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.	K 076	**K 076 NFPA 101 LIFE SAFETY CODE STANDARD** **Scope & Severity: "D"- Isolated** **Specific Action and/or measures to correct the deficiency:** On 1/30/13, the empty oxygen cylinders were marked "EMPTY" in accordance with NFPA 4-3.5.2.2 (b) (1). This would prevent confusion and delay if a full cylinder is needed hurriedly. In addition, the door was fitted with self-closure device. **Staff responsible for the corrective action:** Central Supply Staff Maintenance Supervisor Administrator **Systemic Change Implementation and Performance and Compliance Monitoring and POC Evaluation:** 1. The Central Supply Staff will ensure that empty oxygen cylinders are marked "EMPTY." 2. During daily maintenance rounds, the Maintenance Supervisor shall inspect all hazardous area doors to ensure that these doors are equipped with appropriate door closers to facilitate self-closing as required. Any identified non-compliance shall be immediately corrected. 3. Compliance reports which include immediate corrective	[redacted]

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K 076	Continued From page 6 Findings: During tour of facility with the maintenance director on 1/30/13, the oxygen room was observed. At 3:59 p.m., Oxygen room off the corridor by Room 312 had both the empty and full E- sized oxygen cylinders mix together. The facility failed to equip the door to the oxygen room with a self-closure device.	K 076	actions taken shall be reported to the monthly Safety Committee and to the quarterly Quality Assurance Committee for further recommendations and/or pertinent Quality Improvement actions. **Completion date: 2/30/113 and ongoing**	
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 and interview, the facility failed to ensure that all smoking materials including lighters were removed from the residents possession who are receiving respiratory therapy. This was evidenced by resident on oxygen therapy who had a cigarette lighter in his possession. This affected 1 of 3 smoke compartments. This could result in the increased risk of fire and the potential risk of injury to the resident. NFPA 99, Health Care Facilities 1999 Edition, 8-6.2.1.1 Smoking materials (matches, cigarettes, lighters, lighter fluid, tobacco in any form) shall be removed from patients receiving respiratory therapy and from the area of administration. Findings: At 4:40 p.m., during the observation of the	K 141	**K 141 NFPA 101 LIFE SAFETY CODE STANDARD** **Scope & Severity: "D"- Isolated** **Specific Action and/or measures to correct the deficiency:** On 1/30/13, staff immediately removed and confiscated the affected resident's lighter. The resident was also reminded of the facility's smoking Policy and Procedure with emphasis on his safety and those of other residents. **Staff responsible for the corrective action:** All staff	

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K 141	Continued From page 7 smoking areas, resident in room 306, who has a tracheostomy tube, an opening through the neck and into the trachea, was at the smoking area and produced his own cigarette lighter from his shirt pocket. The respiratory staff that accompanied the resident stated that the resident does not comply with policy and knew it is against regulation to have a lighter in his possession. When the resident was interviewed, he acknowledged that he had the lighter in his possession while on oxygen therapy.	K 141	**Systemic Change Implementation and Performance and Compliance Monitoring and POC Evaluation:** 1. Staff working with the resident shall remove or confiscate matches or lighters found in the possession of the resident. 2. Residents who smoke in the designated smoking area shall be supervised according to established facility smoking guidelines. 3. On 1/22/13 during the certification survey and again on 1/30/13, staff were re-educated on the facility's Policy to have staff member supervise residents who smoke in the designated smoking areas during designated and posted smoking breaks. 4. Discussions and considerations are underway to make CCHLM a non-smoking facility in the very near future. Meanwhile, Administration and Nursing Management continues to re-evaluate the resident's smoking safety assessments to ensure that while it is the resident's choice and privilege to smoke, their individual or group safety remains to be the focus and priority of the facility. **Completion date: 2/30/113 and ongoing**	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain electrical safety as evidenced by electrical appliances plugged into multi-plug, surged protector power strips and not into wall outlets . This affected 1 of 3 smoke compartments. This could potentially cause a fire and potential harm to residents and staff in the event of a fire emergency. NFPA 70 Section 400-8 1999 Ed. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for a fixed wiring of a structure (2) Where run through holes in walls, structural	K 147		

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K 147	Continued From page 8 ceilings, suspended ceilings, dropped ceilings, or floors. (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this code Findings: During a tour of the facility with Head Maintenance on [redacted], the electrical system was observed. At 3:55 p.m. , there were two refrigerators, in the Medication Room on Station 1, plugged into a multi-plug surge protector power strip instead of the wall outlet.	K 147	**K 147 NFPA 101 LIFE SAFETY CODE STANDARD** **Scope & Severity: "D"- Isolated** **Specific Action and/or measures to correct the deficiency:** On 1/30/13, the refrigerators were immediately plugged into the wall outlet. **Staff responsible for the corrective action:** All staff **Systemic Change Implementation and Performance and Compliance Monitoring and POC Evaluation:** 1. Daily during routine maintenance rounds, the Maintenance Supervisor will observe for the use of multi plugs and correct misuse. Any identified non-compliance shall be immediately corrected. 2. Compliance reports which include immediate corrective actions taken shall be reported to the quarterly Quality Assurance Committee for further recommendations and/or pertinent Quality Improvement actions. **Completion date: 2/30/113 and ongoing**	[redacted]