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
	555587	A. BUILDING 01 B. WING	05/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALLY KIDS SPECIALTY HEALTHCARE	1720 MOUNTAIN VIEW LOMA LINDA, CA 92354

(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 K3 BUILDING: 01 K6 PLAN APPROVAL: 2/4/94 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V) (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification 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: 27961 Census:48	K000	This plan of correction constitutes the credible allegation of compliance for the deficiencies noted. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by the provisions of the Health and Safety Code section 1280 and C.F.R. 1907 and State Regulations	
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 1% 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	K018	All non-approved door hold open devices were removed by facility maintenance staff on May 30, 2013. Staff will be educated that these devices may not be used at any time. The doors to rooms 225, and 152 were corrected to properly close and latch by facility maintenance on May 30, 2013. Inspections of doors will be performed regularly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	5/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE — TITLE — (X6) DATE

[signature] DIR-FACILITIES 6-13-2013

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.

POC accepted 6/17/13 M. McKay

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K 018	Continued From page 1 in all health care facilities.	K018		

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to maintain their corridor doors, as evidenced by doors that failed to positive latch and by doors that were impeded from closing. This had the potential to allow the spread of smoke or fire, in the event of a fire, causing harm to residents and staff. This affected 2 of 4 smoke compartments.

Findings:

During a tour of the facility with the Director of Facility Management, on 5/30/13, the corridor doors were observed.

1. At 9:20A.M., a door wedge impeded the door to the staff lounge. The wedge was placed under the door.

2. At 10:22 A.M., the door to Room 225 was equipped with a self-closing device. The door was held open to the fullest extent and allowed to close. The door failed to positive latch.

3. At 10:35 A.M., the door to Room 152 was equipped with a self-closing device. The door was held open to the fullest extent and allowed to close. The door failed to positive latch.

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K 018	Continued From page 2 4. At 10:40 A.M., three office doors in the "Classroom" area were impeded from closing. There were door wedges placed under the doors.	K 018		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure their fire rated smoke barrier doors resisted the passage of smoke. This was evidenced by a smoke barrier door that failed to close and latch. This could result in the spread of smoke and fire from one compartment to another. This affected 1 of 4 smoke compartments. Findings: During fire alarm system testing with the Director of Facility Management, on 5/30/13, the smoke barrier doors were observed and tested. At 11:25 A.M., the smoke barrier doors, by Nursing Station 1; released and closed during fire alarm testing. The left side door closed but failed	K027	The smoke barrier door adjacent to nurse station one was corrected to properly close and latch by facility maintenance on May 30, 2013. Inspections of doors will be performed regularly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	5/30/2013

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K 027	Continued From page 3 to latch after activation of a smoke detector. The door is equipped with latching hardware.	K027		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure exits were readily accessible at all times. This was evidenced by a Hoyer lift, trays and medical equipment in one exit corridor. This could delay evacuation and cause harm to residents and staff in the event of a fire. This affected 1 of 4 smoke compartments. Findings: During the tour of the facility with the Director of Facility Maintenance, on 5/30/13, the corridors and exits were observed. At 11:29 A.M., there were medical trays, a Hoyer lift, wheelchairs and other medical equipment blocking the exit corridor, leading to the outside, across from Room 148. This exit access is part of the evacuation path from the facility.	K038	All items that were obstructing the identified corridor were removed by facility maintenance on May 30, 2013. Staff will receive education concerning the need and requirement to maintain clear evacuation paths from the facility on or before June 30, 2013. Inspections of exits and corridors will be performed regularly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	6/30/2013
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance	K 052		

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K 052	Continued From page 4 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their fire alarm system as evidenced by obstructions in from of a manual pull station. This could delay activation of the fire alarm system, and cause harm to residents and staff in the event of a fire. This affected 1 of 4 smoke compartments. NFPA 72, National Fire Alarm Code, 1999 Edition 2-8.1 Mounting. Each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 3 1/2 ft (1.1 m) and not more than 4 1/2 ft (1.37 m) above floor level. 2-8.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Findings: During a tour of the facility with the Director of Facility Management, on 5/30/13, the manual pull stations were observed. At 11:28 A.M., a Hoyer lift and tray table impeded access to the manual pull station by Room 148.	K 052	All items that were obstructing the identified fire alarm box were removed by facility maintenance on May 30, 2013. Staff will receive education concerning the need and requirement to ensure manual fire alarm boxes are free from obstruction on or before June 30, 2013. Inspections of fire alarm boxes will be performed regularly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	6/30/13

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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, NFPA25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic sprinkler system, as evidenced by one sprinkler with less than 18 inch clearance around the sprinkler head. This could result in a delay for the water spray pattern to develop and a delay in extinguishing a fire. This affected 1 of 4 smoke compartments. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected. NFPA 13, Installation of Sprinkler Systems, 1999 Edition. 5-5.6 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Findings: During a tour of the facility with the Director of Facility Management, on 5/30/13, the sprinkler system was observed. At 11:08 A.M., there was a large stuffed animal stuffed around one sprinkler head in one closet in	K 062	All items that were obstructing the identified fire sprinklers were removed by facility maintenance on May 30, 2013. Staff will receive education concerning the need and requirement to ensure fire sprinklers are free from obstructions closer than 18" on or before June 30, 2013. Inspections of fire sprinklers will be performed quarterly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process	6/30/2013

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K 062	Continued From page 6 Room 126. There were books and toys in a second closet in Room 126. The items were stored approximately 5 inches from the sprinkler heads.	K062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguishers. This was evidenced by a portable fire extinguisher that was obstructed from immediate access. This affected 2 of 4 smoke compartments and could result in a delay to extinguish a fire. NFPA 10, Standard for Portable Fire Extinguishers, 1998 edition 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom	K064	All items that were obstructing the identified fire extinguishers were removed by facility maintenance on May 30, 2013. Staff will receive education concerning the need and requirement to ensure fire extinguishers are free from obstruction on or before June 30, 2013. Inspections of fire extinguishers will be performed regularly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	6/30/2013

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K 064	Continued From page 7 of the fire extinguisher and the floor be less than 4 in. (10.2 em) Findings: During a tour of the facility with the Director Facility Management, on 5/30/13, the portable fire extinguishers were observed. 1. At 10:22 A.M., the fire extinguisher by Nursing Station 2 was impeded from immediate access by a shower gurney. 2. At 11:27 A.M., the fire extinguisher by Room 148 was impeded from immediate access by a Hoyer lift.	K064		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their diesel generators. This was evidenced by no records for generator transfer times for 2 of 2 diesel generators. This could result in a delay for the generator to pick up the load in the event of a power outage. This	K 144	Staff members who are responsible to inspect and perform testing on the facility generators will be educated about the requirement for transfer of power and the need to document the results of testing, which includes the actual transfer time on or before June 30, 2013, by the Director of Facilities Management. These inspections and documentation will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	6/30/2013

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K 144	Continued From page 8 affected 4 of 4 smoke compartments. NFPA 99, Standard for Health Care Facilities, 1999 Edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. Findings: During document review with the Director of Facility Management, on 5/30/13, the generator test and inspection logs were reviewed and Staff was interviewed. At 9:25A.M., the generator records were reviewed. The facility failed to provide a written record of complete testing information. The generator logs for the 150 KW diesel generator failed to list the transfer time on 10/3/12, 12/12/12, 7/5/12 and 5/2/12. The generator logs for the 75 KW diesel generator failed to list the transfertimeon 5/2/12, 7/5/12, 10/3/12and 12/5/12. During an interview, the Maintenance Tech 1 stated that he had forgotten to write the transfer seconds on the log but stated that the generators had transferred in under 10 seconds.	K 144		

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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 the electrical wiring and equipment, as evidenced by broken electrical components. This could result in an increased risk of electrical fire and potential injury to residents and staff. This affected 1 of 4 smoke compartments. Findings: During a tour of the facility with the Director Facility Management, on 5/30/13, the electrical wiring and equipment were observed. At 11:07 A.M., in Room 116 by Bed A, there was a receptacle wall outlet that had a broken cover plate.	K 147	The broken receptacle plate in room 116 was replaced on May 30, 2013 by facility maintenance staff. Inspections of receptacles will be performed regularly. Results of these inspections will be tracked by the Director of Facilities Management to ensure continued compliance as part of the department quality improvement process.	5/30/2013