Accepted [redacted] - 2/4/13

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

PRINTED: 01/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

Annie Woods
Digitally signed by Annie Woods
DN: cn=Annie Woods, o=West District Office, ou=HFID, email=awoods@cdph.ca.gov, c=US
Date: 2013.03.04 10:31:03 -08'00'

(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 Services during the Life Safety Code Survey. Representing the Department of Public Health Services: 13183, HFE I, Life Safety Code Specialist Licensed = 93 beds Census = 88 residents Highest Scope and Severity = E	K 000	**Sunnyview POC** **Disclaimer:** The signing of this plan of corrections is not an admission or agreement by this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This Plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a class A, B, or C flame spread	K 015	**K 015** **Immediate Corrective Action:** Upon notification on 1/10/13, the Maintenance Supervisor repaired the penetrations in the kitchen and maintenance office of ¾-inch diameter, 4-ft by 3-ft and 2-inch by 6-inch on the wall have been sealed with approved fire rated material. **Identification of others at risk:** The Maintenance Supervisor is responsible to ensure that the facility is free of any penetrations. The maintenance supervisor will implement an environmental CQI checklist on a monthly basis to observe if penetrations are present throughout the facility.	1/10/13 1/10/13

HEALTH FACILITIES INSPECTION DIVISION
2013 FEB -1 PM 3:09
RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annie Woods — TITLE: ADMINISTRATOR — (X6) DATE: 2-1-13

ry deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 015	Continued From page 1 rating finish in rooms by having unsealed penetrations through the wall and ceiling surfaces. Penetrations through wall and ceiling surfaces would compromise the flame spread rating, therefore may compromise the containment of smoke and/or fire in the event of a fire. At the time of the survey, the facility was licensed for 93 beds and had a census of 88 residents. Findings: On January 10, 2013, from 8:15 a.m. to 9:45 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed penetrations in the following rooms: 1) There was a 3/4-inch diameter penetration in the wall surface in the kitchen by the dishmachine. 2) There was a 4-ft by 3-ft penetration in the wall surface by the entry door and a 2-inch by 6-inch penetration in the wall surface by the black drain pipe in the maintenance office. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the penetrations but would seal the penetrations with approved rated material. The deficiency affected one out of three smoke compartments on the sleeping room level, and one of one smoke compartments in the basement. The deficiency was brought to the attention of the	K 015	**Immediate Measures/ Process to prevent reoccurrence:** An in-service was given on 1/23/13 to the Maintenance Supervisor and Housekeeping staff by the Administrator regarding the examination and timely reporting of penetrations in walls, ceilings and other areas throughout the facility. The staff will use a maintenance log to report any findings of wall penetrations that need repair. **Monitoring Process:** The process will be monitored by the Maintenance Supervisor by direct observations of the entire facility on a monthly basis utilizing the CQI environmental checklist to ensure all areas of the facility are free of penetrations. Maintenance Supervisor will track all observations monthly and present findings to Administrator. The quality assurance committee will also review findings quarterly to ensure effectiveness and compliance.	1/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 015	Continued From page 2 administrator and maintenance supervisor during the exit conference on January 10, 2013.	K 015		
K 018 SS=D	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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the corridor doors were smoke-proof by having a gap between the top of the door and door frame when the door was closed. In the event of a fire emergency, corridor doors that are smoke-tight when closed, is an essential component in the containment of smoke and/or fire. At the time of the survey, the facility was licensed for 93 beds and had a census of 88 residents.	K 018	**K 018** **Immediate Corrective Action** Upon notification, the Maintenance Supervisor immediately ordered a new corridor door to replace the door with ½ inch by 6-inch gap between door and frame. **Identification of Others at Risk:** The Maintenance Supervisor will conduct environmental rounds to ensure no gaps are present between corridor doors and door frames. **Process to Prevent Recurrence:** An in-service was given on 1/23/13 to the maintenance supervisor and Housekeeping staff by the Administrator regarding the examination and timely reporting of possible gaps between door and door frame throughout the facility. **Monitoring Process:** The process will be monitored by the maintenance supervisor by direct observations of corridor doors of the entire facility on a monthly basis. Maintenance supervisor will conduct monthly rounds to examine condition of all corridor doors for possible gaps between door and door frame. Maintenance Supervisor will track	1/10/13 1/10/13 1/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 018	Continued From page 3 Findings: On January 10, 2013, from 8:15 a.m. to 9:45 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed that there was 1/2-inch by 6-inch gap between the door and the door frame when the corridor door was closed to Room 27. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the gap between the door and the door frame. The deficiency affected one out of three smoke compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on January 10, 2013.	K 018	monthly observations with a CQI Environmental log and present findings to Administrator. The Quality Assurance committee will also review findings on a quarterly basis to ensure effectiveness and compliance.	
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by:	K 022	**K 022** **Immediate Corrective Action:** Upon identification on 1/10/13, the maintenance supervisor installed an exit sign near the rehabilitation room. It is the intent of this facility to comply with this standard. **Identification of Others at Risk** It is the responsibility of the Maintenance Supervisor to ensure all exit signs are visible and have directional indicators. The maintenance supervisor will use a CQI Environmental checklist to observe all exit signs are in compliance.	1/10/13 1/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 022	Continued From page 4 NFPA 101, 2000 edition, Life Safety Code Chapter 7 Means of Egress Section 7.10 Marking of Means of Egress 7.10.1.4 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100-ft from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure access to exits were marked by approved, readily visible signs in all cases where the exit or way to reach exit were not readily apparent to the occupants in accordance to 7.10.1.4, by not having an exit sign on the northeast corridor when the exit was not apparent. Proper identification of exit access and discharge may aid occupants of an immediate and safe evacuation from the building in the event of an emergency. At the time of the survey, the facility was licensed for 93 beds and had a census of 88 residents. Findings: On January 10, 2013, from 8:15 a.m. to 9:45 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed that there was no directional exit sign at the northeast corridor near the rehabilitation room where the nearest exit was not apparent when standing by nursing station 1. There was an exit	K 022	**Process to prevent recurrence:** An in-service was given on 1/23/13 to the Maintenance Supervisor by the Administrator regarding the observation of directional exit signs and their visibility. **Monitoring Process:** The Maintenance Supervisor will monitor by completing environmental rounds quarterly to ensure that all exits are visible. Maintenance supervisor will track quarterly observations with a log and present findings to Administrator. The quality assurance committee will also review findings on a quarterly basis to ensure effectiveness and compliance.	1/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 022	Continued From page 5 in the rehabilitation room and one down the corridor near the kitchen. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the requirement but would have a company install an exit sign near the rehabilitation room to indicate where the exit areas are located. The deficiency affected two out of six exit routes on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on January 10, 2013.	K 022		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a fire resistive rating of at least one-half hour by using unrated materail to seal a penetration through 1 of 3 smoke barrier walls.	K 025	**K 025** **Immediate Corrective Action:** Upon identification on 1/10/13, the Maintenance Supervisor immediately removed the expanding foam and replaced it with approved fire caulking. **Identification of Others at Risk:** The Maintenance Supervisor examined the remaining barrier walls in the attic to ensure that all sealed penetrations have the material approved fire caulking.	1/10/13 1/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 025	Continued From page 6 Penetrations of smoke barrier walls will compromise the integrity of the smoke compartments thereby allowing smoke to travel easily between smoke compartments and other openings such as the ceiling vents during an emergency. At the time of the survey, the facility was licensed for 93 beds and had a census of 88 residents. Findings: On January 10, 2013, from 8:15 a.m. to 9:45 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed that there was the use of expanding foam used to seal a 2-inch penetration in the smoke/ fire barrier wall by Room 34. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the requirement but would seal the penetration with approved rated material. The deficiency affected two out of three smoke compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on January 10, 2013.	K 025	**Process to Prevent Reoccurrence:** The Maintenance Supervisor will monitor the performance by completing environmental rounds monthly using a CQI Environmental checklist to ensure that all sealed penetrations through out the facility have the approved fire caulking material. **Monitoring Process:** The process will be monitored by the Maintenance Supervisor by direct observations of sealed penetrations through out the facility on a monthly basis. The maintenance supervisor will conduct monthly rounds and track monthly observations with a CQI Environmental log and present findings to Administrator. The quality assurance committee will also review findings on a quarterly basis to ensure effectiveness and compliance.	
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	K 029	**K029** **Immediate Corrective Action:** Upon identification on 1/10/13, the Maintenance Supervisor	1/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 029	Continued From page 7 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 separate the laundry (a hazardous area) from other spaces by not allowing the corridor door to self-close completely and positively latch. The separation of the water heater/boiler room from other smoke compartments would not be achieved in the event of fire and/or smoke emergency. At the time of the survey, the facility was licensed for 93 beds and had a census of 88 residents. Findings: On January 10, 2013, from 8:15 a.m. to 9:45 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed that the corridor door (that was connected to an electro-magnetic door holder that was connected to the fire alarm system) to the soiled linen/ linen chute room failed to self-close and latch after the activation of the fire alarm system. There was a 2-inch gap between the door and the door frame. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the problem but would adjust the self-closing device to ensure that the	K 029	immediately repaired the screws on the self closing device and a new door was ordered to replace the door with a 2 inch gap. **Identification of Others at Risk:** The Maintenance Supervisor will be responsible to ensure that all corridor doors are free of gaps. An Environmental CQI checklist will be used to review and observe if there are any gaps between door and door frames. All corridor doors were examined by the maintenance supervisor to ensure there are no gaps between door and door frame. **Process to Prevent Recurrence:** An in-service was given on 1/23/13 to the Maintenance Supervisor and Housekeeping staff by the Administrator regarding the examination and timely reporting of possible gaps between door and door frame throughout the facility. **Monitoring Process:** Maintenance Supervisor will conduct monthly rounds to examine condition of all corridor doors for possible gaps between door and door frame. Maintenance Supervisor will track monthly observations with a log and present findings to Administrator. The quality assurance committee will also review findings quarterly to ensure effectiveness and compliance.	1/10/13 1/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 029	Continued From page 8 door closes completely and positively latches. The deficiency affected one out of a total of four smoke compartments in the facility. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on January 10, 2013.	K 029		
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: NFPA 13 Installation of Sprinkler Systems, 1999 edition. Chapter 5-Installation Requirements 5-5 .5.1 Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. 5-5.5.2.1 Continuous or noncontinuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2. 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11	K 062	**K062** **Immediate Corrective Action:** The Maintenance Supervisor immediately removed the items stored less than 18-inches from the bottom of the sprinkler heads in the basement, restorative nursing storage and storage room for clothing. The Maintenance Supervisor also installed on 1/10/13 a red line indicating the maximum height of items to be stored. **Identification of Others at Risk:** On 1/10/13, the maintenance supervisor examined all storage areas throughout the facility to ensure all items were stored at least 18-inches from the bottom of the sprinkler heads.	1/10/13 1/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 062	Continued From page 9 so that they are located sufficiently away from obstructions such as truss webs can chords, pipes, columns and fixtures. This requirement was not met as evidenced by: Based on observation and interview, the facility failed to be in accordance with NFPA 13, sections 5-5 .5.1, 5-5.5.2.1 and 5-5.5.2.2 by storing items less than 18-inches below sprinkler deflectors in storage rooms. In the event of a fire, the activation and effective operation of the automatic sprinkler system may occur if sprinkler heads are properly maintained, without any corrosion, impediments or foreign materials. At the time of the survey, the facility was licensed for 93 beds and had a census of 88 residents. Findings: On January 10, 2013, from 8:15 a.m. to 9:45 a.m., during a tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed items (boxes and equipment) stored less than 18-inches (3 to 8-inches) from the bottom of the fire sprinkler heads in the basement, in the restorative nursing storage closet and storage room for clothes near Room 35. During an interview with the maintenance supervisor at the time of the observation, he stated he was unaware of the storage problems but would remove the items and remind staff by using a line to indicate the storage height limit. The deficiency affected two out of three smoke	K 062	**Process to Prevent Recurrence:** An in-service was given on 1/23/13 to the maintenance supervisor and housekeeping staff by the Administrator regarding the examination of all storage closets in the facility and timely reporting of possible items being stored less than 18-inches from sprinkler heads. **Monitoring Process:** The process will be monitored by the Maintenance Supervisor, Social Services and Administrator through daily rounds and random visual checks to identify possible storage being stored less than 18-inches from sprinkler heads. Maintenance Supervisor will track monthly observations with a log and present findings to Administrator. The quality assurance committee will also review findings on a quarterly basis to ensure effectiveness and compliance.	1/23/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYVIEW CONV HOSP	2000 W WASHINGTON BL LOS ANGELES, CA 90018

(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 062	Continued From page 10 compartments on the sleeping room level. The deficiency was brought to the attention of the administrator and maintenance supervisor during the exit conference on January 10, 2013.	K 062		