STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. BUILDING _____ B. WING _____	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLHEIM SENIOR COMMUNITY	2236 MERTON AVE. LOS ANGELES, CA 90041

(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: [redacted] REHS, HFE I Highest Scope & Severity: No Deficiencies	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Meg Pierce | Administrator | 10/27/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLHEIM SENIOR COMMUNITY	**2236 MERTON AVE.** **LOS ANGELES, CA 90041**

(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 the Life Safety Code NFPA 101, 2012 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during a Life Safety Code Survey. Representing the Department of Public Health: [redacted]REHS, HFE I	K 000		
K 341 SS=D	Highest Severity and Scope: E Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	K 341	This deficiency involved the failure to maintain one smoke detector (#2041) out of the 16 sampled smoke detectors free from barriers that prevent the device from detecting smoke. 1. Immediate corrective action was taken on 10/10/23 regarding this deficiency by removing the plastic barrier that was discovered which prevented the device from detecting smoke. This was observed by the inspector, as was an immediate subsequent retest which documented that without the plastic barrier covering it, the smoke detector did in fact detect the synthetic smoke that was used to perform the test.	10/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meg Pierce	Administrator	10/27/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLHEIM SENIOR COMMUNITY	**2236 MERTON AVE.** **LOS ANGELES, CA 90041**

(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 341	Continued From page 1 review, the facility failed to maintain one (smoke detector number 2041) out of 16 sampled smoke detectors free from barriers that prevent the device from detecting smoke. This deficient practice has the potential for a fire to spread and remain undetected by the smoke detector affecting the safety of the residents, staff, and visitors within the facility. Findings: During a concurrent observation and interview on 10/10/2023, at 10:34 a.m., in the Breakroom on the basement level, with the Maintenance Supervisor (MS) and the Director of Operations (DOO), a red plastic cover was observed to be covering the sensors of the smoke detector labeled 2041 by the bathrooms. The MS stated that this was a plastic cover that was left on after installation and that the cover should have been removed. During a concurrent observation and interview on 10/10/2023, at 10:39 a.m., in the Breakroom in the basement, with the MS and the DOO, smoke detector 2041 was sprayed with synthetic smoke (an aerosolized can of smoke-like formula sprayed into the air around a smoke detector for the purposes of triggering the smoke detector alarm) while the red plastic cover remained on as it was originally observed. The synthetic smoke was not detected and the fire alarm was not triggered. The MS and DOO stated that the alarm did not appear to be triggered while the detector was tested with the plastic cover on. During a review of the record titled "Event History" (a log of the times the alarm monitoring	K 341	2. On 10/10/23, the Director of Operations personally visually examined every smoke detector device located at the facility and confirmed that no other devices had any barriers on them which might prevent them from detecting smoke. 3. Going forward and continuing for the next four weeks (i.e., through November 17, 2023), the Director of Operations (or a designated staff member acting under his supervision) shall conduct weekly audits of all smoke detectors located at the facility, to continue to confirm that no such devices have any barriers placed on them which might prevent them from detecting smoke. 4. QAPI will review and ensure compliance. These audit inspections shall be tracked in a written log, which shall thereafter be maintained by the facility in its records for one year (i.e., until November 17, 2024). Please see "Exhibit A" for supporting documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLHEIM SENIOR COMMUNITY	**2236 MERTON AVE.** **LOS ANGELES, CA 90041**

(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 341	Continued From page 2 company received a signal from the facility's fire alarm system during testing) dated 10/10/2023, the log did not indicate that the alarm was triggered by smoke detector 2041 at 10:39 a.m. During a review of the record titled "Smoke Alarm Maintenance Policy" last revised on 3/22/2022, the policy indicated "Smoke alarms should be visually inspected (i.e., examined for obstruction, dust, dirt, etc.) ..."	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to: 1) Maintain the sprinkler escutcheons (metal ring around the sprinkler head) on the sprinkler in an	K 351	This deficiency involved the following two findings: (1) the sprinkler eschuteons were not maintained in an approved manner (i.e., flush with the ceiling) in two locations – the ADON's office and the Kitchen, and (2) no sprinkler system was observed within a large walk-in cooler / freezer located within the kitchen. 1a. With regard to the sprinkler eschuteons that needed to be adjusted: On 10/10/23, they were re-adjusted so that they are now flush with the ceiling in both of those locations. 2a. On 10/10/23, the Director of Operations personally visually examined every other sprinkler located at the facility and confirmed that no other devices had any similar issues.	10/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLHEIM SENIOR COMMUNITY	**2236 MERTON AVE.** **LOS ANGELES, CA 90041**

(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 351	Continued From page 3 approved manner. 2) Maintain sprinklers inside of the walk-in cooler and the walk-in freezer. These deficient practices have the potential: 1) For heat and smoke to rise above the ceiling through the gap which may delay the activation of the sprinkler head. 2) For a fire to not be put out inside of the walk-in cooler and/or freezer. Findings: 1) During a concurrent observation and interview on 10/10/2023, at 11:02 a.m., in the Assistant Director of Nursing's (Assistant DON) Office, with the Lead Technician (LT), a sprinkler head without an escutcheon was observed in the ceiling of the office by the door. The LT stated that the sprinkler needed the metal ring around the sprinkler head. During a concurrent observation and interview on 10/10/2023, at 12:41 p.m., in the Kitchen, with the MS and DOO, two sprinkler heads in the dish washing area were observed with 1 inch gaps between the escutcheon and the ceiling. The MS stated that there should not be a gap between the metal escutcheon and the ceiling. 2) During a concurrent observation and interview on 10/10/2023, at 12:35 p.m., in the Kitchen with the MS, the walk-in cooler (large refrigerator that can be walked in to) and the walk-in freezer (large freezer able walked in to, used to store frozen food) were observed without an install sprinkler inside either of the walk-in units. The MS stated that he was not sure if the walk-in units ever had a sprinkler and was not sure if they were	K 351	3a. Going forward and continuing for the next four weeks (i.e. through November 17, 2023), the Director of Operations (or a designated staff member acting under his supervision) shall conduct weekly audits of all sprinklers located at the facility, to continue to confirm that they do not have or develop or similar issues. 4a. QAPI will review and ensure compliance. These audit inspections shall be tracked in a written log, which shall thereafter be maintained by the facility in its records for one year (i.e., until November 17, 2024). 1b. With regard to the lack of a sprinkler system within the large walk-in cooler / freezer located within the kitchen: The facility believes that this area is sufficiently covered, in the event of a fire, via the multiple working and properly-installed sprinklers that are installed immediately above the walk-in cooler / freezer unit. Photos of those sprinklers are attached to this plan of correction. In addition, the facility has also reached out to HCAI via email to seek guidance on this issue and confirm that the current confirmation of the walk-in cooler / freezer is acceptable. A true and correct copy of that email is also attached to this plan of correction. Please see “Exhibit B” for supporting documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555432	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLHEIM SENIOR COMMUNITY	**2236 MERTON AVE.** **LOS ANGELES, CA 90041**

(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 351	Continued From page 4 approved for installation without the sprinkler.	K 351		