STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055884	A. BUILDING **02** B. WING _____	**01/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN TOMAS CONVALESCENT HOSPITAL	**3580 PAYNE AVENUE** **SAN JOSE, CA 95117**

(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 Surveyor: 32973 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness re-certification 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: 32973 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 81	E 000		
K 000	INITIAL COMMENTS Surveyor: 32973 K3 BUILDING: 01 K6 PLAN APPROVAL: 1968 K7 SURVEY UNDER: 2012 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 re-certification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public	K 000		

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

Electronically Signed | 01/21/2022

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.

1/24/22 Accepted by Cynthia Luc

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K 000	Continued From page 1 Health: 32973 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 81	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain a clear and identifiable path of egress. This was evidenced by the failure to post directional signs where the line of exit travel was not obvious. This affected one of five smoke compartments, and could result in delayed egress by staff, residents, and visitors during an emergency evacuation. NFPA 101 Life Safety Code, 2012 edition 19.2.7 Discharge from Exits. Discharge from exits shall be arranged in accordance with Section 7.7. 7.7 Discharge from Exits. 7.7.3 Arrangement and Marking of Exit Discharge.	K 271	This plan of correction is submitted as required under Federal and State regulation and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility or it's employees/agents, and such liability is herby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, and the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	1/28/22

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K 271	Continued From page 2 7.7.3.2 The exit discharge shall be arranged and marked to make clear the direction of egress travel from the exit discharge to a public way. Findings: During a facility tour and interview with staff on 1/11/22, the exit access, exit, and exit discharge, were observed At 12:20 p.m., the designated exit located in the 200 Hall corridor, next to Resident Room 214, was observed. The exit discharged into the Rear Courtyard, enclosed with a perimeter wall and two gates. Two paths of travel existed, a gravel path to the right, and an all-weather concrete path to the left. The approved all-weather path and exit gate to the public way, were located to the left, and across the length of the courtyard. No directional sign to the exit gate was available, and an exit sign was not posted on the exit gate. Upon interview, Staff 1 confirmed the finding, and stated that they could see the need for directional and exit gate signs.	K 271	Corrective action for the alleged deficient practice regarding exit paths: (1) Corrective action will be accomplished where Facility Maintenance Staff shall post directional signs where the line of exit travel is not obvious. Namely, directional arrows have been posted outside of the 200 Hall corridor near Resident Room 214 to the proper exit path. (2) Directional arrows shell be posted to the direction through the exit gate by the Maintenance staff. (3) To identify potential exit ways affected, Facility Maintenance Staff will reassess exit paths to ensure they are properly marked. (4) During the next Quarterly Safety Meeting, Facility Maintenance Staff and Administrator will reassess facility map and ensure proper markation of exit paths using the floorplan.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit	K 293		1/19/22

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K 293	Continued From page 3 travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the exit signs. This was evidenced by the failure to identify and post a non-exit guidance sign. This affected one of five smoke compartments, and could result in entrapment and re-entry into the building during a fire, and egress delay and confusion by staff, residents, and visitors during an emergency evacuation. NFPA 101, Life Safety Code, 2012 Edition 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.8.3* No Exit. 7.10.8.3.1 Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT 7.10.8.3.2 The NO EXIT sign shall have the word NO in letters 2 in. (51 mm) high, with a stroke width of 3?8 in. (9.5 mm), and the word EXIT in letters 1 in. (25 mm) high, with the word EXIT below the word NO, unless such sign	K 293	Corrective action for the alleged deficient practice regarding exit ways: Facility maintenance has: (1) taken corrective action and affixed a guidance sign reading: "NOT AN EXIT" to the identified area to prevent entrapment and re-entry should an emergency occur. (2) Employees will be in-serviced on utilization of proper exits during an emergency. (3) To identify potential non-exit ways affected, Facility will reassess exit paths to ensure they are properly marked. (4) During the next Quarterly Safety Meeting, Facility will reassess facility map and ensure proper markation of exit and non-exit paths using the floorplan.	

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K 293	Continued From page 4 is an approved existing sign. Findings: During a facility tour and interview with staff on 1/11/22, the path of egress and exits, were observed. At 12:10 p.m., the sleeping room corridor by Nursing Station 2, was observed with two full-length glass and steel framed doors. The doors exited outside into a central courtyard enclosed by the building structure. No sign was posted that would have indicated the doors were not an exit. Upon interview, Staff 1, confirmed the finding, and stated that they had removed a previously posted exit sign, and could understand the reason for having the sign posted.	K 293		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		1/28/22

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K 321	Continued From page 5 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the hazardous areas. This was evidenced by not maintaining the minimum opening protection. This affected two of five smoke compartments, and could result in a delay in containing smoke and/or fire to a hazardous area. Findings: During a facility tour and interview with staff on 1/11/22, the hazardous area enclosures, were observed. 1. At 11:55 a.m., the Station 2, Water Heater Room, was observed. The room contained a natural gas (LP) fuel-fired water heater. The corridor door was opened to the fullest extent and allowed to close by staff. The door failed to fully close and latch due to the bottom of the door dragging against the floor. Upon interview, Staff 1, confirmed the finding and stated that the door	K 321	Corrective action for the alleged deficient practice regarding enclosure for hazardous areas: 1. Facility has repaired the door containing Station 2 Water Heater. The door now can be opened to fullest extent and can now latch upon closing. 2. Facility has repaired the Medical Records Storage Room door. The door can now be opened to the fullest extent and and latch can latch upon closing. 3. Maintenance department will conduct a daily check of all doors in a single station/wing to ensure latch integrity and identify doors in need of repair. A different station/wing will be checked daily.	

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K 321	Continued From page 6 was obstructed by the floor. 2. At 12:30 p.m., the Medical Records Storage Room, was observed. The room was greater than 50 square feet (approximately 100 square feet), and contained multiple stored paper records and files. The corridor door was opened to the fullest extent by staff, and allowed to close. The door failed to fully close and latch due to a malfunctioning self-closing device. Upon interview, Staff 1, confirmed the finding and stated that the door needed to be fixed.	K 321	4. Employees will be in-serviced on how to observe and utilize a properly closed door. 5. Maintenance department will begin and maintain a log of door checks. Maintenance will check 15 doors in a given wing/station to ensure integrity/identify areas in need of repair. 6. To identify potential additional doorways affected, Facility Maintenance will include door checks in their logging system.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 32973	K 353	Corrective action for the alleged	1/28/22

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K 353	Continued From page 7 Based on observation and interview, the facility failed to maintain the integrity of the automatic fire sprinkler system. This was evidenced by a damaged sprinkler head. This affected one of five smoke compartments, and could result in the ineffective operation of the sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 4.3 Records 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request.	K 353	deficient practice regarding maintenance of sprinkler system: (1) Automatic sprinkler system is scheduled for assessment/repair 1/21/2022. Licensed company will conduct the proper repairs to ensure integrity of the system. (2) Kitchen sprinklers have been outfitted with markers to make sprinkler heads more pronounced and allow staff to recognize and avoid those areas. (3) Maintenance department will conduct a walkthrough of one corridor per day to identify any parts of system in need for repair. Check will be appropriately logged and filed. (3) To identify potential non-exit ways affected, Facility will continue the walkthrough practice to ensure sprinkler system is properly maintained.	

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K 353	Continued From page 8 Chapter 5 Sprinkler Systems. 5.1.1 Minimum Requirements. 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. 5.2.1 Sprinklers. 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer Findings: During a facility tour and interview with staff on 1/11/22, the automatic fire sprinkler system, was observed. At 12:40 p.m., the standard pendant style sprinkler that was located inside the Kitchen walk-in freezer, was observed. The deflector component was twisted and bent in an upward position towards the frame. Upon interview, Staff 1 confirmed the finding, and stated that it looked like somebody hit it.	K 353		
K 363 SS=D	Corridor - Doors	K 363		1/28/22

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K 363	Continued From page 9 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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,	K 363		

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K 363	Continued From page 10 etc. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a door that was obstructed from fully closing and latching. This affected one of five smoke compartments, and could result in the inability to contain smoke and/or fire to a room. Findings: During a facility tour and interview with staff on 1/11/22, the corridor doors, were observed. At 12:15 p.m., the corridor door to the Station 2, Shower Rooms, was equipped with a self-closing device. The door was held open to the fullest extent and allowed to close by staff. The door failed to fully close and latch due to a malfunctioning self-closing device arm. Upon interview, Staff 2, confirmed the finding after retesting the door.	K 363	Corrective action for the alleged deficient practice regarding sprinkler system maintenance: 1. Facility has repaired the self-closing latch on the Station 2 Shower Room Door. 2. Facility maintenance will include these self-closing door identification in daily rounds. Rounds/repairs will be appropriately logged and filed. (3) To identify potential additional door ways affected, Facility will continue the practice of checking doors to ensure proper repairs are completed immediately. (4) During the next Quarterly Safety Meeting, Facility will reassess and review logs to ensure task is being completed.	