Acceptable POC 12/8/16

PRINTED: 11/10/2016
FORM APPROVED
OMB NO. 0938-0391

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
	555165	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PARK SKILLED NURSING AND WELLNESS CENTER	5125 MONTE VISTA ST. LOS ANGELES, CA 90042

(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 The following represents the findings of the Department of Public Health Services during the Life Safety Code Survey. Representing the Department of Public Health: Surveyor ID #12007, REHS, HFE-I Census: 57 Highest Scope and Severity - E	K 000	Highland Park Skilled Nursing & Wellness Centre (hereinafter HPSNWC) submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: NFPA 101, 2012 Edition Section 19.2.3.4* Based on observation and interview the facility failed to continuously maintain egress pathways, corridors, exit location free of all obstructions to full use in case of emergency. The facility also failed to establish and implement provisions associated with the allowance of wheeled equipment that were left unattended in four of four corridors and egress pathways. The deficiency affected two of two smoke compartments. Findings:	K 211	K211 I. Corrective Action/s Facility established a fire safety plan and training program to address the relocation of wheeled equipment to the south end of the facility grounds. II. How to Identify Other Residents: Staff will be designated at each corridor to ensure the effective facility-wide relocation of wheeled equipment during a fire or similar emergency. III. Systemic Changes: Maintenance Supervisor will ensure the upkeep of the designated relocation area and conduct quarterly training drills to familiarize the staff with the new wheeled equipment relocation system.	11/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 11/17/16

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.

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K 211	Continued From page 1 During the LSC (Life Safety Code) inspection that included the test of the fire alarm on 11/04/16 and 11/05/16, the evaluator, in the presence of the maintenance supervisor observed two Hoyer lift equipment, 13 residents' wheelchairs, nine clean linen carts, one weight-chair, Geri-chair, four medication carts and two wood pallets containing boxes of diapers and food (formula) cans that were stored in facility corridors and path of egress during the survey inspection. These equipment obstructions were noted in corridor between Room 1 and the front entrance egress pathway in corridor between Rooms 3 and 10, corridor in front of Rooms 19 and 20 and in corridor between Rooms 10 and 18. In an interview on 11/05/16, at 10:50 a.m., the maintenance supervisor stated he was not aware of the provisions associated with storing wheeled equipment in facility corridor and egress pathways. The assistant administrator stated during the interview on the same date at 3:50 p.m., that she too was not aware of any required provision associated with storing wheeled equipment in the corridors. The assistant administrator and the maintenance supervisor also stated that the facility had not established a fire safety plan and training program to address the relocation of the wheeled equipment during a fire or similar emergency. The deficiency was brought to the attention of the assistant administrator and the maintenance supervisor during the exit conference on 11/05/16.	K 211	IV. Monitoring: Maintenance Supervisor will generate a quarterly report of the results from the training drills for presentation to the QAA committee on a quarterly basis. QAA committee shall make recommendations as necessary based on the results.	
K 291 SS=D	NFPA 101 Emergency Lighting	K 291	K291 I. Corrective Action/s Visual inspection of required emergency lighting	11/19/16

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	555166	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PARK SKILLED NURSING AND WELLNESS CENTER	6125 MONTE VISTA ST. LOS ANGELES, CA 90042

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K 291	Continued From page 2 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that required battery-powered emergency lighting located above the front entrance exit door was tested annually. This deficient practice had the potential to affect all residents, staff and visitors during an emergency in one of two smoke compartments. Findings: On 11/04/16 and 11/05/16, during the facility's LSC tours and the test of the fire alarm system in the presence of the maintenance supervisor, the evaluator observed a battery operated emergency light above the front entrance exit door. On 11/04/16 at 11:05 a.m., the review of the facility's monitoring emergency lights record was requested. The maintenance supervisor stated that the facility did not conduct an annual 11/2 hour (90 minutes) testing on the battery-powered emergency light. A review of the emergency light manual indicated that the test switch provides manual activation of 30-second diagnostic testing for on-demand visual inspection. Self-diagnostic testing for 30 seconds every 30 days, 30 minutes at 180-day interval, and 90 minutes annually however, the facility could not provide any documented evidence to show that the written records of visual inspections and testing of the emergency lights was being carried out in the facility and shall be kept by the owner for inspection by the authority having jurisdiction.	K 291	systems shall be conducted and documented by the Maintenance Supervisor in 30 day Intervals. Maintenance Supervisor will also coduct annual testing of required emergency lighting systems for 90 minutes. **II. How to Identify Other Residents:** The facility will maintain a separate emergency supply of batteries to ensure the emergency lights will always be powered. **III. Systemic Changes:** Maintenance Supervisor will create a log to record all visual inspections and fuctional testings. **IV. Monitoring:** Maintenance Supervisor will report the findings of the testing of required emergency lighting systems quarterly to the QAA committee.	

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K 291	Continued From page 3 The above findings were acknowledged by the assistant administrator and maintenance supervisor during the exit conference on 11/05/16. The NFPA 101, LSC 2012 Edition Section: 7.9.3.1.2 - Testing of required emergency lighting systems shall be permitted to be conducted as follows: Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failure by a status indicator. A visual inspection shall be performed at intervals not exceeding 30 days. Functional testing shall be conducted annually for a minimum of 1 1/2 hrs. (90 mins.) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1 1/2 hrs. test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction.	K 291		
K 293 SS=D	NFPA 101 Exit Signage 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 travel is obvious.) This STANDARD is not met as evidenced by: Exit Signage NFPA 101, 2012 edition, Life Safety Code Exit and directional signs are displayed in	K 293	K293 I. Corrective Action/s Facility will display a readily visible exit directional sign outside the northern corridor. II. How to Identify Other Residents: The exit directional sign will be clearly visible and reflective with an arrow pointing south towards the exit access route. III. Systemic Changes: Maintenance supervisor will monitor and inspect all exit directional signs that lead to routes of egress in preparation for emergency evacuations.	11/19/16

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K 293	Continued From page 4 accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 7.10.2 Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to display an exit directional sign in accordance with NFPA 101, section 7.10 by not marking an exit route with a readily visible sign thereby, not making the exit readily apparent to the occupants. In the event of an emergency evacuation, unmarked route of egress may hinder or impede the location of exit access route to the public way and area of safety. The deficiency affected one of two smoke compartments. Findings: During the Life Safety Code survey observation tour of the facility on 11/05/16 at 3:05 p.m., the evaluator, in the presence of the maintenance supervisor, did not observe an approved signs that led to the route of egress outside of the North side corridor exit door located in front of Room 12. The available exit (without the directional exit sign) led to a public way and area of safety on the right. There was no directional exit sign to indicate which way the occupants should turn after exiting the door in order to access the public way and area of safety. During the interview the maintenance supervisor stated that the facility would provide a directional	K 293	**IV. Monitoring:** Maintenance supervisor will monitor and inspect all exit directional signs that lead to routes of egress in preparation for emergency evacuations.	

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K 293	Continued From page 5 sign to indicate access route to area of safety during emergency evacuation. The deficiency was brought to the attention of the assistant administrator and maintenance supervisor during the exit conference on 11/05/16.	K 293		
K 751 SS=D	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the window curtains in the laundry room were flame resistant in accordance with 10.3.1. Flame resistant window curtains and valances are essential in preventing a fire from spreading. The deficient practice affected one of two smoke compartments. Finding: On 11/05/16, at 4:45 p. m., during the LSC the review of the maintenance record, the supervisor was unable to provide proof to show that the laundry room window drapes were flame resistant. The facility was unable to provide	K 751	K751 I. Corrective Action/s Facility will purchase new flame resistant laundry drapes and the Maintenance Supervisor will install them to prevent a potential fire spread. II. How to Identify Other Residents: Facility will ensure that the drapes are clearly labeled as fire resistant, for visible assurance and inspection. III. Systemic Changes: Maintenance Supervisor will immediately remove the laundry drapes in the laundry in the laundry room and install the new fire resistant drapes upon delivery. IV. Monitoring: Invoice orders confirming the laundry drapes are fire resistant will be kept and saved by the Maintenance Supervisor. Removal of previous laundry drapes were completed on 11/6/16 and the new fire resistant laundry drapes were ordered on 11/18/16 by the Maintenance Supervisor.	11/19/16

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K 751	Continued From page 6 documentation/s indicating that the fabric materials on the window were flame resistant. The maintenance supervisor acknowledged the findings and stated that the facility will provide flame resistant drapes. The deficiency was brought to the attention of the assistant administrator and the maintenance supervisor during the exit conference on 11/05/16.	K 751		