POC accepted on 4/28/15 by 05373, REHS

PRINTED: 04/17/2015
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
	056039	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT OASIS HEALTHCARE	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 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 during a Life Safety Code Survey. Representing the Department of Public Health: Evaluator ID 05373, REHS, HFE Evaluator ID 12774, REHS, HFE Highest S/S = E Census = 207	K 000	NOTICE: THIS PLAN OF CORRECTION CONSTITUTES THE LICENSEE'S CREDIBLE ALLEGATION OF COMPLIANCE. PREPARATION & OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY OR AN AGREEMENT BY THE LICENSEE OF THE FACTS ALLEDGED OR THE CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS SUBMITTED AS PART OF THE STATUTORY REQUIREMENTS SET FORTH IN THE CALIFORNIA HEALTH & SAFETY CODE & OTHER STATE & FEDERAL REGULATIONS. BY SUBMITTING THE PLAN OF CORRECTION, THE LICENSEE DOESN'T WAIVE ANY OBJECTION TO THE MERITS TO THE DEFICIENCY OR THE ALLEGATIONS & THE BASIS OF THE ALLEGATION CONTAINED IN THE DEFICIENCY. FURTHERMORE, THE LICENSEE DOESN'T WAIVE ITS RIGHT TO CONTEST THE MERITS OF THE DEFICIENCY NOR DOES IT WAIVE ITS RIGHTS TO PURSUE AN APPEAL OF THE DEFICIENCY AS ALLOWED UNDER THE STATE & FEDERAL LAW.	
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 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.	K 018	K018 1. Upon verbal notification of this deficient practice on March 03, 2015, the maintenance supervisor and maintenance staff repaired the fire door near room 427 and 502 they now latch properly (6) magnetic door holder in dining room 5. It now releases properly. 2. All in house residents have the potential to be affected by this same alleged deficient practice. 3. An in service was conducted by DSD and QA on March 19, 2015 to all maintenance staff re; life and safety on maintaining corridor doors from obstruction that prevented the doors form closing freely and latching properly. This will be done every month X3 months and annually thereafter. 4. Compliance to this POC will be monitored by the maintenance supervisor then weekly inspection of the fire doors, inspection results will	

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LOS ANGELES COUNTY PUBLIC HEALTH ENVIRONMENTAL HEALTH DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 4-27-15

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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors free from obstructions that prevented the doors from closing freely and latching properly. It is essential that corridor doors be quickly closed and secured to prevent the spread of fire and smoke. The deficient practice affected four of six smoke compartments. Findings: a. On March 3, 2015, at 10:30 a.m., during the smoke alarm test accompanied by the Maintenance Supervisor, the fire doors near Rooms 427 and 502 did not latch in three out of three attempts. The Maintenance Supervisor stated he was not aware of the condition of the door and would correct them right away. b. On March 3, 2015, at 10:50 p.m., during observation of the facility accompanied by the Maintenance Supervisor, the Evaluators noted the magnetic door holder failed to release the door to the Dining Room 5 to be able to latch in one of two attempts.	K 018	be documented in the maintenance log immediate corrective actions will be done as soon as problem is identified. The administrative coordinator will review maintenance inspection reports monthly. Significant findings will be submitted to the administrator and will be forwarded to the QA &A committee for CQI 5. Corrective action will be completed on or before April 27, 2015	04/27/2015
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.	K 050	K050 1. Upon notification of this alleged deficient practice on March 04, 2015, a comprehensive in service was conducted by the DSD and ADSD and QA to all kitchen staff regarding Life and	

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K 050	Continued From page 2 Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the dietary staff was familiar with the fire suppression system in the kitchen. This deficient practice had the potential to affect one of six smoke compartments. Findings: On March 4, 2015, at 11:10 a.m., during an interview with one of the dietary employees, she did not know the procedure on what to do if there was a fire at the stove area. She pointed out to the light switch and stated she would activate that and did not know when or how to activate the hood fire suppression system. The Maintenance Supervisor stated he will make sure the dietary staff members will be trained in the proper way of using and activating the fire suppression system in the kitchen.	K 050	Safety with emphasis on ensuring that the kitchen staff are knowledgeable in the use of the fire suppression system in the dietary department. 2. All in house residents have the potential to be affected by this same alleged deficient practice. 3. On April 20, 2015 and April 23, 2015 the facility contacted the fire prevention safety vendor to conduct a fire drill with the focus on the kitchen staff and emphasis on the proper operation of the fire suppression system in the kitchen. All staff are now knowledgeable in the operation of the fire suppression system in the kitchen. This will be done quarterly. 4. Compliance to this POC will be monitored by the DSD then review of quarterly fire in service and drills in the kitchen. The administrator coordinator will conduct random kitchen inspection and interview of dietary staff to ensure that they are knowledgeable in the operating of the fire suppression system in the dietary department. Significant finding will be forwarded to the administrator to be incorporated into the QA&A committee for CQI.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10		5. Corrective action will be in placed on or before April 27, 2015	04/27/2015

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K 072	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the corridor egress pathways free from obstructions to full instant use. In the event of smoke and/or fire, an unobstructed means of egress is essential in the prompt evacuation of residents and staff as well as facilitating easy access into the facility by the fire department in response to an emergency. The deficient practice affected three of six smoke compartments. Findings: During the survey of the facility on March 4, 2015, at 10:30 am, the Evaluators observed Hoyer lifts, medication/treatment carts and soiled linen barrels stored in the corridor located near Stations III, IV and V on both sides of the corridors. According to the Maintenance Supervisor, they have to keep all the items on one side of the corridor. A review of the facility evacuation plan indicated these were part of the route of evacuation.	K 072	K072 1. Upon notification of this alleged deficient practice on March 04, 2015 the maintenance and DSD supervised the nursing staff in clearing the hallways of station 3, 4, 5 the area was cleared and items such as treatment carts soiled linen barrels and hoyer lifts are now only kept on one side of the hallway when in use. 2. All in-house resident can be affected by the same deficient practice. 3. An in service was conducted to all staff on March 11, 2015 by the DSD and Maintenance supervisor re; fire and safety with emphasis on maintaining all areas to be free of equipment, in case of a fire or other emergency. This will be done monthly X 3 and annually thereafter. 4. The DSD or designee will monitor compliance to this through daily visual rounds of the facility, to ensure that corridors and pathways are free from obstacles and to ensure that all equipment is kept to one side of the hallway on the even number side for in the event of a fire and or emergency. The supervisor in charge shall do visual rounds during the day to ensure that the hallways are clear and that we are in compliance with this practice. The observation will be documented on the facility internal rounds form. Significant finding will be forwarded to the administrator to be incorporated into the QA&A committee for CQI. 5. Corrective action will be in placed on or before April 27, 2015	04/27/2015