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

PRINTED: 07/14/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 055728 06/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE SANTA CLARITA CONV. HOSPITAL NEWHALL, CA 91321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) · K 000 I INITIAL COMMENTS · · K 000 "This Plan of Correction constitutes Santa Clarita Convalescent Hospital's written This facility was surveyed under 42 CFR Part credible allegation of 483.70 (a) Life Safety Code NFPA 101, 2000 compliance. Santa Clarita Edition, Chapter 19 Existing Health Care Convalescent Hospital Occupancies, and other applicable codes. (hereinafter SCCH) makes its best effort to operate in full The following represents the findings of the compliance with both federal Department of Public Health during a Life Safety and state laws. Nothing Code Survey. included in this plan of correction is an admission otherwise. SCCH has Representing the Department of Public Health: submitted this plan of correction Evaluator ID No. 05373, REHS, HFE in order to comply with its regulatory obligation and does Highest S/S = D not waive any objections to the Census = 86 allegations contained herein. NFPA 101 LIFE SAFETY CODE STANDARD K 029 Please note that SCCH may K 029 SS=D contest the merits and/or from any deficiency findings alleged One hour fire rated construction (with 3/4 hour below and may take appropriate fire-rated doors) or an approved automatic fire actions to appeal them." extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When K 029 7/25/15 the approved automatic fire extinguishing system It is the policy of SCCH to have option is used, the areas are separated from doors to hazardous areas be other spaces by smoke resisting partitions and automatically self-closing and doors. Doors are self-closing and non-rated or latch field-applied protective plates that do not exceed 48 inches from the bottom of the door are IMMEDIATE CORRECTIVE permitted. 19.3.2.1 On 6/26/15 a automatic selfclosing device that latched was installed to the break room in the basement. The microwave in the basement corridor that This STANDARD is not met as evidenced by: was identified was placed in the Based on observation and interview, the facility employee break room. failed to ensure that doors to the hazardous areas were automatically self-closing and latching. The separation of hazardous areas from other smoke compartments would not be achieved in the event :

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 ollowing 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 lays 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.

OR!M CIMS-2557(02-99) Previous Versions Obsolete

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: R0P521

Facility ID: CA920000053 •

TITLE

If continuation sheet Page 1 of 3

(X5) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/14/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 COMPLETED 055728 06/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE SANTA CLARITA CONV. HOSPITAL NEWHALL, CA 91321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION מו (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 029 | Continued From page 1 K 029 RESIDENTS AT RISK of fire and/or smoke emergency. The deficient The Maintenance Supervisor practice affected the basement reviewed other doors in hazardous areas for this Findings: deficient practice. No other residents were affected by this During the facility tour on June 26, 2015, at 11:40 deficient practice. a.m., accompanied by the Maintenance CORRECTIVE ACTION Supervisor, it was noted that the microwave used The Maintenance Supervisor by the employee was kept on a small table in the was in-serviced by the corridor next to the wall across from the Administrator on 7/24/15 to employee's room. There was no means of ensure corridor doors in creating a separation and isolating the hazardous hazardous areas have area from other areas. Maintenance Supervisor automatic self-closing devices with a latching mechanism to agreed that it needed to be kept in the create separation to other parts employee's room separating the corridor from of the facility. the employees lunch room with an automatic self-closing device on the door. The basement **MONITORING OF** housed the linen storage closet, dietary services, CORRECTIVE ACTION employee's lunch room and maintenance work At the direction of the QAA shop. committee, the Maintenance NFPA 101 LIFE SAFETY CODE STANDARD K 047

svstem.

SS=D

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the exit signs were illuminated continuously. Properly illuminated exit signs may ensure safe and immediate evacuation

Exit and directional signs are displayed in

19.2.10.1

accordance with section 7.10 with continuous

illumination also served by the emergency lighting

away from the building in the event of an emergency.

K 047

Supervisor will conduct daily room rounds to ensure

> corridors is separated by an automatic self-closing door with a latch. The results of the audits will be presented to the QAA committee at a minimum of

hazardous equipment in

quarterly for further action planning and monitoring as necessary.

K 047 It is the policy of SCCH to ensure that exit signs were illuminated continuously. .

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		055728	B. WING	B. WING		20/20/20	
NAME OF PROVIDER OR SUPPLIER SANTA CLARITA CONV. HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREF	STREET ADDRESS, CITY, STATE, ZIP CODE 23801 NEWHALL AVENUE NEWHALL, CA 91321 ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL)			(x5)
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PROPRIATE COMPLETION DATE	
	noted that the exit si posted above the do leading to the parkin guide the residents, means of exits. This rehabilitation room, to medical record room Maintenance Supervand stated that there	at 3:30 p.m., the Evaluator gn posted at two exit signs ors next to the kitchen g lot were not illuminated to visitors and staff to the area contained the he laundry room, kitchen, and the elevator. The isor confirmed the finding was no illumination for the d always been like this and	KO)47	IMMEDIATE CORRECTIVE ACTION On 7/28/15 the 2 exit signs posted at above the kitchen doors leading to the parking lot were replaced with a continuous illuminating exit sign. RESIDENTS AT RISK The Maintenance Supervisor reviewed all exit signs in the facility to ensure all were continuously illuminated. Those exit signs identified as being deficient were replaced with illuminating exit signs on 7/28/15. CORRECTIVE ACTION An in-service was conducted by the Administrator to the Maintenance Staff on 6/30/15 to ensure exit signs be illuminated continuously. MONITORING OF CORRECTIVE ACTION At the direction of the QAA committee, the Maintenance Supervisor will conduct monthly QA rounds to check exit signs be continuously illuminated. The results of the audits will be presented to the QAA committee at a minimum of quarterly for further action planning and monitoring as necessary.		7/38/15
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