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POC ACCEPTABLE 6/24/19

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

PRINTED: 05/15/2019
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
	055523	A. BUILDING 01 B. WING #16279	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDALE POST ACUTE CENTER	250 N. VERDUGO ROAD GLENDALE, CA 91206

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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. The facility was not in substantial compliance with 42 CFR 483.73, Requirement for LTC Facilities. Representing the Department of Public Health: Evaluator #: 16279, REHS, HFE I	E 000	This is a Plan of Correction constitutes my written credible allegation of compliance to the findings of the Department of Public Health during the recertification survey. The provider submits the Plan of correction in accordance with specific regulatory requirements under STate and Federal Law.	June 1, 2019
E 041 SS=C	Highest Severity & Scope: C Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim	E 041	The facility must develop a detailed emergency preparedness policy regarding the emergency power's fuel source. CORRECTIVE ACTION: The Administrator developed a detailed emergency preparedness policy regarding the emergency's power fuel source on 5/7/2019 and to be presented to QAPI meeting on 5/23/2019 for approval. Upon approval, an in-service will be conducted by the Administrator to all staff to discuss the policy for education and implementation. Maintenance supervisor purchased additional two(2) 5 gallon containers each on 5/22/2019 making up the total of 15 gallons of fuel in the storage room. MONITORING SYSTEM: In the event of an extended power failure emergency, the maintenance supervisor will assign his assistant to monitor the gas consumption of the emergency generator and log the amount of gas used for replenishment and will purchase from the gas station which is two (2) blocks away from the facility.	June 1, 2109

2019 MAY 24 PM 2:09 HEALTH FACILITIES DIVISION

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

Admn. 5/24/19

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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E 041	Continued From page 1 Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of	E 041	Maintenance supervisor will check weekly the amount of fuel to ensure that essential care and services to the residents will not be delayed or adveresely affected by the shortage. QAPI Committee will review the emergency preparedness policy to ensure proper implementation quarterly.	

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E 041	Continued From page 2 _federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a detailed emergency preparedness policy regarding the emergency power's fuel source. The facility's emergency generator policy did not indicate how the facility would maintain an onsite fuel source to power the emergency generator and keep the emergency	E 041		

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E 041	Continued From page 3 power systems operational, during an emergency. The lack of this emergency preparedness policy could delay care and services or cause harm to the residents, during an emergency. Findings: On May 1, 2019, at 9:30 a.m., a review of the facility's emergency preparedness documentation was conducted. It was noted that the facility's emergency power policy did not indicate how the facility would maintain an onsite fuel source to power the emergency generator to operate, during an emergency. On May 1, 2018, at 10:45 a.m., an interview was conducted with the administrator and the maintenance supervisor regarding the facility's emergency power policy. It was indicated that the facility did not have specific details to show how the facility would provide emergency power and to maintain an onsite fuel source in the event of an emergency. The administrator stated that the emergency power policy would be revised to indicate how the facility will maintain an additional fuel source to power the emergency generator.	E 041		
K 000	INITIAL COMMENTS This facility was surveyed under 42 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following reflects the findings of the California Department of Public Health during the Life Safety Code Survey.	K 000		

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K 000	Continued From page 4 Representing the Department of Public Health: Evaluator #: 16279, REHS, HFE I Resident census: 119 Bed capacity: 136 Highest Severity & Scope: F	K 000		
K 321 SS=E	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. 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)	K 321	The facility must ensure that hazardous areas are maintained with one hour fire rated construction separating rooms to ensure that smoke/fire will not travel from one area to another. IMMEDIATE CORRECTIVE ACTION; Maintenance Supervisor sealed the penetration inside the maintenance room using 3M fire barrier sealant CP25WB + on 5/3/2019 and the areas that were found and identified by the State surveyor. On 5/3/2019, the maintenance supervisor sealed the 2 3/4 inch penetration in the boiler room using #M fire barrier sealant CP25WB+. To ensure that other areas in the facility are not affected by this deficiency, the Administrator and Maintenance Supervisor checked all areas 5/6/2019 and findings were immediately corrected. CORRECTIVE ACTION: Maintenance Supervisor will check all weekly all areas in the facility and findings will be corrected immediately to ensure continious compliance.	6.01.19

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K 321	Continued From page 5 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous areas were maintained with a one-hour fire rated construction, regarding two rooms. In the event of a fire, the separation of these two rooms would not be achieved, which would allow smoke and/or fire to travel from one area to another. Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, the following were observed: 1. At 9:13 a.m., upon entering the maintenance room: a) a 2-inch penetration with three computer cables going through) which extended through the wall above the door. b) a 2-inch penetration which extended through the wall behind the door above the door. c) a 3-inch penetration with two computer cables going through which extended through the wall above the desk. 2. At 9:35 a.m., the boiler room was located at the north side of the facility. Upon entering the boiler room, there were three 100-gallon gas fueled hot water heaters observed inside. A closer observation revealed that there were two 3/4-inch penetrations on the wall, behind two of the three hot water heaters.	K 321	Department Heads during their 3 x a week room rounds document their findings in the maintenance log book and report their findings to the Maintenance Supervisor for immediate repair. MONITORING SYSTEM: Administrator will visually inspect and validate bi-monthly all reportedfindings and repair to ensure continious compliance. Quality Assurance Committee will review quarterly all findings and repair to ensure continious compliance.	

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K 321	Continued From page 6 During this LSC tour, the maintenance supervisor was informed that because the two rooms are considered hazardous areas, the penetrations need to be sealed to prevent the possibility of fire and/or smoke from spreading. At the end of the interview, the maintenance supervisor stated he would seal these penetrations with an approved fire retardant sealant. The deficient practice affected one of four smoke compartments. On April 30, 2019, and May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 321		
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of walls and ceilings by having penetrations at five rooms, thereby compromising	K 331	The facility must maintain a Class A, B, C flame spread rating finish of walls and ceilings to prevent the spread of smoke/fire to another areas. IMMEDIATE CORRECTIVE ACTION: Maintenance Supervisor sealed on 5/6/2019 the following areas using 3M Fire barrier sealant CP25WB+ 1. 1 inch penetration on wall above the desk inside the dietary office. 2,3. 3x4 inch penetration and missing outlet cover plate in the conference room and outlet cover plate was provided. 4. The 3 & 6 inch penetration inside the wall of the medication room was fixed using Great Stuff Filler Insulating Foam sealant. 5. 1 inch penetration inside the office of the DON.	6/1/19

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K 331	Continued From page 7 the fire rated surfaces. In the event of a fire, the separation of these areas would not be achieved because these penetrations would allow smoke and/or fire to travel from one area to another. Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 9:25 a.m., there was a 1-inch penetration which extended through one wall (above the desk), inside a dietary office. 2. At 10:58 a.m., there was a 3-inch by 4-inch penetration (where an electrical outlet cover plate was missing), which extended through one wall, inside the conference room. 3. At 11:03 a.m., there were two 3-inch by 4-inch penetrations (where an electrical outlet cover plate was missing), which extended through two different walls, inside the main dining room. 4. At 1:05 p.m., inside Station 1's medication room there was: a) a 3-inch penetration (with four computer cables going through), which extended through one wall, and b) a 6-inch penetration (with a 4-inch pipe going through), which extended through another wall. 5. At 1:20 p.m., there was a 1-inch penetration (with three cables going through) which extended through one wall (above the door), inside the office for the Director of Nursing.	K 331	On 5/6/2019, the Administrator and the Maintenance Supervisor visually checked all other areas in the facility to ensure that other areas are not affected by this deficiency and findings. All findings were repaired 5/6 & 7/2019. CORRECTIVE ACTION: Maintenance Supervisor will check weekly all areas in the facility for continious compliance. Department Heads during their 3 x a week room rounds will report their findings to the Maintenance Supervisor and write on maintenance log book for immediate repair. MONITORING SYSTEM: Administrator and Maintenance Supervisor will do walking rounds bi-monthly to visually inspect and validate findings and repair for continuous compliance. Quality Assurance Committee will review submitted findings and corrections for continuous compliance.	

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K 331	Continued From page 8 During this LSC tour, the maintenance supervisor was informed that these penetrations need to be sealed to prevent the possibility of fire and/or smoke from spreading. At the end of the interview, the maintenance supervisor stated he would seal these penetrations with an approved fire retardant seal and approved electrical outlet cover plates. The deficient practice affected three of four smoke compartments. On April 30, 2019, and May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 331		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the fire alarm system goes out of service for more than 4 hours in a 24-hour period. In the event the fire alarm system goes out of service, a fire watch policy will assist with the appropriate emergency procedures to be implemented.	K 346	The facility must established a detailed fire watch policy and procedure in the event the fire alarm system goes out of service for more then 4 hours in a 24 hour period. CORRECTIVE ACTION: The Administrator revised the current Fire Watch Policy and Procedure on 5/16/2019 that will specifically stipulate that when the Fire Alarm System goes out of service for more than 4 hour period, the facility shall notify the Fire Department and the State Regulatory/Licensing Agency on the loss of the Fire Alarm System. To ensure other related policies are not affected by this deficiency, the Administrator and Maintenance Supervisor reviewed on 5/16/2019 are all correct and appropriate . MONITORING SYSTEM: Administrator will review semi-annually the Life Safety and Emergency Policy for accuracy. QAPI Committee will review semi-annually the policies presented by the Administrator for continuous compliance.	6/1/19

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K 346	Continued From page 9 Findings: On May 1, 2019, at 8:05 a.m., a review of the facility's fire watch policy and procedure was conducted. The policy stated to notify the fire department and the State Regulatory/Licensing Agency of the loss of the fire alarm system. It was noticed that this policy did not state that the facility will began a fire watch when the facility's fire alarm system goes out of service for more than 4 hours. At 9:30 a.m., an interview was conducted with the administrator regarding this fire watch policy and procedure. It was pointed out that there were no detailed procedures, regarding the fire watch being implemented after the fire alarm system goes out of service for more than 4 hours in a 24-hour period. The administrator stated that the fire watch policy would be revised. The deficient practice affected four of four smoke compartments. On May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 346		
K 353 SS=F	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	K 353	The facility must have a documentation on sprinklers that had been replaced or tested by a recognized testing laboratory in accordance with NFPA25 Standard for the Inspection Testing and Maintenance of Water-Based Fire Protection systems.	6/1/19

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K 353	Continued From page 10 maintained in a secure location and readily available. a) Date sprinkler system last checked 5/8/2019 b) Who provided system test GNA BROOKS c) Water system supply source GLENDALE WATER & POWER 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: Based on observation, interview and record review, the facility failed to provide documentation that the facility's sprinklers had been replaced or tested by a recognized testing laboratory, in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. Sprinklers that have been in service for 50 years or more should be tested or replaced. Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, it was observed that most of the sprinklers on the ceilings appeared to be dull, old and tarnished. On May 1, 2019, at 8:05 a.m., a review of the facility's fire inspection reports and documentation was conducted. During this review, it was noted that the annual fire sprinkler system inspection report, dated November 5, 2018, was conducted by an approved service	K 353	The State surveyor informed the Administrator and the Maintenance Supervisor that sprinklers that have been in service for over 50 years are required to be tested by a recognized testing laboratory. IMMEDIATE CORRECTIVE ACTION: Maintenance Supervisor called GNA Brooks immediately on 5/2/2019 to schedule a 50 year sprinkler test. On 5/8/2019, GNA Brooks did the quarterly sprinkler test and removed 4 pieces of sprinkler head for 50 year laboratory testing. Still waiting for the result. To ensure that other sprinklers are not affected by this deficiency, the technician from GNA Brooks tested other sprinkler heads on 5/8/2019 and found out that all are in accordance with safety regulation.	

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

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	055523	A. BUILDING 01 B. WING	05/01/2019

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K 353	Continued From page 11 company. This report indicated that the facility was constructed in 1966. At the completion of the facility's fire inspection reports and documentation, it was noted that there was no documentation to indicate the facility's sprinklers were replaced or tested by a recognized testing laboratory. According to NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.1.1.1 where sprinklers have been in service for 50 years, they shall be replaced or representative samples from one or more sample areas shall be tested by a recognized testing laboratory. At 9:30 a.m., an interview was conducted with the administrator and the maintenance supervisor. During this interview, the administrator and the maintenance supervisor were informed that facilities built over 50 years are required to test or replace their sprinklers and the testing must be conducted by a recognized testing laboratory. The maintenance supervisor stated that she did not have any documentation to show that the sprinklers were tested. The deficient practice affected four of four smoke compartments. On May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 353	MONITORING SYSTEM: Maintenance Supervisor will keep a record/ documentation on Sprinkler Test quarterly and annually or any required time frame per State Regulatory/Licensing Agency. As soon as the result from the Laboratory Testing becomes available to GNA Brooks and submitted, Administrator will notify the Governing Body immediately to ensure corrective actions are implemented. QAPI Committee will follow up on reports submitted by the Administrator monthly for residents' safety and for continuous compliance.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the	K 354	The facility must established a detailed fire watch policy when the automatic sprinkler system goes out of service for more than 10 hoursas indicated in NFPA 25.	6/1/19

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

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K 354	Continued From page 12 extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the automatic sprinkler system goes out of service for more than 10 hours in a 24-hour period. In the event the automatic sprinkler system goes out of service, a fire watch policy will assist with the appropriate emergency procedures to be implemented. Findings: On May 1, 2019, at 8:05 a.m., a review of the facility's fire watch policy and procedure was conducted. The policy stated to notify the fire department and the State Regulatory/Licensing Agency of the loss of the sprinkler system. It was noted that this policy did not state that the facility would begin a fire watch when the facility's automatic sprinkler system goes out of service for more than 10 hours (as indicated in NFPA 25, Standard for the Inspection, Testing and Maintenance of the Water-Based Fire Protection Systems).	K 354	CORRECTIVE ACTION: The Administrator revised the Fire Watch Policy and Procedure on 5/16/2019 which states that the facility will begin a fire watch when the automatic sprinkler system goes out of service for more than 10 hours in a 24 hour period. A Fire watch log is designed to document the Fire Watch on 5/17/2019. The revised Fire Watch Policy and Procedure will be presented to QAPI Committee meeting on 5/23/2019 for approval. MONITORING SYSTEM: Administrator will conduct an in-service to all staff on the revised Fire Watch Policy on 5/24/2019 as soon as it will be approved by the QAPI Committee to ensure awareness and guidance to all staff. Maintenance Supervisor will test quarterly the automatic sprinkler system through GNA Brooks for continuous compliance and for residents safety QAPI Committee will review all findings, corrections and implemantations submitted by the Administrator during the quarterly meeting.	

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K 354	Continued From page 13 At 9:30 a.m., an interview was conducted with the administrator regarding this fire watch policy and procedure. It was pointed out that there were no detailed procedures, regarding the fire watch being implemented after the automatic sprinkler system goes out of service for more than 10 hours in a 24-hour period. The administrator stated that the fire watch policy would be revised. The deficient practice affected four of four smoke compartments. On May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 354		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a fire resistance rating of at least one-half hour by having a penetration	K 372	The facility must maintain a fire resistance rating of at least one half hour to prevent the smoke to travel between compartments during a fire emergency. IMMEDIATE CORRECTIVE ACTION: On 5/8/2019, the Maintenance Supervisor sealed the following: 1. The 2x4 inch smoke barrier penetration above room 11 using 5/8 inch USG Sheetrock Brand Eco Smart Panel Fire code X and panel sealed pipe using Great Stuff Filler Insulating Foam Sealant. 2. The 4 inch penetration inch smoke barrier above room 17 was sealed using Great Stuff Filler Insulating Foam Sealant. on 5/9/2019, Maintenance Supervisor rechecked above ceiling to ensure that there are no barrier penetration and nothing was found. MONITORING SYSTEM: Maintenance Supervisor will inspect monhtly the wall barrier and log his findings for immediate corrections.	6/1/19

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K 372	Continued From page 14 through two smoke barrier walls. Penetrations on smoke barrier walls may compromise the integrity of the smoke compartments, thereby allowing smoke to travel easily between smoke compartments, during a fire emergency. Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, it was observed that there were four smoke barriers throughout the facility and the following were observed: 1. At 9:15 a.m., it was observed that there was a 2-inch by 4-inch penetration which extending through the smoke barrier wall, above Room 11. 2. At 9:20 a.m., it was observed that there was a 4-inch penetration (with ten computer cables going through) which extending through the smoke barrier wall, above Room 17. During this LSC tour, the maintenance supervisor was informed of these penetrations and he stated that he would seal the penetrations with an approved fire retardant sealant. The deficient practice affected three of four smoke compartments. On April 30, 2019, and May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 372	Safety Committee will review the log on any repair and correction monthly or when needed. Administrator will review the Inspection Log and check repair monthly for compliance. QAPI Committee will review quarterly all findings and corrections for continuous compliance.	
K 741	Smoking Regulations	K 741	The facility must post a "NO SMOKING" signs in areas where oxygen is stored or in use.	

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K 741 SS=E	Continued From page 15 CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to post "No Smoking" signs in areas where oxygen is stored or in use. Areas where oxygen tanks and oxygen equipment are stored or in use without the proper signs could lead to accident hazards and/or fire emergencies.	K 741	IMMEDIATE CORRECTIVE ACTION: On 5/2/2019, "No Smoking" signs were installed by the Maintenance Supervisor on the door of Oxygen Room, Utility Room, Station2 and Enteral Room. The Central Supply Staff chekced all the rooms of residents who are using oxygen on 5/2/2019 to ensure no one is affected by this deficiency practice. MONITORING SYSTEM: All Staff and Department Heads will check all rooms where oxygen is stored or in use to make sure "No Smoking" signs are posted on the door at all times (when in use) during their daily room rounds. The Safety Committee will review all findings monthly to ensure continuous compliance. QAPI Committee will review quarterly the findings and recommendations of Safety Committee for residents' safety and compliance.	6/1/19

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K 741	Continued From page 16 Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, the following were observed: 1. At 9:40 a.m., an oxygen storage closet was next to Room 10. A closer observation revealed there were twenty-eight oxygen tanks measuring twenty-five cubic feet (cu ft) inside the closet with a sign that read, "Oxygen Room" posted on the door. It was noted that a "No Smoking" sign was not posted outside of this closet. 2. At 1:10 p.m., there was a "crash" cart not in use, with a 25 cu ft oxygen tank, stored inside Station 1's utility room. A closer observation revealed a "No Smoking" sign was not posted outside of this room. 3. At 1:25 p.m., there was a "crash" cart not in use, with a 25 cu ft oxygen tank, stored inside Station 2's enteral feeding room and a sign that read, "Crash cart and treatment card inside" was posted on the door. A closer observation revealed a "No Smoking" sign was not posted outside of this room. At 2:30 p.m., an interview was conducted with the Director of Nursing (DON) regarding the missing "No Smoking" signs. The DON stated, "No Smoking" signs should be posted at all areas where oxygen is stored or is being used. At the end of the interview, the DON stated that "No Smoking" signs would be posted at these locations.	K 741		

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K 741	Continued From page 17 At 3:25 p.m., a review of the facility's fire safety and prevention policy stated to use visible "No Smoking" signs where oxygen is stored or being administered. The deficient practice affected three of four smoke compartments. On April 30, 2019, and May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 741		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the electrical power outlets, near resident bathrooms sinks, were ground-fault circuit interrupters (GFCI) protection. In the event water accidentally entered 25 of 28 electrical power outlets, the residents or staff could sustain an electric shock hazard. GFCIs prevent the possibility of serious harm to residents and staff from any electric shock hazards.	K 912	The facility must ensure that the electrical power outlet near residents bathroom sinks were ground fault circuit interrupts protection. IMMEDIATE CORRECTIVE ACTION: Maintenance Supervisor checked and counted GFCI outlets on 5/3/2019 and found 25 pcs of ordinary electrical receptacles. On 5/7/2019 Maintenance Supervisor removed 25 pcs of ordinary electrical receptacles that were identified and covered the electrical receptacles with wire knots and tape and cover with blank face. On 5/7/2019 an in-service was conducted by the Maintenance Supervisor to all his staff to make sure they check all bathroom outlets daily while cleaning the rooms and to report any findings for immediate correction. MONITORING SYSTEM: Department Heads during their 3 x a week room rounds will visually check bathroom outlets to ensure that they are covered with blank face for residents' safety. Maintenance Supervisor will check bathroom outlets during his daily building inspection.	6/1/19

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K 912	Continued From page 18 Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, it was observed that there were 28 resident bathroom sinks throughout the facility. Close observations at the resident bathroom sinks revealed 26 sinks had electrical power receptacles 12 to 24 inches away from the sinks. Twenty-five of the 26 electrical power receptacles were not GFCIs. (GFCIs are wall-mounted electrical receptacles with devices that instantly disconnect an electric circuit to prevent the possibility of serious harm from an electric shock.). One electrical power receptacle was a GFCI electrical power receptacle, in Room 40. The bathrooms in Room 18 and Room 25 did not have any electrical power receptacles. During the LSC tour, an interview was conducted with the maintenance supervisor regarding the electrical power receptacles near the resident bathroom sinks. It was pointed out that only one electrical power receptacle was a GFCI and the others were not. The maintenance supervisor stated he would correct these electrical power receptacles. The deficient practice affected four of four smoke compartments. On April 30, 2019, and May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 912	Safety Committee will review quarterly all findings to ensure implementation and compliance. QAPI Committee will review monthly all finsings and implementation to ensure compliance.	

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K 920 K 920 SS=E	Continued From page 19 Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to plug electrical equipment directly into electrical outlets without the use of power strips plugged into power strips, domestic electrical extension cords, and medical equipment plugged into unapproved power strips. The use of power strips plugged into power strips, domestic electrical extension cords, and medical equipment plugged into unapproved power strips could create the possibility of an electrical	K 920 K 920	The facility must plug electrical equipment into electrical outlets without the use of power strips to plugged into another power strip and using domestic electrical extension cords. Medical equipments must be plugged only into approved power strips. CORRECTIVE ACTION: Maintenance Supervisor checked all rooms that may have extension cords without surge protectors on 5/2/2019 and found only those that were identified by the State surveyors on 5/2/2019. On 5/6,7,& 8/2019 Maintenance Supervisor started removing all domestic extension wire, extra extension cords in the Medical Records Office, room 15, 17, 27, 29, 33 and 37. Maintenance Supervisor removed all domestic cords in rooms that were identified and replaced them with power extension cords with surge protector and cover with PVC wire mold for rooms 15 and 17. For MDS Office, he ran gauze #12 covered with metal wire mold. In room 27, he rerouted tube feeding pump and plugged to wall provided outlet. In rooms 27 and 29, the bed cords were directly plugged to the wall provided outlet. MONITORING SYSTEM: Department Heads during their 3x a week room rounds will inspect extension cords and will report any findings for immediate correction. Maintenance Supervisor will visually check weekly all electrical outlets to ensure compliance. QAPI Committee will review all findings and implementation submitted by the Administrator for continuous compliance.	6/1/19

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K 920	Continued From page 20 overload and/or possible fire. In addition, electrical extension cords are not to be substituted for fixed electrical wiring of a structure. Findings: On April 30, 2019, between 8:35 a.m. and 2:15 p.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 11:01 a.m., a cell phone charger was plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, inside the social service office. 2. At 12:58 p.m., a computer and a computer monitor were plugged into a domestic electrical extension cord, which was plugged into a second domestic electrical extension cord. This second domestic electrical extension cord was plugged into an electrical wall outlet, in the minimum data set office. 3. At 1:12 p.m., a cell phone charger was plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, inside Room 15. Three residents were in this room. 4. At 1:15 p.m., a flat screen TV was plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, inside Room 17. Three residents were in this room. 5. At 1:28 p.m., a tube feeding pump (an electrical medical device which provides liquid formula to residents, who are unable to eat by	K 920		

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K 920	Continued From page 21 mouth), was plugged into an unapproved power strip, which was plugged into an electrical wall outlet, inside Room 27. Four residents were in this room. 6. At 1:30 p.m., an electric bed was plugged into an unapproved power strip, which was plugged into an electrical wall outlet, inside Room 29. Three residents were in this room. 7. At 1:39 p.m., an electric fan and a cell phone charger were plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, inside Room 33. Three residents were in this room. 8. At 1:45 p.m., an electric bed was plugged into an unapproved power strip, which was plugged into an electrical wall outlet, inside Room 37. Three residents were in this room. During the LSC tour, an interview was conducted with the administrator regarding these electrical problems. The administrator was informed that the use of power strips plugged into power strips, domestic electrical extension cords, and medical equipment plugged into unapproved power strips were unapproved practices. The maintenance supervisor was also informed that the power strips for medical equipment (such as the electric beds and tube feeding pump) were the unapproved type. The approved power strips for the medical equipment should be a UL 1363A or UL 60601-1 power strip. UL is the Underwriters Laboratories which is an independent American agency that analyzes new technologies to promote new safety standards for electrical devices. This agency tests, inspects, validates and certifies most electrical devices as being safe	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. BUILDING 01 B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDALE POST ACUTE CENTER	250 N. VERDUGO ROAD GLENDALE, CA 91206

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K 920	Continued From page 22 to use. At the end of the interview, the maintenance supervisor stated that these electrical problems would be corrected. The deficient practice affected three of four smoke compartments. On April 30, 2019, and May 1, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 920		