PRINTED: 10/04/2012
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
	055619	A. BUILDING 01 B. WING _____	09/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLOTT NURSING HOME	800 EAST FIFTH STREET ONTARIO, CA 91764

(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 K3 BUILDING: 01 K6 PLAN APPROVAL: 6/1/1977 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SINGLE STORY, 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 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: Federal ID Number 26387. The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 178	K 000	Plott Nursing Center ("PNC") makes its best effort to operate in full compliance with both Federal and State Law. Nothing included in this Plan of Correction is an admission otherwise. PNC has submitted this Plan of Correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that PNC may contest the merits and/or form of any of the deficiencies or findings alleged below and may take reasonable steps to appeal them. This Plan of Correction constitutes PNC's written credible allegation of com-pliance for the deficiencies noted in the Life Safety Survey dated September 27, 2012.	
K 018 SS=D	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	K 018	**[K018]** It is the policy and practice of PNC that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes . . . doors are provided with a means suitable for keeping the door closed . . . **Corrective Action** On or before October 26, 3023, under the supervision of the Administrator, the doors to the kitchen, Shower Room B71, and the Main Dining Room near Nursing Station 2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tony Lopez — TITLE: Administrator — (X6) DATE: 10/15/2012

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.

POC accepted 10/16/12 Jeina Naser

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 6/1/1977 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SINGLE STORY, 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 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: Federal ID Number 26387. The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 178	K 000	Plott Nursing Center ("PNC") makes its best effort to operate in full compliance with both Federal and State Law. Nothing included in this Plan of Correction is an admission otherwise. PNC has submitted this Plan of Correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that PNC may contest the merits and/or form of any of the deficiencies or findings alleged below and may take reasonable steps to appeal them. This Plan of Correction constitutes PNC's written credible allegation of compliance for the deficiencies noted in the Life Safety Survey dated September 27, 2012. **[K018]** It is the policy and practice of PNC that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. . .doors are provided with a means suitable for keeping the door closed. . . **Corrective Action** On or before October 26, 3023, under the supervision of the Administrator, the doors to the kitchen, Shower Room B71, and the Main Dining Room near Nursing Station 2	10/26/12
K 018 SS=D	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	K 018		

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

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K 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors to resist the passage of smoke. This was evidenced by doors that failed to latch and by doors that were impeded from closing. This affected 1 of 7 smoke compartments and had the potential to allow the spread of smoke in the event of a fire. Findings: During the facility tour with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the corridor doors were observed. At 6:50 a.m., the self-closing corridor door to the kitchen failed to latch when tested. At 6:52 a.m., the self-closing door to the kitchen pantry was impeded from closing by a food cart full of watermelons, in front of the door, holding the door open. At 6:54 a.m., the self closing door to the refrigerator room was impeded from closing by a bread cart (with 8 racks full of bread) and a condiment cart (salt, pepper, and spices) in front	K 018	will be repaired or replaced so as to latch upon closing. Also, on or before October 26, 2012, under the supervision of the Administrator, the doors to the kitchen pantry and the refrigerator room will be unimpeded. **Measure to Ensure Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, kitchen personnel and maintenance will be in-serviced on ensuring doors are not impeded from closing. Also, on or before October 26, 2012, under the supervision of the Administrator, maintenance personnel will be in-serviced on maintaining corridor doors so they latch. **Monitoring of Corrective Actions** On or before October 26, 2012, under the supervision of the Administrator, and quarterly thereafter, doors equipped with self-closing devices will be monitored to verify compliance with CMS regulations. **[K027]** It is the policy and practice of PNC that door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with	10/26/12

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K 018	Continued From page 2 of the door. At 1:02 p.m., the self-closing corridor door to the Shower Room B71 failed to close and latch when tested. At 2:12 p.m., the self-closing corridor door, to the Main Dining Room, near Nursing Station 2, was connected to the fire alarm system. The door failed to close and latch, in two attempts. At 2:13 p.m., Staff 2 stated during an interview "the air conditioning must be preventing the door from closing."	K 018	7.2.2.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7. **Corrective Action** On or before October 26, 2012, under the supervision of the Administrator, the North smoke barrier door near the kitchen will be unimpeded and the East smoke barrier door near Room 401 will be repaired or replaced so as to latch upon closing.	10/26/12
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain its smoke barrier doors to prevent the spread of smoke and fire. This was evidenced by one smoke barrier door that failed to latch and by a smoke barrier door that was impeded from closing. This affected 3 of 7 smoke compartments and could result in the spread of	K 027	**Measures to Ensure Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, the maintenance personnel will be in-serviced on the importance of smoke barrier doors to latch and have no impediment. **Monitoring of Corrective Actions** On or before October 26, 2012, under the supervision of the Administrator, and quarterly thereafter, smoke barrier doors will be unimpeded and doors equipped with self-closing and latching devices will be monitored to verify compliance with CMS regulations.	

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K 027	Continued From page 3 smoke and fire. This could cause potential harm to residents. Findings: During a tour of the facility with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the smoke barrier doors were observed. At 8:46 a.m., the North smoke barrier door near the kitchen was impeded from closing by a food cart full of dirty trays. The door was prevented from closing. Staff 1 removed the cart. At 1:53 p.m., the East smoke barrier door near Room 401 failed to latch when tested. Two attempts were made without the door latching.	K 027	**[K047]** It is the policy and practice of PNC that exit and directional signes are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1. **Corrective Action** On or before October 26, 2012, under the supervision of the Administrator, exit signs will be replaced. **Measures to Ensure Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, maintenance personnel will be in-serviced on checking illumination of exit signs. **Monitoring of Corrective Actions** The Quality Assurance Nurse or designee will quarterly monitor the repaired or replaced exit signs to verify compliance with CMS regulations and to prevent the recurrence of the deficient conduct. The monitoring will be unannounced and a written report of monitoring findings will be made by the Quality Assurance Nurse or designee to the DON and Administrator, who will review the results and bring the report to the Quarterly Quality Assurance Committee, which will also review the results and recommend changes as necessary for compliance.	10/26/12
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their exit signs. This was evidenced by an exit sign that failed to illuminate. This affected 1 of 7 smoke compartments, and could result in a delay in evacuation. Findings: During a tour of the facility with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the	K 047		

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K 047	Continued From page 4 exit signs were observed. At 9:11 a.m., the exit sign outside of the accounts receivable office was not illuminated. At 9:12 a.m., Staff 1 stated, during an interview, that he was aware the sign was not working and was planning on replacing it tomorrow.	K 047	[K050] It is the policy and practice of PNC that 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. 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. **Corrective Action** On or before October 26, 2012, under the supervision of the General Counsel, the Administrator will be in-serviced regarding preparing staff to respond to emergency situations on all shifts. Further, on or before October 26, 2012, and quarterly thereafter, the facility will conduct two drills on each shift, per quarter in compliance with the regulation. **Measures to Ensure Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, the Director of Staff Development will be in-serviced on the requirement of conducting quarterly fire drills.	10/26/12
K 050 SS=E	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. 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 document review and interview, the facility failed to prepare staff to respond to emergency situations on all shifts. This was evidenced by missing fire drills for two of four quarters. This could result in a delay in staff response to a fire. Findings: During document review with Staff 1, Staff 3, and Staff 4, on September 27, 2012, the fire drill records were reviewed. At 3:17 p.m., there were two missing drills for the	K 050		

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K 050	Continued From page 5 P.M. shift, and one missing drill for the NOC shift. 1. There were no documents provided for a fire drill during the first quarter (January, February, March) of 2012 on the P.M. shift. There were no fire drill records for the fourth quarter (October, November, December) of 2011, on the P.M. shift. 2. No fire drill records were provided for the first quarter of 2012 (January, February, March) for the NOC shift. At 3:16 p.m., Staff 4 stated during an interview "I just took over this position and just found out that we were missing fire drills."	K 050	**Monitoring of Corrective Actions** On or before October 26, 2012, under the supervision of the Director of Staff Development or designee, and bi-monthly thereafter, unannounced audits will be made of the completion of fire drills utilizing the fire drill records to verify compliance with CMS regulations and to prevent the recurrence of the deficient conduct. Audits will be unannounced and a written report of audit findings will be made by the Quality Assurance Nurse or designee to the DON and Administrator, who will review the results and bring the report to the Quarterly Quality Assurance Committee, which will also review the results and recommend changes as necessary for compliance.	10/26/12
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of their fire alarm system. This was evidenced by one smoke detector that failed to activate a notification device or fire alarm. This could result in the potential failure of the fire alarm system to notify occupants in the event of a fire. This affected 1 of 7 smoke compartments. Findings: During fire alarm testing with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the	K 054	**[K054]** It is the policy and practice of PNC that all required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3. **Corrective Action** On or before October 26, 2012, under the supervision of the Administrator, the smoke detector (Number 13) will be cleaned and repaired or replaced.	

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K 064	Continued From page 6 smoke detectors were tested. At 1:59 p.m., the smoke detector (Number 13), did not activate an alarm when tested with canned smoke. The detector was located East of Room 208 and near the smoke barrier doors. The smoke detector failed to activate after three attempts with canned smoke. Staff 1 activated the smoke detector with a magnet and the fire alarm sounded.	K 064	**Measures to Ensure Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, maintenance personnel will be in-serviced on the testing of smoke detectors. **Monitoring of Corrective Actions** On or before October 26, 2012, under the supervision of the Administrator, the fire alarm system will be monitored for any smoke detectors that fail to activate a notification device or fire alarm; any non-working smoke detectors discovered will be removed.	10/26/12
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their portable fire extinguishers in accordance with NFPA 10. This was evidenced by a portable fire extinguisher that was obstructed from immediate access. This affected 1 of 7 smoke compartments and could result in a delay in access to the fire extinguisher resulting in the spread of smoke and fire. NFPA 10, Standard for Portable Fire Extinguishers, 1998 edition 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 4-3.2* Procedures. Periodic inspection of fire	K 064	**[K064]** It is the policy and practice of PNC that portable fire extinguishers are provided. **Corrective Action** On or before October 26, 2012, under the supervision of the Administrator, the fire extinguisher near Room 120 will be monitored for immediate access and the monitoring results recorded. Also, on or before October 26, 2012, all housekeeping staff will be in-serviced that fire extinguishers must not be obstructed from immediate access.	

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K 064	Continued From page 7 extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) "Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place Findings: During a tour of the facility with Staff 1 and Staff 3, on September 27, 2012, the portable fire extinguishers were observed. At 9:16 a.m., the fire extinguisher near Room 120 was impeded from immediate access by a linen cart placed in front of the fire extinguisher. At 9:17 a.m., Staff 1 removed the linen cart. During an interview, Staff 1 stated, "this is the second time today that I removed this linen cart from being in front of this fire extinguisher."	K 064	**Measures to Ensure Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, housekeeping staff will be in-serviced on the importance of not obstructing fire extinguisher access. **Monitoring of Corrective Actions** On or before October 26, 2012, under the supervision of the Administrator, the fire extinguishers will be monitored for documentation of monthly inspections. **[K147]** It is the policy and practice of PNC that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2. **Corrective Action** On or before October 26, 2012, under the supervision of the Administrator, the switches in Electrical Panel B, in the electrical panel room, near Room 123 were labeled as to what they controlled.	10/26/12
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	**Measures to Ensures Practice Does Not Recur** On or before October 26, 2012, under the supervision of the Administrator, maintenance personnel will be in-serviced on maintaining electrical circuit panels, including proper labeling.	

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PLOTT NURSING HOME	800 EAST FIFTH STREET ONTARIO, CA 91764

(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 147	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the electrical circuit panels, as evidenced by a circuit panel with an unidentified circuit breaker. This failure could delay identifying a circuit breaker in the event of a electrical fire or emergency. This affected 1 of 7 smoke compartments. NFPA 70, National Electrical Code (1999 Edition) 384-13, General. All panelboards shall have a rating not less than the minimum feeder capacity required for the load computed in accordance with Article 220. Panelboards shall be durably marked by the manufacturer with the voltage and the current rating and the number of phases for which they are designed and with the manufacturer's name or trademark in such a manner so as to be visible after installation, without disturbing the interior parts or wiring. All panelboard circuits and circuit modifications shall be legibly identified as to purpose or use on a circuit directory located on the face or board. Findings: During a tour of the facility with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the facility electrical system was observed. At 9:04 a.m., 1 of 22 circuits was unidentified, in Electrical Panel B, in the electrical panel room, near Room 123. Circuit 22 was unlabeled to it's purpose. At 9:06 a.m., Staff 1 stated during an interview "I do not know what that circuit is connected to."	K 147	**Monitoring of Corrective Actions** On or before October 26, 2012, under the supervision of the Administrator, the facility will create a log sheet to assist in monitoring the facility's electrical panels for appropriate labeling of switches. The Quality Assurance Nurse or designee will quarterly monitor, utilizing the created log sheet, the electric panels for appropriate labeling to verify compliance with CMS regulations and to prevent the recurrence of the deficient conduct. Monitoring will be unannounced and a written report of monitoring findings will be made by the Quality Assurance Nurse or designee to the DON and Administrator, who will review the results and bring the report to the Quarterly Quality Assurance Committee, which will also review the results and recommend changes as necessary for compliance.	10/26/12