FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING B. WING 09/27/2012 055619 STREET ADDRESS CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91764 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X4) ID PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Plott Nursing Center ("PNC") makes K 000 INITIAL COMMENTS its best effort to operate in full com-K 000 pliance with both Federal and State Law. Nothing included in this Plan of K3 BUILDING: 01 Correction is an admission other-K6 PLAN APPROVAL: 6/1/1977 wise. PNC has submitted this Plan K7 SURVEY UNDER: 2000 EXISTING of Correction in order to comply with its regulatory obligation and does not STRUCTURE TYPE: SINGLE STORY, TYPE (V) walve any objections to the merits or (111), FULLY SPRINKLERED. form of any allegations contained herein. Please note that PNC may The following reflects the findings of the California contest the merits and/or form of Department of Public Health, during an annual any of the deficiencies or findings Life Safety Code re-certification survey. The alleged below and may take findings are in accordance with 42 CFR (Code of reasonable steps to appeal them. Federal Regulations) 483.70 (a) and NFPA This Plan of Correction constitutes (National Fire Protection Association) 101, Life PNC's written credible allegation of Safety Code 2000 edition, Existing codes. com-pliance for the deficiencies noted in the Life Safety Survey Representing the California Department of Public dated September 27, 2012. Health: Federal ID Number 26387 [K018] It is the policy and practice of PNC that doors protecting corridor The facility is not in substantial compliance with openings in other than required 42 CFR 483.70 (a) for Long Term Care Facilities. enclosures of vertical openings. exits, or hazardous areas are Census = 178 K D1B substantial doors, such as those K 018 NFPA 101 LIFE SAFETY CODE STANDARD constructed of 1-3/4 inch solid-SS=D bonded core wood, or capable of Doors protecting corridor openings in other than resisting fire for at least 20 minutes required enclosures of vertical openings, exits, or ... doors are provided with a means hazardous areas are substantial doors, such as suitable for keeping the door closed those constructed of 1% 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 Corrective Action On or before October 26, 3023, no impediment to the closing of the doors. Doors under the supervision of the Adminiare provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 strator, the doors to the kitchen, Shower Room B71, and the Main 19.3.6.3 are permitted. Dining Room near Nursing Station 2

ayes 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 discloseble 14 days following the date these documents are made evallable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

O.C. Class FORM CM5-2567 (02-99) Previous Versions Obsolete

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

Ina EVENTID SEBD21

Facility ID: CA240000094

TITLE

Administrator

10/15/2012

(XB) DATE

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER AND PLAN OF CORRECTION A. BUILDING B. WING 09/27/2012 085619 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91784 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION 10 REFIX PREFIX DATE TAG DEFICIENCY) K 000 Plott Nursing Center ("PNC") makes its 10/26/12 INITIAL COMMENTS K 000 best effort to operate in full compliance with both Federal and State Law. Nothing K3 BUILDING: 01 included in this Plan of Correction is an K6 PLAN APPROVAL: 6/1/1977 admission otherwise. PNC has submitted K7 SURVEY UNDER: 2000 EXISTING this Plan of Correction in order to comply STRUCTURE TYPE: SINGLE STORY, TYPE (V) with its regulatory obligation and does not (111), FULLY SPRINKLERED. waive any objections to the merits or form of any allegations contained herein. The following reflects the findings of the California Please note that PNC may contest the Department of Public Health, during an annual Life Safety Code re-certification survey. The merits and/or form of any of the findings are in accordance with 42 CFR (Code of deficiencies or findings alleged below and Federal Regulations) 483.70 (a) and NFPA may take reasonable steps to appeal them. (National Fire Protection Association) 101, Life This Plan of Correction constitutes PNC's Safety Code 2000 edition, Existing codes. written credible allegation of compliance for the deficiencies noted in the Life Safety Representing the California Department of Public Health: Survey dated September 27, 2012. Federal ID Number 26387. [K018] It is the policy and practice of PNC The facility is not in substantial compliance with that doors protecting corridor openings in 42 CFR 483.70 (a) for Long Term Care Facilities. other than required enclosures of vertical openings, exits, or hazardous areas are Census = 178 substantial doors, such as those K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 constructed of 1-3/4 inch solld-bonded SS=D core wood, or capable of resisting fire for Doors protecting condor openings in other than required enclosures of vertical openings, exits, or at least 20 minutes. . . doors are provided hazardous areas are substantial doors, such as with a means suitable for keeping the those constructed of 1% inch solid-bonded core door closed. . . wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only Corrective Action required to resist the passage of smoke. There is On or before October 26, 3023, under the no impediment to the closing of the doors. Doors supervision of the Administrator, the doors are provided with a means sultable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 to the kitchen, Shower Room B71, and the are permitted. 19.3.6.3 Main Dining Room near Nursing Station 2

Any deficiency statement ending with an esteriak (*) 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 disclosuble 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 disclosuble 14 days following the date these documents are made evaliable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program panicipation.

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

TITLE

CX6) DATE

PRINTED: 10/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A BUILDING 01 B. WING 065619 09/27/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91784 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 10 (X4) ID PREFIX TAG EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 10/26/12 K 018 will be repaired or replaced so as to latch K 018 Continued From page 1 upon closing. Also, on or before Roller latches are prohibited by CMS regulations in all health care facilities. 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 This STANDARD is not met as evidenced by: personnel and maintenance will be Based on observation and interview, the facility in-serviced on ensuring doors are not failed to maintain corridor doors to resist the impeded from closing. Also, on or before passage of smoke. This was evidenced by doors that falled to latch and by doors that were October 26, 2012, under the supervision impeded from closing. This affected 1 of 7 of the Administrator, maintenance amoke compartments and had the potential to personnel will be in-serviced on allow the spread of smoke in the event of a fire. maintaining confider doors so they latch. Findings: . Monitoring of Corrective Actions During the facility tour with Staff 1, Staff 2, Staff 3, On or before October 26, 2012, under the and Staff 4, on September 27, 2012, the corridor supervision of the Administrator, and doors were observed. quarterly thereafter, doors equipped with self-closing devices will be monitored to At 8:50 a.m., the salf-closing corridor door to the verify compliance with CMS regulations. kitchen falled to latch when tested. At 8:52 a.m., the self-closing door to the kitchen [K027] It is the policy and practice of PNC pantry was impeded from closing by a food cart that door openings in smoke barriers have full of watermetons, in front of the door, holding at least a 20-minute fire protection rating the door open. or are at least 1 3/4-Inch thick solid bonded wood core. Non-rated protective At 8:54 a.m., the self closing door to the plates that do not exceed 48 inches from refrigerator room was impeded from closing by a bread cart (with 8 racks full of bread) and a the bottom of the door are permitted. condiment cart (sait, pepper, and spices) in front Horizontal sliding doors comply with

PRINTED: 10/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 09/27/2012 055619 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91764 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION DATE (X4) IC PREFIX PREFIX TAG DEFICIENCY) 10/26/12 K 018 7.2.2.14. Doors are self-closing or K D18 Continued From page 2 automatic closing in accordance with of the door. 19.2.2.2.6. Swinging doors are not At 1:02 p.m., the self-closing corridor door to the required to swing with egress and positive Shower Room B71 falled to close and latch when latching is not required. 19.3.7.5, 19.3.7.6, tested. 19.3.7.7. At 2:12 p.m., the self-closing corridor door, to the Corrective Action Main Dining Room, near Nursing Station 2, was On or before October 26, 2012, under the connected to the fire alarm system. The door falled to dose and latch, in two attempts. supervision of the Administrator, the North smoke barrier door near the kitchen will be At 2:13 p.m., Staff 2 stated during an interview unimpeded and the East smoke barrier "the air conditioning must be preventing the door door near Room 401 will be repaired or from closing." replaced so as to latch upon closing. K 027 K 027 NFPA 101 LIFE SAFETY CODE STANDARD SS-E Measures to Ensure Practice Does Not Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least Recur 1%-inch thick solid bonded wood core. Non-rated On or before October 26, 2012, under the protective plates that do not exceed 48 inches supervision of the Administrator, the from the bottom of the door are permitted. maintenance personnel will be in-serviced Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in on the importance of smoke barrier doors accordance with 19.2.2.2.6. Swinging doors are to latch and have no impediment. not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, Monitoring of Corrective Actions 19,3.7.7 On or before October 26, 2012, under the supervision of the Administrator, and

This STANDARD is not met as evidenced by:

maintain its smoke barrier doors to prevent the

spread of smoke and fire. This was evidenced by

one smoke barrier door that falled to latch and by a smoke barrier door that was impeded from

compartments and could result in the apread of

Based on observation, the facility failed to

closing. This affected 3 of 7 smoke

CMS regulations.

quarterly thereafter, smoke barrier doors

with self-closing and latching devices will

will be unimpeded and doors equipped

be monitored to verify compliance with

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 B. WING 09/27/2012 055619 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER BOD EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91764 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX FIAT DEFICIENCY [K047] It is the policy and practice of PNC 10/26/12 K 027 Continued From page 3 K 027 that exit and directional signes are smoke and fire. This could cause potential harm displayed in accordance with section 7.10 to residents. with continuous illumination also served by the emergency lighting system. Findings: 19.2.10.1. During a tour of the facility with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the Corrective Action smoke barrier doors were observed. On or before October 26, 2012, under the At 8:46 a.m., the North smoke barrier door near supervision of the Administrator, exit signs the kitchen was impeded from closing by a food will be replaced. cart full of dirty trays. The door was prevented from closing. Staff 1 removed the cart. Measures to Ensure Practice Does Not At 1:53 p.m., the East smoke barrier door near Recur On or before October 26, 2012, under the Room 401 falled to latch when tested. Two supervision of the Administrator. attempts were made without the door latching. K 047 NFPA 101 LIFE SAFETY CODE STANDARD K 047 maintenance personnel will be in-serviced 35-D on checking Illumination of exit signs. Exit and directional signs are displayed in accordance with section 7.10 with continuous Monitoring of Corrective Actions illumination also served by the amergency lighting The Quality Assurance Nurse or designee system. 19.2.10.1 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 This STANDARD is not met as evidenced by: monitoring will be unannounced and a Based on observation and interview, the facility written report of monitoring findings will be falled to maintain their exit signs. This was evidenced by an exit sign that falled to illuminate. made by the Quality Assurance Nurse or This affected 1 of 7 smoke compartments, and designee to the DON and Administrator, could result in a delay in evacuation. who will review the results and bring the report to the Quarterly Quality Assurance Findings: Committee, which will also review the During a tour of the facility with Staff 1, Staff 2, results and recommend changes as Staff 3, and Staff 4, on September 27, 2012, the necessary for compliance.

CENTERS FOR MEDICARE & MEDICAID SERVICE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIENT IDENTIFICATION NUMBER 055619		(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		-EL CONTONION	(X3) DATE SURVEY COMPLEYED 09/27/2012	
	ROVIDER OR SUPPLIER			80	EET ADDRESS, CITY, STATE, ZIP CODE DO PAST FIFTH STREET INTARIO, CA 91764		
(X4) ID PREFIX TAG	FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	COMPLETION DATE
K 050 6S=E	exit signs were ob At 9:11 a.m., the e receivable office w At 9:12 a.m., Staff that he was aware was planning on n NFPA 101 LIFE So Fire drills are held varying conditions The staff is familia that drills are pert Responsibility for assigned only to c qualified to exercit conducted betwee announcement m alarms. 19.7.1. This STANDARD Based on docum facility failed to pri emergency situati evidenced by miss quarters. This cour response to a fire Findings: During document Staff 4, on Septer records were revi-	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION) 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. 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 pert 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 elarms. 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.		050	[K050] It is the policy and practice that fire drills are held at unexpect times under varying conditions, at quarterly on each shift. The staff familiar with procedures and is aw drills are part of established routing Responsibility for planning and conditions who are qualified to exercise the each ship. Where drills are conditions are supported between 9 pm and 6 am, a coded announcement may be used instraudible alarms. 19.7.1.2. Corrective Action On or before October 28, 2012, a supervision of the General County Administrator will be in-serviced preparing staff to respond to emission and shifts. Further, the facility will conduct drills on each shift, per quarter in compilance with the regulation. Measures to Ensure Practice in Recur On or before October 26, 2012, supervision of the Administrator Director of Staff Development with the requirement of conducting quarterly fire drills.	ted t least is were that ne. conducting int raise ducted deed of ead of under the sel, the regarding ergency on or uarterly of two ne.	0

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A BUILDING B. WING 09/27/2012 065619 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 MAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 81764 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Monitoring of Corrective Actions 10/26/12 K 050 K 050 Continued From page 5 On or before October 28, 2012, under the P.M. shift, and one missing drill for the NOC shift. aupervision of the Director of Staff Development or designee, and bi-monthly There were no documents provided for a fire drill during the first quarter (January, February, thereafter, unannounced audits will be March) of 2012 on the P.M. shift. There were no made of the completion of fire drills fire drill records for the fourth quarter (October, utilizing the fire drill records to verify November, December) of 2011, on the P.M. shift. compliance with CMS regulations and to prevent the recurrence of the deficient 2. No fire drill records were provided for the first conduct. Audits will be unannounced and quarter of 2012 (January, Fabruary, March) for a written report of audit findings will be the NOC shift. made by the Quality Assurance Nurse or At 3:18 p.m., Staff 4 stated during an Interview "I designee to the DON and Administrator, just took over this position and just found out that who will review the results and bring the we were missing fire drills." report to the Quarterly Quality Assurance K 054 NFPA 101 LIFE SAFETY CODE STANDARD K 054 Committee, which will also review the SS=D All required smoke detectors, including those results and recommend changes as activating door hold-open devices, are approved. necessary for compliance. maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 [K054] it is the policy and practice of PNC that all required smoke detectors, including those activating door hold-open This STANDARD is not met as evidenced by: devices, are approved, maintained, Based on observation, the facility falled to inspected and tested in accordance with maintain the integrity of their fire alarm system. the manufacturer's specifications, 9,6,1,3. This was evidenced by one smoke detector that falled to activate a notification device or fire aterm. This could result in the potential failure of Corrective Action the fire alarm system to notify occupants in the On or before October 26, 2012, under the event of a fire. This affected 1 of 7 smoke supervision of the Administrator, the compartments. smoke detector (Number 13) will be cleaned and repaired or replaced. Findings: During fire alarm teating with Staff 1, Staff 2, Staff 3, and Staff 4, on September 27, 2012, the

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES QMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING 01 R. WING 09/27/2012 058619 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91784 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 054 Measures to Ensure Practice Does Not 10/26/12 K 054 Continued From page 6 Recur amoke detectors were tested. On or before October 26, 2012, under the At 1:59 p.m., the smoke detector (Number 13), supervision of the Administrator. did not activate an alarm when tested with maintenance personnel will be in-serviced canned smoke. The detector was located East of on the testing of smoke detectors. Room 208 and near the smoke barrier doors. The smoke detector falled to activate after three Monitoring of Corrective Actions attempts with canned smoke. On or before October 26, 2012, under the Staff 1 activated the smoke detector with a supervision of the Administrator, the fire magnet and the fire alarm sounded. K 064 NFPA 101 LIFE SAFETY CODE STANDARD alarm system will be monitored for any K 064 SS=D smoke detectors that fall to activate a Portable fire extingulahers are provided in all notification device or fire alarm; any nonhealth care occupancies in accordance with working smoke detectors discovered will 9.7.4.1. 19.3,5.6, NFPA 10 be removed [K064] It is the policy and practice of PNC that portable fire extinguishers are provided. This STANDARD is not met as evidenced by: Based on observation and Interview, the facility falled to maintain their portable fire extinguishers Corrective Action in accordance with NFPA 10. This was evidenced On or before October 26, 2012, under the by a portable fire extinguisher that was obstructed supervision of the Administrator, the fire from immediate access. This affected 1 of 7 extinguisher near Room 120 will be smoke compartments and could result in a delay monitored for immediate access and the in access to the fire extinguisher resulting in the monitoring results recorded. Also, on or spread of smoke and fire. before October 28, 2012, all housekeeping NFPA 10, Standard for Portable Fire staff will be in-serviced that fire Extinguishers, 1998 edition extinguishers must not be obstructed from 1-8.3 Fire extinguishers shall be conspicuously immediate access. 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

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING		RVEY ED		
	ROMDER OR SUPPLIER	055619	1	REET ADDRESS, CITY, STATE, ZIP CODE 300 EAST FIFTH STREET ONTARIO, CA 91764	/2012	
(X4) IID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY)	HOULD BE COMPLETIO	
K 147 SS-D	extinguishers shall following Items: (a) Location in desicip No obstruction (c) Operating Instruction (d) "Safety seals a broken or missing (e) Futiness determined for corrosion, leakage (g) Pressure gauge operable range or (h) Condition of the nozzle checked (for (i) HMIS label in planting a tour of the 3, on September 2 extinguishers were cart placed in from At 9:15 a.m., the fivas impeded from cart placed in front During an Interview second time today from being in front NFPA 101 LIFE Sciences (e) Desired wiring as Electrical wiring as	include a check of at least the ignated place to access or visibility actions on nameplate legible indicators not mined by weighing or "hefting" obvious physical damage, or clogged nozzle a reading or indicator in the position as, wheeled units) ace	K 084	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 28, 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 28, 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. 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.		

Oct 15 2012 5:00PM

PRINTED: 10/04/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 B. WHO 09/27/2012 065819 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 EAST FIFTH STREET PLOTT NURSING HOME ONTARIO, CA 91784 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX TAG DEFICIENCY) 10/26/12 K 147 Monitoring of Corrective Actions K 147 Continued From page 8 On or before October 26, 2012, under the This STANDARD is not met as evidenced by: supervision of the Administrator, the Based on observation, and interview, the facility facility will create a log sheet to assist in failed to maintain the electrical circuit panels, as monitoring the facility's electrical panels for evidenced by a circuit panel with an unidentified circuit breaker. This failure could delay identifying appropriate labeling of switches. The a circuit breaker in the event of a electrical fire or Quality Assurance Nurse or designee will emergency. This affected 1 of 7 smoke quarterly monitor, utilizing the created log compartments. sheet, the electric panels for appropriate labeling to verify compliance with CMS NFPA 70. National Electrical Code (1999 Edition) regulations and to prevent the recurrence 384-13. General. All panelboards shall have a rating not less than the minimum feeder capacity of the deficient conduct. Monitoring will be required for the load computed in accordance unannounced and a written report of with Article 220. Panelboards shall be durably monitoring findings will be made by the marked by the manufacturer with the voltage and Quality Assurance Nurse or designee to the current rating and the number of phases for the DON and Administrator, who will which they are designed and with the manufacturer's name or trademark in such a review the results and bring the report to manner so as to be visible after installation. the Quarterly Quality Assurance without disturbing the interior parts or wiring. All Committee, which will also review the panelboard circuits and circuit modifications shall results and recommend changes as be legibly identified as to purpose or use on a necessary for compliance. 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."