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

PRINTED: 08/14/2013
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
	555140	A. BUILDING 01, 02 B. WING	08/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRADLEY COURT	675 E BRADLEY EL CAJON, CA 92021

(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 K000 tags for SNF K3 BUILDING: 01 K6 PLAN APPROVAL: 1990 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TYPE UPPER Building (111) (200) MAIN Building (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: 29566 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: Building Upper: 27 Building Main: 27	K 000	The Bradley Court makes every effort to operate in full compliance with both Federal and State law. Nothing included in this Plan of Correction is an admission otherwise. The Bradley Court 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 allegations contained herein. This Plan of Correction is The Bradley Court's credible allegation of compliance.	
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	K 018	**K 018** It is the intent and policy of The Bradley Court to comply with regulatory standards as noted in NFPA Life Safety Code Standard **Procedure for Identifying Potentially Affected Residents:** As all residents are potentially affected by the alleged deficient practice contained herein, the facility will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary.	

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

ADMINISTRATOR 8/23/13

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.

8/27/13 PoC Acceptable Per Joel Yalung, HFES II

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K 018	Continued From page 1 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their doors. This was evidenced by corridor door that failed to latch. This affected 1 of 3 smoke compartments. This failure could result in spread of smoke and fire and injury to residents and staff in the event of a fire. Findings: During a tour of the facility with the Head Maintenance on 08/13/13, the corridor doors were observed. At 10:24 a.m., the door of Room 1 failed to positively latch. The door failed latch due to heavy drag on the door frame. The above finding was acknowledged by the Administrator and Head Maintenance at the time and during the exit conference on 8/13/13.	K 018	**Corrective Action:** 1. Room 1 Door has been adjusted by the Maintenance Supervisor so that it latches properly. 8/19/13 2. The staff will implement a weekly check to ensure all doors positively latch. 8/23/13 3. In-Service to Maintenance staff to review this document and ensure Life Safety Code Standard. 8/22/13 **Measures Adopted for Systemic Change:** Systematic change will be accomplished during weekly documented observations/monitoring of corrective action. **Monitoring Corrective Action and Quality Assurance:** Under the supervision of the Administrator the Maintenance supervisor will be responsible for weekly checks of doors throughout building to ensure they positively latch.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 025	Continued From page 2 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke barrier wall. This was evidenced by two penetrations in the smoke barrier wall. This affected 1 of 3 smoke compartments. This could result in the spread of smoke and fire and possible harm to residents and staff, in the event of a fire. Findings: During a tour of the facility with the Head Maintenance on 8/13/13, the smoke barrier wall was observed. At 10:15 a.m., there were two circular penetrations in the attic space smoke barrier wall by Room 7. The penetrations were around cables that ran through the smoke barrier wall. The above finding was acknowledged by the Head Maintenance at the time and during the exit	K 025	**Monitoring Corrective Action and Quality Assurance Contiued:** A QA monitoring tool will be utilized to ensure compliance. Results of the review will be submitted to the QA committee for evaluation for any further recommendations. **K025** It is the intent and policy of the Bradley Court to comply with regulatory standards as noted NFPA Life Safety Code Standard. **Procedure for Identifying Potentially Affected Residents:** As all residents are potentially affected by the alleged deficient practice contained herein, the facility will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary. **Corrective Action:** 1. The two circular penetrations in the attic space have been sealed with a four hour rating sealant.	8/16/13

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K 025	Continued From page 3 conference on 8/13/13.	K 025		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic sprinkler system. This was evidenced by shelves and supplies blocking sprinkler deflectors waterflow pattern. This affected 2 of 3 smoke compartments. An 18" clearance is required to be maintained between the sprinkler heads and storage items. If this clearance is not maintained, water dispersion from an activated sprinkler head would be compromised and thereby rendering sprinkler ineffective. This could result in the disruption of the sprinkler spray pattern, a delay in extinguishing a fire and potential harm to residents and staff, in the event of a fire. Findings: During the tour of the facility with the Head Maintenance on 8/13/13, the sprinkler deflectors were observed. Deflectors determined and deferred the spray pattern of water released from the sprinkler heads. 1. At 10:06 a.m., in the storage closet, boxes of supplies stored on a shelf approximately 14 inches from the sprinkler deflectors obstructed	K 062	2. The Staff will implement a monthly check to ensure there are no penetrations in the walls utilizing a QA monitoring tool 3. In-service to Maintenance Supervisor to review this document to ensure compliance and Life Safety Code Standard. **Measures Adopted for Systematic Change:** Systematic change will be accomplished during monthly documented observations/monitoring of corrective action.	8/23/13 8/22/13

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K 062	Continued From page 4 the water flow pattern of the deflector. 2. At 10:30 a.m., in the kitchen pantry, storage shelves positioned approximately 14 inches below the sprinkler deflector obstructed the water flow pattern of the deflector. The above findings were acknowledged by the Administrator and the Head Maintenance at the time and during exit conference on 8/13/13.	K 062	**Monitoring CorrectiveAction and Quality Assurance:** Under the Supervision of the Administrator, the Maintenance Supervisor will be responsible for monthly checks of penetrations. Audits which will be performed with a QA monitoring tool. Findings will be submitted to the QA committee for evaluation for any further corrective action. **K062** It is the intent and policy of The Bradley Court to comply with regulatory standards as noted NFPA 101 Life Safety Code Standard.	

Administrator

Page 5 A Continued
Procedure for Identifying Potentially Affected Residents:

As all residents are potentially affected by the alleged deficient practice contained herein, the facility will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary.

Corrective Action:

1. The items in the storage closet were moved to 18 inches from the sprinkler deflectors, during the walk thru by the Administrator. 8/13/13
2. A Red line has been placed in the storage closet showing where 18 inches is, so that staff will know to not store items above that line. 8/22/13
3. The Maintenance Supervisor has removed the top portion of the Kitchen pantry shelves to ensure the sprinkler defectors do not have any obstruction of the water flow pattern. 8/21/13
4. The Maintenance staff will implement a monthly check to ensure adequate clearance for the automatic sprinkler system utilizing a QA monitoring tool 8/23/13
5. In-Service staff to review this document and well Life Safety Code Standards. 8/22/13

Administrator

Page 5 B Continued
Measures Adopted for Systematic Change:
Systematic change will be accomplished during monthly documented observations/monitoring of corrective action.

Monitoring Corrective Action and Quality Assurance:

Under the Supervision of the Administrator, the Maintenance Supervisor will be responsible for monthly checks of ensuring sprinkler defectors water flow patterns are not deflected. Audits which will be performed with a QA monitoring tool. Findings will be submitted to the QA committee for evaluation for any further corrective action.