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

Poc a (left) 12/15/16 05373

PRINTED: 12/05/2016
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
	555690	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMEDA CARE CENTER	925 W. ALAMEDA AVE. BURBANK, CA 91506

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70 (a) Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during a Life Safety Code Survey. Representing the Department of Public Health: Surveyor ID No. 05373, REHS, HFE Census = 86 Highest S/S = E	K 000	The signing of this plan of correction is not an admission or agreement by the facility of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance. **K223** 1. 11/21/16 the door to the front office was closed. 11/22/16 thru 12/14/16 staff was in-serviced to keep the Business Office door closed.	12/15/16
K 223 SS=D	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the door to the office which housed a commercial copy machine, toaster, microwave, and coffee maker, that had an	K 223	2. Maintenance Supervisor checked all other doors that have automatic self-close devices and they were observed closed. 3. The following measures will be put in place to ensure the deficient practice does not recur. Until a release device is installed on door the Business Office door will remain closed to maintain compliance with Life Safety requirements. 4. The facility will monitor by reporting any deficient practices to the Administrator and the Quality Assurance Committee for review and further recommendation to maintain compliance.	

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LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

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

Lorie DeKruif | Admin | 12/15/16

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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K 223	Continued From page 1 automatic self-close device was kept closed at all times to establish conditions conducive to the rapid spread of fire, smoke, and heat to the rest of the facility. The deficient practice affected one of two smoke compartment. Findings: On November 21, 2016, it was noted that the door to the front office was kept open at all times. The room housed a commercial type copy machine, a microwave, toaster and coffee machine. There was a self-closing device on the door and a door stopper under the door to keep it open. During the observation, the Maintenance Supervisor accompanying the Evaluator stated he did not know the door needed to be kept closed at all times.	K 223	Continued from page 1	
K 281 SS=E	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: Chapter 7 Means of Egress Section 7.9 Emergency Lighting 7.9.1 General. 7.9.1.1 Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: 1) Buildings or structures where required in	K 281	See page 3	

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K 281	Continued From page 2 Chapters 11 through 43 2) Underground and limited access structures as addressed in Section 11.7 3) High-rise buildings as required by other sections of this code 4) Doors equipped with delayed-egress locks 5) Stair shaft and vestibule of smokeproof enclosures, for which the following also apply: a) The stair shaft and vestibule shall be permitted to be include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. A.7.9.1 Emergency lighting outside the building should provide illumination to either a public way or a distance away from the building that is considered safe, whichever is closest to the building being evacuated. 7.9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle, and not less than 0.1 foot candles, measured along the path of egress at floor level. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 281	Continued from page 2 **K281** 1. The facility has two motion censored lights in the egress pathway and 1 constant light. 12/1/16 Delta Fire came to assess the pathway for additional lighting to be installed. The lights will be installed up receipt. 2. All other egress pathways have adequate lighting in the event there is a need for evacuation during a power outage. 3. The following measures will be put in place to ensure the deficient practice does not recur. The Maintenance Supervisor will check egress pathways during his monthly rounds for adequate lighting. Maintenance Supervisor will request additional lighting be installed if identified. 4. The facility will monitor by reporting any deficient practices to the Administrator and the Quality Assurance Committee for review and further recommendation to maintain compliance.	12/15/16

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K 281	Continued From page 3 Based on observation and interview, the facility failed to provide emergency lighting to the path of egress from the side and back exit door. In the event of an emergency evacuation during interruption of normal power, areas used for means of egress that are illuminated may allow occupants to evacuate away from the building in a safe and immediate manner. The deficient practice affected four out of four exit routes to the outside. Findings: During a tour of the exterior area of the facility accompanied by the Maintenance Supervisor on November 21, 2016, the following was observed: a. There were four exit doors going toward the parking lot and outside the facility. During an interview, the Maintenance Supervisor stated he was not sure if the exterior lightings were on regular power or emergency power system and/or battery operated. b. There were two locked gates which were located on the path of evacuation toward the parking lot on the back side of the facility. There was no means of lighting either battery operated and/or on emergency generator to help the staff member in an event there was a need for evacuation during power outage.	K 281	Continued from page 3	
K 293 SS=D	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K 293	See page 5	

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K 293	Continued From page 4 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs. Based on observation, interview and record review, the facility failed to post a "NO EXIT" sign on the doors leading to the court yard (patio). Readily visible and marked signs would prevent confusion and delay of rapid evacuation during an emergency. The deficient practice affected two of two doors leading to the courtyard. Findings: During a tour of the facility accompanied by the Maintenance Supervisor on November 21, 2016 at 4:30 p.m., the Evaluator observed two separate dining rooms with glass doors leading to a common patio without a sign indicating "NO EXIT." A review of the floor plan indicates the facility had	K 293	Continued from page 4 **K293** 1. 12/1/16 Delta Fire came to assess the dining room exits to the patio area for ordering of the "NO EXIT" signs. Delta Fire will install the signs upon receipt 2. Delta Fire and Maintenance Supervisor checked all doorways leading to the patio areas and one additional door was identified to need a "NO EXIT" sign. 3. The following measures will be put in place to ensure the deficient practice does not recur. Delta Fire has ordered the "NO EXIT" signs and will install upon receipt of signs. The Maintenance Supervisor will check for signs during his monthly rounds. 4. The Administrator will report any deficient practices to the Quality Assurance Committee for review and further recommendation to maintain compliance.	12/15/16

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K 293	Continued From page 5 identified the area as "COURTYARD DO NOT ENTER." The Maintenance Supervisor confirmed the finding.	K 293	Continued from page 5 **K351** 1. 11/21/16 the housekeeping staff removed the bedspreads to prevent obstructions under the sprinkler heads.	
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: NFPA 13 5-5.5.3 Obstructions that prevent sprinkler discharge from reaching the hazard. Continuous or non-continuous obstructions that interrupt the water discharge in a horizontal plane more than 18 inches (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 5-5.5.3. Based on observation and interview, the facility failed to maintain 18 inches clearance from the	K 351	2. The Maintenance Supervisor and Housekeeping Supervisor checked facility sprinklers for any additional obstructed areas. No further obstructions were identified. 11/21/16 thru 12/14/16 Housekeeping and facility staff were in-serviced to maintain 18" clearance from all sprinkler head deflectors. 3. The following measures will be put in place to ensure the deficient practice does not recur. The Housekeeping Supervisor will checked the laundry room during daily rounds to ensure 18" clearance from all sprinkler head deflectors is in compliance. The Maintenance Supervisor will check for 18"clearance from all sprinkler head deflectors during daily facility rounds. 4. The Maintenance Supervisor will report any deficient practices to the Administrator. Any deficient practices will be reported to the Quality Assurance Committee for review and further recommendation to maintain compliance.	12/15/16

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K 351	Continued From page 6 sprinkler head deflector in the laundry room. Findings: On November 21, 2016, during the tour of the facility with the Maintenance Supervisor, bed spreads were observed stored on a linen cart all the way to the ceiling. During an interview, the Maintenance Supervisor stated there should be 18 inches clearance from the sprinkler head deflector and he would have the items remove to prevent the obstructions under the sprinkler heads in the laundry room.	K 351	Continued from page 6	
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be 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 in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.	K 363	See page 8	

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K 363	Continued From page 7 Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors free from obstructions that prevented the doors from closing freely and latching properly. It is essential that corridor doors be quickly closed and secured to prevent the spread of fire and smoke. The deficient practice affected two of five smoke compartments. Findings: On November 21, 2016, the Evaluator observed the small dining room door was propped open. One side of the door had a bench kept against it and the other side was a chair kept against the door and a resident was sitting on the chair. During an interview with the Maintenance Supervisor, he acknowledged that the doors should be clear from obstructions.	K 363	**K363** 1. 11/21/16 the bench and chair was removed from in front of the dining room doors to allow for the doors to close freely. 2. Maintenance Supervisor check all dining room doors and no additional doors were identified to have obstructions preventing the doors to close freely. 11/21/16 thru 12/14/16 the Director of Staff Development in-serviced staff on corridor doors being free from obstructions and closing freely. 3. The following measures will be put in place to ensure the deficient practice does not recur. All staff will remove any obstructions from corridors as identified. The Maintenance Supervisor and Dir. of Staff Development will monitor for compliance during facility rounds and remove obstructions if identified. 4 The Maintenance Supervisor will report any deficient practices to the Administrator. Any deficient practices will be reported to the Quality Assurance Committee for review and further recommendation to maintain compliance.	12/15/16