STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING 02 B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness initial certification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 32973 Census: 162	E 000		
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide policies and procedures for a method to share information from the emergency plan with residents and their families or representatives. This affected residents, staff, and families, and could potentially result in ineffective emergency planning and evacuation. (c) Communication plan. The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The	E 029		

RECEIVED
By CDPH-L&C-Life Safety Code Unit at 3:40 pm, Oct 16, 2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	10/14/18

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.

10/17/18 Accepted by Jose Gonzalez

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E 029	Continued From page 1 communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Residents' physicians. (iv) Other LTC facilities. (v) Volunteers. (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff. (ii) Federal, State, tribal, regional, or local emergency management agencies. (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii). (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). (7) A means of providing information about the	E 029		

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E 029	Continued From page 2 LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. (8) A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Findings: During document review and interview with Administrative Staff on 9/27/18, the EP was reviewed. At 3:30 p.m., the EP plan failed to provide policy and procedure for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families or representatives. Upon interview, Administrative Staff 1 confirmed the finding.	E 029	Re: E 029 In response to this finding, Laguna Hills Health and Rehab Center has developed a Policy and Procedure that complies with the E029 regulation. The Communication Plan Policy is attached as Exhibit A and will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee during the next meeting on October 31, 2018.	10/11/18
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and	E 036		

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E 036	Continued From page 3 testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the emergency preparedness (EP) plan. This was evidenced by the failure to complete a community-based full-scale exercise. This affected residents and staff, and had the potential to have an ineffective Emergency Preparedness (EP) plan. (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in	E 036		

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E 036	Continued From page 4 paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. (1) Training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility- based.	E 036	. Re: E036 Laguna Hills Health and Rehabilitation Center recognizes the community based & facility tabletop exercises were not completed and is committed to meeting this requirement. On 10/12/2018, the facility Administrator of Laguna Hills Health & Rehab contacted the Health Care Coalition Coordinator and formed plan to do a tabletop exercise on November 15, 2018. This exercise is Orange County Statewide Medical and Health Exercise and supporting documentation to describe its objectives are shown in Exhibit B . In addition, Administrator has confirmed with Orange County public health coordinator and joined the Orange County Health Care Coalition in order to stay up to date on exercises, regulations and trainings. . These initiatives will ensure Laguna Hills Health & Rehab, and it's staff, are prepared for an emergency.	10/12/18

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E 036	Continued From page 5 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed. Findings: During record review and interview with Administrative Staff on 9/27/18, the EP drills were requested and reviewed. At 3:00 p.m., the drills provided failed to include a community-based full-scale exercise. Upon interview, Administrative Staff 1 confirmed the finding stating that the facility had not completed or documented efforts to complete a community-based full-scale exercise.	E 036		
E 041 SS=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	E 041		

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E 041	Continued From page 6 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 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	E 041		

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E 041	Continued From page 7 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_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:	E 041	Re: E 041 Laguna Hills Health and Rehab has confirmed that the 130kw generator on-site will run for approximately 33 hours on a full tank (100 gallons). In the event of an emergency, the facility has planned the following in order keep the generator running and maintaining an on-site fuel source: - Purchase five 5-gallon gasoline containers to have on-site to refuel generator. - Make frequent visits to local gas stations to refill gasoline containers - Formed an agreement with Site Fuel, which is a national fuel delivery company, which services all 50 states. This policy has been added to the facility's Emergency Plan and includes contact information, location of items and general instructions in the event of an emergency.	10/12/18

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E 041	Continued From page 8 Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide policy and procedure for maintaining the emergency power system and on-site fuel source during an emergency. This affected residents and staff, and had the potential to have an ineffective Emergency Preparedness (EP) plan. Findings: During record review and interview with Administrative Staff on 9/27/18, the EP plan was requested and reviewed. At 3:20 p.m., the facility was observed with a permanent 130 kilowatt diesel generator. The EP plan failed to provide policy and procedure for maintaining an on-site fuel source and a plan for how the facility will keep the emergency power system operational during an emergency, unless the facility evacuates. Upon interview, Administrative Staff 1 confirmed the finding.	E 041		
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1971 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of	K 000		

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K 000	Continued From page 9 Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 32973 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 162	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered	K 161		

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K 161	Continued From page 10 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by an unsealed wall penetration. This affected one of six smoke compartments, and could result in the passage of smoke to other areas in the event of a fire. Findings: During a facility tour and interview with staff on 9/27/18, the walls and ceiling were observed. At 12:05 p.m., the walls in the Emergency Disaster Supply Room, were observed. There was an approximately one-half inch diameter penetration located in the West Wall. Upon interview, Staff 3 confirmed the finding.	K 161	The penetration found in the Disaster Supply Storage Room has been filled, textured and painted. In addition to this effort, the Maintenance Director and Maintenance assistant have completed a building survey to find other penetrations. When and where a penetration was found, the penetration was immediately filled with wall patching material to prevent any further damage and minimize the potential to spread a fire or smoke in the event of a fire. This building audit included all hallways, resident rooms, closets, bathrooms, storage rooms, doors and any other penetrable surface. In order to prevent further damage and/or address damage in the future, the staff will be educated during our next all-staff meeting on what is considered a penetration and also the proper form of reporting damage by immediately writing a communication in the maintenance log book. The next all staff meeting will be held on October 31, 2018.	10/4/18 10/7/18 10/31/18
K 293 SS=D	Exit Signage CFR(s): NFPA 101	K 293		

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K 293	Continued From page 11 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. 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clear and identifiable path of egress. This was evidenced by the failure to identify and post a non-exit guidance sign, and an exit sign that failed to direct to the approved path of egress and exit. This affected two of six smoke compartments, and could potentially result in entrapment and re-entry into the building during a fire, and egress delay and confusion by staff, residents, and visitors during an emergency evacuation. NFPA 101, Life Safety Code, 2012 Edition 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.1.2 Exits. 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. 7.10.2 Directional Signs. 7.10.2.1* A sign complying with 7.10.3, with a directional indicator	K 293		

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(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 293	Continued From page 12 showing the direction of travel, shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. 7.10.3.1 Signs required by 7.10.1 and 7.10.2 shall read as follows in plainly legible letters, or other appropriate wording shall be used: EXIT 7.10.8.3* No Exit. 7.10.8.3.1 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 7.10.8.3.2 The NO EXIT sign shall have the word NO in letters 2 in. (51 mm) high, with a stroke width of 3?8 in. (9.5 mm), and the word EXIT in letters 1 in. (25 mm) high, with the word EXIT below the word NO, unless such sign is an approved existing sign. Findings: During a facility tour and interview with staff on 9/27/18, the path of egress and exits were observed. 1. At 11:05 a.m., the designated exits and exit	K 293		

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	056110	A. BUILDING **02** B. WING _____	**09/27/2018**

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K 293	Continued From page 13 signs in the Nursing Station 2 Exit Corridor, were observed. Facing East, the exit sign stationed at the corridor exit doors by Social Services, and the Shower Room, had two directional arrows directing traffic to the left into the Shower Room and to the right into the Social Services Office. The designated corridor exit was located straight ahead and through the cross-corridor doors. Upon interview, Staff 3 confirmed the finding. 2. At 1:15 p.m., the corridor exit door leading out to the Central Courtyard 1, was observed. The door was designed as an exit door. The door did not have signage that indicated it was not an exit. The Courtyard was enclosed by the building structure requiring re-entry into the building to exit to the public way. Upon interview, Staff 3 confirmed the finding stating that the door appeared to be an exit.	K 293	Re: K293 Immediately following the Life Safety inspection, Maintenance Director purchased three "No Exit" signs for the doors leading to the enclosed courtyards These signs were placed on the doors on 10/12/2018. In addition to this effort, Maintenance Director ensured that all exit doors were marked clearly in the event of an emergency.	10/12/18
K 321 SS=D	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	K 321		

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K 321	Continued From page 14 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) 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 maintain the hazardous areas. This was evidenced by an obstructed enclosure opening door. This affected one of six smoke compartments, and could result in a delay in containing smoke and/or fire to a hazardous area. NFPA 101, Life Safety Code, 2012 Edition. 19.3.2 Protection from Hazards. 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L)	K 321	Re: K321 *Clarification on findings: It is the facility's belief that the surveyor mistakenly labeled this room the "Social Services Storage Room" which stores no hazardous materials, but rather was referring to the Central Supply Storage Room. Laguna Hills Health and Rehab Center recognizes that the door to the Central Supply storage room was obstructed and unable to self-close due to a rubber door stop. Upon realization of this finding, facility immediately removed the door stop and in-serviced the Central Supply designee of this regulation. Furthermore, the facility has posted this regulation and policy on the door of the Central Supply storage room to be a visual reminder to have the door remain closed, unless occupied. In order for this issue to be prevented in the future, the policy will be posted for three months starting on October 4, 2018 and will end on January 4, 2019.	10/4/18

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K 321	Continued From page 15 (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Findings: During a facility tour and interview with staff on 9/27/18, the hazardous areas were observed. At 11:20 a.m., the Social Services Storage Room, was observed. The room was greater than 50 square feet (200 square feet approximately) in size, and contained multiple boxed storage items on shelves. The corridor door to the room was equipped with a self-closing device. The door was obstructed from fully closing and latching by a rubber wedge stationed under the base of the door. Upon interview, Staff 3 confirmed the finding.	K 321		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345	Re: K 345 Upon inspection of this finding, the facility determined that the contracted company was never scheduled to do this service. On October 12, 2018, a contract with Quick Response Fire Protection was formed to perform an annual and semi-annual test and inspection of the facility's fire alarm system.	10/12/18

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K 345	Continued From page 16 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by the failure to perform a semi-annual inspection. This affected six of six smoke compartments, and could result in a system malfunction or delay in notification in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1* General. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. Chapter 14 Inspection, Testing, and Maintenance 14.1 Application. 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. 14.3 Inspection. 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections	K 345	As a certified fire alarm security service company, this agreement with Quick Response Fire Protection will ensure that Laguna Hills Health and Rehab is compliant with all NFPA guidelines and Life Safety Code regulations. Since the facility has missed the mark for it's semi-annual inspection, a new schedule for the fire alarm system will start on 12/3/18 with the annual inspection and 6/3/19 with the semi-annual inspection. These appointments were scheduled on 10/12/2018.	10/12/18

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K 345	Continued From page 17 shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 14.3.2 Devices or equipment that is inaccessible for safety considerations (e.g., continuous process operations, energized electrical equipment, radiation, and excessive height) shall be permitted to be inspected during scheduled shutdowns if approved by the authority having jurisdiction. 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance. Table 14.3.1 Visual Inspection Frequencies-semiannually 3. Batteries 4. Transient suppressors 5. Fire alarm control unit trouble signals 7. In- building fire emergency voice/alarm communications equipment 8. Remote annunciators 9. Initiating devices 10. Guard's tour equipment 11. Combination systems (a) Fire extinguisher electronic monitoring device/systems (b) Carbon monoxide detectors/systems 12. Interface equipment 13. Alarm notification appliances 14. Exit marking audible notification appliances 15. Supervising station alarm systems-transmitters 16. Special procedures 17. Supervising station alarm systems-receivers	K 345		

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K 345	Continued From page 18 18. Public emergency alarm reporting system transmission equipment 20. Mass notification system, non-supervised systems installed prior to adoption of this edition 14.6.2 Maintenance, Inspection, and Testing Records. 14.6.2.1 Records shall be retained until the next test and for 1 year thereafter. 14.6.2.4* A record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(vies) (7) Designation of the detector(S) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units	K 345		

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K 345	Continued From page 19 (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer ' S published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) Findings: During a facility tour, document review, and interview with staff on 9/27/18, the FAS was observed and records were requested. At 10:20 a.m., the facility was observed with an automatic FAS. The current Annual Fire Alarm Inspection/Testing Report was dated 12/28/17, and the previous report dated 12/1/16. No semi-annual inspection was available for review. Upon interview, Staff 3 confirmed that the FAS is inspected and tested on an annual basis.	K 345		
K 346 SS=D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service	K 346		

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K 346	Continued From page 20 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 document review and interview, the facility failed to maintain interim fire measures. This was evidenced by the failure to provide written protocol to ensure that if the fire alarm system was out of service for more than 4 hours in a 24 hour period, the authority having jurisdiction (AHJ) would be notified. This affected six of six smoke compartments, and could potentially result in the AHJ not having the ability to exercise oversight if the fire alarm system should become inoperable. Findings: During document review and interview with staff on 9/27/18, the interim fire measures and policy were reviewed. At 9:45 a.m., the approved Fire Watch policy was reviewed. The policy did not include time parameters or notification to the Department of Public Health if the fire alarm system was out of service for more than 4 hours in a 24 hour period. Upon interview, Staff 2 confirmed the finding.	K 346	Re: K 346 Laguna Hills Health and Rehab has updated its Fire Watch policy to include the time parameters set forth in this regulation. The policy is attached as Exhibit C . This policy will be reviewed at the next QAPI Committee meeting and during the next all-staff meeting, which will be held on 10/31/2018.	10/11/18
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection	K 347		

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K 347	Continued From page 21 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain the smoke detectors. This was evidenced by the failure to provide a current smoke detector sensitivity testing. This affected six of six smoke compartments, and could result in delayed notification or false alarm of a fire due to a malfunctioning smoke detector. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72, National Fire Alarm Code, 2010 Edition 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be	K 347	Re: K 347 Upon review of this finding, Laguna Hills Health and Rehab Center sought after the vendor eM Fire Prevention Services to request the current sensitivity report and schedule the next required prevention inspection. The previous sensitivity report was located on 10/4/18 and is attached as Exhibit D. We have confirmed that the next inspection will be held on 12/28/18 which will include an annual inspection and sensitivity report. EM Fire Prevention Services will keep record of Laguna Hills Health and Rehab Center's schedule to ensure that the facility is in compliance will all fire protection regulations.	10/4/18

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K 347	Continued From page 22 extended to a maximum of 5 years. 14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained. 14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction. 14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. 14.4.5.3.6 Smoke detectors or smoke alarms listed as field adjustable shall be permitted to either be adjusted within the listed and marked sensitivity range, cleaned, and recalibrated, or be replaced. 14.4.5.3.7 The detector or smoke alarm sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector or smoke alarm. Findings: During a facility tour, document review, and interview with staff on 9/27/18, the smoke	K 347		

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K 347	Continued From page 23 detectors were observed, and records were requested for review. At 10:30 a.m., the facility was observed with hard wired smoke detectors located in corridors and rooms. The current smoke detector sensitivity report was requested for review. No current or previous reports were available. Upon interview, Staff 3 confirmed the finding stating the date of sensitivity testing was unknown.	K 347		
K 353 SS=D	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 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 and interview, the facility failed to maintain the integrity of the automatic fire sprinkler system. This was evidenced by foreign material on sprinkler components. This affected	K 353	Re: K 353 The two sprinklers in the kitchen that listed in this finding were cleaned on October 10, 2018. The Maintenance Director inspected each fire pendant sprinkler head in the building to confirm that all sprinklers were free from debris. To prevent this from occurring in the future, the facility has added a log monthly log to the list of logs for the Maintenance Director, or designee, to inspect. If a sprinkler head is found to be dirty, obstructed or damaged, plan to fix or clean the sprinkler head will be accomplished within 72 hours.	10/10/18 10/12/18

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K 353	Continued From page 24 one of six smoke compartments, and could result in the ineffective operation of the automatic fire sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. Chapter 5 Sprinkler Systems. 5.1.1 Minimum Requirements. 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. 5.2.1 Sprinklers. 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g.,	K 353		

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K 353	Continued From page 25 upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer Findings: During a facility tour and interview with staff on 9/27/18, the automatic fire sprinkler system, was observed. At 11:30 a.m., the sprinkler heads in the Kitchen, were observed. Two of four pendant style sprinklers located in the dish-washing area above the sink, had black-colored debris covering the frames, deflectors, and fusible links. Upon interview, Staff 3 confirmed the finding.	K 353		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the 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	K 354		

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K 354	Continued From page 26 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 document review and interview, the facility failed to maintain interim fire measures. This was evidenced by the failure to provide written protocol to ensure that if the automatic sprinkler system was out of service for more than 10 hours in a 24 hour period, the authority having jurisdiction (AHJ) would be notified. This affected six of six smoke compartments, and could potentially result in the AHJ not having the ability to exercise oversight if the fire sprinkler system should become inoperable. Findings: During document review and interview with staff on 9/27/18, the interim fire measures and policy were reviewed. At 9:45 a.m., the approved Fire Watch policy was reviewed. The policy did not include time parameters or notification to the Department of Public Health if the fire sprinkler system was out of service for more than 10 hours in a 24 hour period. Upon interview, Staff 2 confirmed the finding.	K 354	Re: K 354 Laguna Hills Health and Rehab has updated its Fire Sprinkler Systems Protocol policy to include instructions on what to do if the sprinklers are inoperable for 10 hours in a 24 hour period. The policy is attached as Exhibit E. This policy will reviewed at the next QAPI Committee meeting and during the next all-staff meeting, which will be held on 10/31/2018.	10/12/18
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls	K 362		

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K 362	Continued From page 27 constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of the corridor construction. This was evidenced by an unsealed ceiling penetration. This affected one of six smoke compartments, and could result in the passage of smoke to other areas in the event of a fire. Findings: During a facility tour and interview with staff on 9/27/18, the corridor walls and ceiling were observed. At 11:15 a.m., there was an approximately one inch diameter ceiling penetration located in the corridor by Nursing Station 4. Upon interview, Staff 3 Confirmed the finding stating it was caused by a previous air-conditioner leakage.	K 362	The penetration found in the corridor ceiling has been filled, textured and painted. In addition to this effort, the Maintenance Director and Maintenance assistant have completed a building survey to find other penetrations. When and where a penetration was found, the penetration was immediately filled with wall patching material to prevent any further damage and minimize the potential to spread a fire or smoke in the event of a fire. This building audit included all hallways, resident rooms, closets, bathrooms, storage rooms, doors and any other penetrable surface. In order to prevent further damage and/or address damage in the future, the staff will be educated during our next all-staff meeting on what is considered a penetration and also the proper form of reporting damage by immediately writing a communication in the maintenance log book. The next all staff meeting will be held on October 31, 2018.	10/4/18 10/5/18

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K 524 SS=D	HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3 (2), 19.5.2.3(2), NFPA 54 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the direct-vent gas fireplace heating system. This was evidenced by the failure to install safety glass enclosures, and a carbon monoxide (CO) detector in the immediate area. This affected one of six smoke compartments, and could result in an increased safety risk for burns and the spread of Carbon Monoxide in the facility. NFPA 101. Life Safety Code, 2012 Edition 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.3 The requirements of 19.5.2.2 shall not apply where otherwise permitted by the following: (2) Direct-vent gas fireplaces, as defined in NFPA 54, National Fuel Gas Code, shall be permitted inside of smoke compartments containing patient sleeping areas, provided that all of the following criteria are met: (a) All such devices shall be installed, maintained, and	K 524		

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K 524	Continued From page 29 used in accordance with 9.2.2. (b) No such device shall be located inside of a patient sleeping room. (c) The smoke compartment in which the direct-vent gas fireplace is located shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 9.7.1.1(1) with listed quickresponse or listed residential sprinklers. (d)*The direct-vent fireplace shall include a sealed glass front with a wire mesh panel or screen. (e)*The controls for the direct-vent gas fireplace shall be locked or located in a restricted location. (f) Electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is located. 9.2.2 Ventilating or Heat-Producing Equipment. Ventilating or heat-producing equipment shall be in accordance with NFPA 91, Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists, and Noncombustible Particulate Solids; NFPA 211, Standard for Chimneys, Fireplaces, Vents, and Solid Fuel-Burning Appliances; NFPA 31, Standard for the Installation of Oil-Burning Equipment; NFPA 54, National Fuel Gas Code; or	K 524		

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K 524	Continued From page 30 NFPA 70, National Electrical Code, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. 9.8 Carbon Monoxide (CO) Detection and Warning Equipment. Where required by another section of this Code, carbon monoxide (CO) detection and warning equipment shall be provided in accordance with NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment. NFPA 54, National Fuel Gas Code, 2012 edition. 3.3.43.1 Gas Fireplace. 3.3.43.1.1 Direct Vent Gas Fireplace. A system consisting of (1) an appliance for indoor installation that allows the view of flames and provides the simulation of a solid fuel fireplace, (2) combustion air connections between the appliance and the vent air intake terminal, (3) flue-gas connections between the appliance and the vent-air intake terminal, and (4) a vent air intake terminal for installation outdoors, constructed such that all air for combustion is obtained from the outdoor atmosphere and all flue gases are discharged to the outdoor atmosphere.	K 524		

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K 524	Continued From page 31 NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment, 2012 edition. 9.5 Power Supplies. 9.5.1 General. 9.5.1.1 All power supplies shall have sufficient capacity to operate the alarm signal(s) for at least 12 continuous hours. Findings: During a facility tour and interview with staff on 9/27/18, the gas fireplace heating system, was observed. At 11:50 a.m., the Main Living Room had a brick and mortar constructed fireplace equipped and modified for use as a direct-vent gas fireplace. The fireplace had two openings, one on each side. No safety glass enclosures were installed for both of the openings. No CO detector was installed in the room area. A black discoloration was observed above both of the fireplace openings. Upon interview, Staff 3 confirmed the findings.	K 524	Re: K 524 Upon the exit of the survey, Maintenance Director consulted with three companies to receive quotes for the fireplace openings. This call was made on 9/28/2018. The facility is still consulting will vendors to evaluate the best option. The facility has committed to install the safety glass for the fireplace no later than November 1, 2018, pending availability of installation company and available materials. Until the fireplace safety glass can be installed, the facility has posted a sign on the fireplace, displaying to residents, family members and staff that the fire shall not be ignited until the safety glass is installed, thereby preventing any injuring or accidents. This sign was placed on 9/28/2018. A CO detector was also placed in the room area on 10/12/2018.	9/28/18 9/28/2018
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		10/12/18

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K 712	Continued From page 32 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to conduct fire drills one per shift per quarter. This was evidenced by no documentation for the performance of three of twelve fire drills. This affected six of six smoke compartments, and could result in staff being untrained and unaware of shift-specific roles and responsibilities during an emergency. NFPA 101 Life Safety Code, 2012 edition 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1. 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712		

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K 712	Continued From page 33 19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following: (1) Use of alarms (2) Transmission of alarms to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire 19.7.2.3 Staff Response. 19.7.2.3.1 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. 19.7.2.3.2 All health care occupancy personnel shall be instructed in the use of the code phrase to ensure transmission of an alarm under any of the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system 19.7.2.3.3 Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as	K 712	Re: K 712 Upon review of this finding, Laguna Hills Health and Rehab Center sought after the vendor Fire Safety Service Inc to request the current fire drill reports from Q2 of 2018. The fire drill documentation was located on 10/4/18 and is attached as Exhibit F. We have confirmed that next set of fire drills will be held in October. Fire Safety Service Inc will keep record of Laguna Hills Health and Rehab Center's schedule to ensure that the facility is in compliance will all fire protection regulations.	

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K 712	Continued From page 34 outlined in the fire safety plan. Findings: During document review and interview with Staff on 9/27/18, the fire drill records were requested and reviewed. At 9:30 a.m., no documentation was available for A.M. Shift, P.M. Shift, and Night Shift fire drills, second quarter (April, May, June) 2018. Upon interview, Staff 3 confirmed the findings.	K 712	.	10/4/18
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923	Re: K 923 Upon the written finding of this regulation, the facility immediately replaced the door knobs on the oxygen storage rooms to knobs that restrict access to unauthorized persons. These knobs include keypad locks, which codes will only be given to staff that are permitted to enter and administer the oxygen. These knobs were installed on 10/12/2018.	10/12/18

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K 923	Continued From page 35 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the oxygen storage. This was evidenced by an oxygen storage room door that was not secured against unauthorized entry. This affected one of six smoke compartments, and could result in the unsafe and unauthorized use of oxygen. NFPA 99, Health Care Facilities Code, 2012 Edition. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. Findings: During a facility tour and interview with staff on 9/27/18, the oxygen storage was observed. At 1:30 p.m., the Inside Oxygen Storage Room contained approximately 1,300 cubic feet of stored oxygen. The room door was not secured	K 923		

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K 923	Continued From page 36 against unauthorized entry. Upon interview, Staff 3 confirmed the finding.	K 923		
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain oxygen safety. This was evidenced by the absence of a continuing in-service/safety training program for all personnel associated with the use of oxygen delivery equipment and maintenance. This affected six of six smoke compartments, and could result in the unsafe handling and maintenance of oxygen delivery equipment. NFPA 99, Health Care Facilities Code, 2012 Edition. 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be	K 926		

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(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 926	Continued From page 37 trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders. 11.5.2.1.4 Equipment shall be serviced only by personnel trained in the maintenance and operation of the equipment. 11.6.2 Special Precautions for Handling Oxygen Cylinders and Manifolds. Handling of oxygen cylinders and manifolds shall be based on CGA G-4, Oxygen. 11.6.2.1 Oxygen cylinders, containers, and associated equipment shall be protected from contact with oil or grease by means of the following specific precautions: (1) Oil, grease, or readily flammable materials shall not be permitted to come in contact with oxygen cylinders, valves, pressure reducing regulators, gauges, or fittings. (2) Pressure reducing regulators, fittings, or gauges shall not be lubricated with oil or any other flammable substance. (3) Oxygen cylinders or apparatus shall not be handled with oily or greasy hands, gloves, or rags. 11.6.2.2 Equipment associated with oxygen shall be protected	K 926		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING **02** B. WING _____	**09/27/2018**

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LAGUNA HILLS HEALTH AND REHABILITATION CENTER	**24452 HEALTH CENTER DRIVE** **LAGUNA HILLS, CA 92653**

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K 926	Continued From page 38 from contamination by means of the following specific precautions: (1) Particles of dust and dirt shall be cleared from cylinder valve openings by slightly opening and closing the valve before applying any fitting to the cylinder valve. (2) The high pressure valve on the oxygen cylinder shall be opened slowly before bringing the apparatus to the patient or the patient to the apparatus. (3) An oxygen cylinder shall not be draped with any materials such as hospital gowns, masks, or caps. (4) Cylinder-valve protection caps, where provided, shall be kept in place and be hand-tightened, except when cylinders are in use or connected for use. (5) Valves shall be closed on all empty cylinders in storage. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be	K 926		

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K 926	Continued From page 39 repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts. Findings: During observation, document review, and interview with administrative staff on 9/27/18, the oxygen delivery equipment was observed, and training records were requested. At 3:45 p.m., the facility was observed with a	K 926		

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K 926	Continued From page 40 portable oxygen tank delivery system. No documentation was available for a current safety/ risk training for all personnel associated with the handling and maintenance of the oxygen delivery system. Upon interview, Administrative Staff 1, confirmed the finding stating that the Director of Nursing (DON), also confirmed that training was not completed in the past 12 months.	K 926	Re: K926 On 10/13/18, Interactive Medical Supply, the facility's oxygen supply vendor, provided the facility a comprehensive training guide that reference the proper handling, storing and using the portable oxygen system. This training will be given during the next all-staff meeting on 10/31/18 to ensure the proper usage and handling of oxygen is known and safety guidelines are adhered to. The training can be seen in Exhibit G.	10/13/18