PRINTED: 05/26/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICE **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 (X2) MULTIPLE CONSTRUC (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/C STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING 555832 05/12/2021 STREET ADDRESS, CITY, STATE, ZIB CODE NAME OF PROVIDER OR SUPPLIER 527 S VALINDA AVENUE **CLARA BALDWIN STOCKER HOME WEST COVINA, CA 91790** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) This Plan of Correction (POC) constitutes E 000 E 000 **Initial Comments** the facility's credible allegation of compliance. " Clara Baldwin Stocker The following reflects the findings of the Home, hereinafter, "CBSH" makes its best California Department of Public Health, during an Emergency Preparedness Recertification survey. effort to operate in full compliance with both Federal and State Laws. Nothing The findings are in accordance with 42 Code of included in this POC is an admission Federal Regulations (CFR) 483.73, Requirement otherwise. CBSH has submitted this POC for Long Term Care (LTC) Facilities. in order to comply with its regulatory The facility was not in substantial compliance obligation and does not waive any with 42 CFR 483.73, Requirement for LTC objections to the merits or form of any Facilities. allegations contained herein. Please note that CBSH may contest the merits and /or Representing the Department of Public Health: form of any of the deficiency findings Evaluator ID #16279, REHS, HFE I alleged below. Evaluator ID #43230, REHS, HFE I Highest Severity & Scope: F E 041 E 041 | Hospital CAH and LTC Emergency Power E 041 HOSPITAL CAH and LTC SS=F CFR(s): 483.73(e) EMERGENCY POWER §482.15(e) Condition for Participation: How corrective actions will be (e) Emergency and standby power systems. The accomplished hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the The Facility Emergency Power Policy policies and procedures plan set forth in including the Fire Watch Policy was paragraphs (b)(1)(i) and (ii) of this section. revised and updated by the Administrator §483.73(e), §485.625(e) on 5/13/2021 to include the name of gas (e) Emergency and standby power systems. The stations and addresses and the procedure [LTC facility and the CAH] must implement to maintain an onsite fuel source to emergency and standby power systems based power emergency generators. on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (b) 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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STREETADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZP CODE \$27 8 VALINDA AVENUE WEST COVINA, CA 91790 SUMMARY STREMENT OF DEPCIENCIES			555832	B. WING			05/	12/2021
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) E 041 Continued From page 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 T1A 12-2, T1A 12-3, T1A 12-4, T1A 12-2, T1A 12-3, and T1A 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 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),			ie		527 S VALINDA AVENUE			
to the Maintenance Supervisor on 5/13/2021 on the revised and updated Policy and Procedure on Emergency Power Policy / Fire Watch Policy. 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 LTC facility must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and LTG 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. **Teor hospitals at §482.15(h), LTC at §483.73(g),** **Teor hospitals at §482.15(h), LTC at §483.73(g),** **To hospitals at the leating national dark and undated Policy and Procedure on Emergency Power Policy / Fire Watch Policy. **How the facility will identify **How the facility will identify **The	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
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 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD West Covina, CA or the alternate "Chevron" located at 206 N. Vincent. Maintenance Supervisor will maintain a log book to indicate the amount of fuel on hand, receipts of fuel purchases, receipts of refill of generator tank. MS will follow the procedure on the revised and updated Policy and Procedure.	E 041	Emergency generator must be located in acrequirements found in Code (NFPA 99 and Amendments TIA 12-12-5, and TIA 12-6), I and Tentative Interim 12-2, TIA 12-3, and T when a new structure structure or building is 482.15(e)(2), §483.73 Emergency generator The [hospital, CAH at implement the emerginspection, testing, ar requirements found in Code, NFPA 110, and 482.15(e)(3), §483.73 Emergency generator LTC facilities] that mat to power emergency for how it will keep en operational during the evacuates. *[For hospitals at §48 and CAHs §485.625() The standards incorp section are approved reference by the Directed Federal Register in ac 552(a) and 1 CFR paraterial from the sou inspect a copy at the	r location. The generator cordance with the location in the Health Care Facilities Tentative Interim 2, TIA 12-3, TIA 12-4, TIA Life Safety Code (NFPA 101 Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, is built or when an existing is renovated. B(e)(2), §485.625(e)(2) Inspection and testing. Ind LTC facility] must ency power system and [maintenance] in the Health Care Facilities I Life Safety Code. B(e)(3), §485.625(e)(3) In fuel. [Hospitals, CAHs and cintain an onsite fuel source generators must have a plan in the generators of the life source generators of the systems of the cordance with 5 U.S.C. The system of the cordance with 5 U.S.C. The system of the cordance with 5 U.S.C. The system of the system of the cordance with 5 U.S.C. The system of the system of the cordance with 5 U.S.C. The system of the system of the cordance with 5 U.S.C. The system of the system of the cordance with 5 U.S.C. The system of the system of the cordance with 5 U.S.C. The system of the system of the system of the cordance with 5 U.S.C. The system of the s	E	041	to the Maintenance Supervisor on 5/13/2021 on the revised and update Policy and Procedure on Emergency Power Policy / Fire Watch Policy. How the facility will identify The Administrator and the Maintena Supervisor reviewed the Policy and Procedure on Emergency Preparednessee what other areas are affected by same deficient practice. So far, every else is in place. What measures will be put into place what systemic changes the facility will make to ensure that the deficient practice does not recur. The Facility will maintain 55 gallons of diesel fuel on the premises at all time the event the fuel is depleted the Maintenance Supervisor or Designee obtain additional diesel from the "76 Station located at 105 S. Vincent Ave West Covina, CA or the alternate "Chevron" located at 206 N. Vincent. Maintenance Supervisor will maintain log book to indicate the amount of fuel purchases, receipts of fuel purchases, receipts of fuel purchases, receipts of refill of generator tank. MS will fol the procedure on the revised and up	nce ess to the thing e or vill of ess. In will " gas nue, n a nel on eipts low	

PRINTED: 05/26/2021 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 555832 B. WING 05/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 527 S VALINDA AVENUE CLARA BALDWIN STOCKER HOME WEST COVINA, CA 91790 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) E 041 Continued From page 2 E 041 How the facility plans to monitor its or at the National Archives and Records performance to make sure that solutions Administration (NARA), For information on the are sustained. This plan must be availability of this material at NARA, call implemented, and the corrective action 202-741-6030, or go to: evaluated for its effectiveness. The POC is http://www.archives.gov/federal_register/code_of_ integrated into the quality assurance federal regulations/ibr locations.html. system 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 Maintenance Supervisor will report the changes. the Diesel Fuel Maintenance to the QAPI (1) National Fire Protection Association, 1 Batterymarch Park, Committee during monthly meeting for Quincy, MA 02169, www.nfpa.org, resolution and recommendation for three 1.617.770.3000. (3) months or until resolved. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. Include dates when corrective action will (ii) Technical interim amendment (TIA) 12-2 to be completed. The corrective action NFPA 99, issued August 11, 2011. completion dates must be acceptable to (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. the State Agency. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. 6/15/2021 (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:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 041	failed to implement it's policy with regard to repower system. The fare policy indicated that the emergency genered order, in case of an expolicy did not indicate maintained to keep the lack of maintaining the could affect the care a harm to the occupant emergency. Findings: On May 12, 2021, at conducted with the maregarding the facility's During this interview, stated that if the generated that if the generated that if the generated that the factor of the maintained, on May 12, 2021, at conducted with the factor of the maintained, on May 12, 2021, at conducted with the actor of the generator's fuel left was mentioned that the factor of the generator's fuel left was mentioned that	and record review, the facility is emergency preparedness maintaining the emergency acility's emergency generator the facility would maintain ator in proper working mergency. However, the show the fuel would be see generator running. The emergency generator and services and/or causes, during an actual 10:55 am, an interview was aintenance supervisor emergency generator. The maintenance supervisor erator's fuel started to run 5-gallon container (for gas), station down the street, direfill the generator's tank. of the facility's emergency entation was conducted. It cility's emergency power thow the generator's fuel if the fuel was running low. 3:30 pm, an interview was	E	041			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREF TAG		PROVIDER'S PLAN OF GORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
E 041	to refill the generator's interview, the adminis	station, purchase the fuel s tank. At the end of the strator stated she would preparedness policy to	E	041			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICE OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/ STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBE** COMPLETED AND PLAN OF CORRECTION A. BUILDING A1 - CLARA BALDWIN STO 555832 05/12/2021 NAME OF PROVIDER OR SUPPLIER **CLARA BALDWIN STOCKER HOME** WEST COVINA, CA 91790 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 **INITIAL COMMENTS** This Plan of Correction (POC) constitutes the facility's credible allegation of This facility was surveyed under 42 Code of compliance. " Clara Baldwin Stocker Federal Regulations, Part 483.70(a), Life Safety Home, hereinafter, "CBSH" makes its best Code NFPA 101, 2012 Edition, Chapter 19 effort to operate in full compliance with Existing Health Care Occupancies, and other both Federal and State Laws. Nothing applicable codes. included in this POC is an admission otherwise. CBSH has submitted this POC The following reflects the findings of the California Department of Public Health during the Life in order to comply with its regulatory Safety Code Recertification Survey. obligation and does not waive any objections to the merits or form of any Representing the Department of Public Health: allegations contained herein. Please note Evaluator ID #16279, REHS, HFE I that CBSH may contest the merits and /or Evaluator ID #43230, REHS, HFE I form of any of the deficiency findings alleged below. Resident census: 19 Bed capacity: 48 Highest Severity & Scope: F K 293 Exit Signage K 293 **K 293 EXIT SIGNAGE** SS=F CFR(s): NFPA 101 Corrective actions Exit Signage The Administrator gave an In-service 2012 EXISTING Training to Maintenance Department on Exit and directional signs are displayed in accordance with 7.10 with continuous Monthly Checking of the Exit Signages on illumination also served by the emergency 5/13/2021. Administrator created a Log to lighting system. be used and maintained by the 19.2.10.1 Maintenance Supervisor (MS). (Indicate N/A in one-story existing occupancies All batteries of all Exit Lighting Fixtures in with less than 30 occupants where the line of exit the building were tested on 5/13/2021 by travel is obvious.) This REQUIREMENT is not met as evidenced the MS and were logged in the Maintenance Book entitled Exit Signage Based on observation, interview and record Monthly Battery Check. review, the facility failed to provide documentation LABORATORY PIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Any deficiency statement ending with an aster k (*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VWRB21

Facility ID: CA950000088

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING A1 - CLARA BALDWIN STOCKER HOME B. WING 555832 05/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 527 S VALINDA AVENUE **CLARA BALDWIN STOCKER HOME WEST COVINA, CA 91790** . SHMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) How the facility will identify K 293 K 293 Continued From page 1 that the facility's battery-operated exit lighting The Administrator and the Maintenance fixtures were tested and maintained on a monthly Supervisor visited all the Exit Signages in basis. The periodic testing of the the facility on 5/13/21, these were all battery-operated exit lighting fixtures will ensure tested and logged in the Exit Signage that they will be functioning properly, in the event of a fire emergency. Monthly Battery Check. What measures will be put into place or Findings: what systemic changes On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance A Battery Check for Exit lighting Fixtures supervisor conducted a Life Safety Code (LSC) will be conducted by the Maintenance tour of the facility. During this LSC tour, it was Supervisor or Designee on a monthly basis observed that there were 13 exit lighting fixtures and record the date on which the test was throughout the facility. done in the log. Testing and Maintenance Exit Signs shall be inspected for operation At 1:05 pm, a review of the facility's fire inspection reports and documentation was of the illumination sources and conducted. During this review, it was noticed that periodically monitored every month. there was no documentation to show that the exit lighting fixtures were tested and maintained on a monthly basis. According to NFPA 101, 2012 How the facility plans to monitor its Edition, Life Safety Code Handbook, 7.10.9 performance Testing and Maintenance exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or The Maintenance Supervisor will report shall be periodically monitored in accordance the Exit Signages Monthly Battery Check with 7.9.3.1.3 and exits signs connected to, or to the QAPI Committee during monthly provided with, a battery-operated emergency meeting for resolution and illumination source, where required in 7.10.4, recommendation for three (3) months or shall be tested and maintained in accordance with 7.9.3. until resolved. Include dates when corrective action will At 3:30 pm, an interview was conducted with the administrator and maintenance supervisor be completed regarding the exit lighting fixtures. During this 6/15/2021 interview, the maintenance supervisor was

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
	555832	B. WING		<u> </u>	05/12/	
	E		STREET ADDRESS, CITY, STATE, ZIP CODE 527 S VALINDA AVENUE WEST COVINA, CA 91790			
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informed that the exit inspected, tested and basis. At the end of the maintenance supervise the exit lighting fixture monthly log. The deficient practice compartments. On May 12, 2021, the	lighting fixtures should be maintained on a monthly are interview, the sor stated that he would test as and record it on a affected five of five smoke above findings were	K	293			
during the exit confers and the maintenance Interior Wall and Ceilit CFR(s): NFPA 101 Interior Wall and Ceilit 2012 EXISTING Interior wall and ceilin exposed interior surfatixed or movable wallshave a flame spread The reduction in class sprinkler system as permitted. 10.2, 19.3.3.1, 19.3.3 Indicate flame spread This REQUIREMENT by: Based on observation failed to maintain a Corating finish of walls to three areas, thereby	ence, with the administrator supervisor. ng Finish ng Finish ng finishes, including aces of buildings such as s, partitions, columns, and rating of Class A or Class B. s of interior finish for a rescribed in 10.2.8.1 is .2 I rating(s). is not met as evidenced n and interview, the facility lass A, B, or C flame spread by having penetrations at compromising the fire rated	K	331	Corrective actions The three (3) inch penetrations under countertop inside Station 2 Employer Lounge were sealed with an approve retardant sealant on 5/12/2021 by the Maintenance Supervisor. The two 1 and ½ inch penetrations in Station 1's Medication Room were sewith an approved fire retardant sealed on 5/12/2021 by the Maintenance Supervisor. The 1 inch penetration in the Radio Fewas sealed with an approved fire retardant sealant on 5/12/2021 by the	er the e ed fire ne nside ealed ant	
	CORRECTION ROVIDER OR SUPPLIER SUMMARY STI (EACH DEFICIENC' REGULATORY OR LE Continued From page informed that the exit inspected, tested and basis. At the end of the maintenance supervise the exit lighting fixture monthly log. The deficient practice compartments. On May 12, 2021, the acknowledged during during the exit conferrand the maintenance Interior Wall and Ceilli CFR(s): NFPA 101 Interior Wall and Ceilli CFR(s): NFPA 101 Interior wall and ceilling exposed interior surfafixed or movable wall have a flame spread interior the reduction in class sprinkler system as permitted. 10.2, 19.3.3.1, 19.3.3 Indicate flame spread interior wall and ceilling spread interior in class sprinkler system as permitted. 10.2, 19.3.3.1, 19.3.3 Indicate flame spread interior wall and ceilling sprinkler system as permitted. 10.2, 19.3.3.1, 19.3.3 Indicate flame spread interior wall and ceilling sprinkler system as permitted. 10.2, 19.3.3.1, 19.3.3 Indicate flame spread interior wall and ceilling sprinkler system as permitted. 10.2, 19.3.3.1, 19.3.3 Indicate flame spread interior walls in the spread interior walls in the spread interior walls.	CORRECTION IDENTIFICATION NUMBER: 555832 ROVIDER OR SUPPLIER ALDWIN STOCKER HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 informed that the exit lighting fixtures should be inspected, tested and maintained on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly log. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor. Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s).	CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Informed that the exit lighting fixtures should be inspected, tested and maintained on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly log. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor. 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WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 informed that the exit lighting fixtures should be inspected, tested and maintained on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly log. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor. Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of walls by having penetrations at three areas, thereby compromising the fire rated surfaces. In the event of a fire, the separation of	CONTIDER OR SUPPLIER LOWIN STOCKER HOME SUMMARY STATEMENT OF PERCENDIES BY PULL REGULATORY OR LSE IDENTIFYING INFORMATION) Continued From page 2 Informed that the exit lighting fixtures should be inspected, tested and maintained on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly log. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were adknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor. Interior Wall and Ceilling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior Wall and Ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a fame spread rating of Class A D. Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of walls by having penetrations at Tiree areas, thereby compromising the fire rated surfaces. In the event of a fire, the separation of Maintenance Supervisor. The two 1 and ½ inch penetrations in the Radio fire, the separation of Maintenance Supervisor. The two 1 and ½ inch penetration in the Radio fire, the separation of Maintenance Supervisor. The two 1 and ½ inch penetration in the Radio fire retardant sealart on 5/12/2021 by the Maintenance Supervisor. The 1 inch penetration in the Radio fire retardant sealart on 5/12/2021 by the Maintenance Supervisor. The two 1 and ½ inch penetration in the Radio fire retardant sealart on 5/12/2021 by the Maintenance Supervisor. The two 1 and ½ inch penetration in the Radio fire retardant sealart on 5/12/2021 by the Maintenance Supervisor.	A BUILDING A1 - CLARA BALDWIN STOCKER HOME STREETADDRESS, CITY, STATE, ZIP CODE SZT S VALINDA AVENUE SUMMARY STATEMENT OF DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 2 Informed that the exit lighting fixtures should be inspected, tested and maintained on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly log. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor. Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable wells, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flames spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of walls by having penetrations at three areas, thereby compromising the fire rated surfaces. In the event of a fire, the separation of Maintenance Supervisor. The 1 inch penetration in the Radio Room was sealed with an approved fire retardant sealant on 5/12/2021 by the Maintenance Supervisor. The 1 inch penetration in the Radio Room was sealed with an approved fire retardant sealant on 5/12/2021 by the Maintenance Supervisor.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING A1 - CLARA BALDWIN STOCKER HOME			(X3) DATE SURVEY COMPLETED	
		555832	B. WING			05/ ⁻	12/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA BA	ALDWIN STOCKER HOM	E	ſ		27 S VALINDA AVENUE		
				W	/EST COVINA, CA 91790		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE/ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 331	Continued From page	3	K	331	How the facility will identify		
	•	ould allow smoke and/or fire			During his daily rounds the Mainten	ance	
	to travel from one are	a to another.			Supervisor will make visual inspection	ns on	
	Findings:		1		the Interior Wall and Ceilings and wi	il seal	
	rindings.				every identified penetrations using a	n	,
	On May 12, 2021, be	tween 8:30 am and 11:25			approved Fire Retardant Seal.		
	On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the				What measures will be put into pla	ce .	
	following was observe	ed:			All Staff are instructed to report to		
	4 44 40 00 4				Administrator and to the Maintenar	ce	
	1. At 10:03 am, there	were two 3-inch ktended through one wall			Supervisor any identified penetration	n in	
	•	es going through each			the Interior Wall and Celings to prev		
		e countertop, inside Station			the possibility of fire and/or smoke	rom	
	2's employee lounge.				spreading.		
	penetrations which ex	e were two 1-and-1/2-inch ktended through two walls ables going through), inside n room.			The Maintenance Department will continue Visual Inspections daily for penetration in the interior walls and ceiling and will immediately seal wit		
					Approved Fire Retardant Seal when		
		was a 1-inch penetration			identified.		
		igh one wall (with four ig through), inside the				Ì	
'	"radio" closet, near S				How the facility plans to monitor	,	
					The Maintenance Supervisor will rep	ort	
	During this LSC tour,				Summary of Sealed Penetrations to		
	•	t he understood that these sealed to prevent the	İ		QAPI Committee during monthly me	1	
	•	or smoke from spreading. At			for resolution and recommendation		
	the end of the intervie	ew, the maintenance			three (3) months or until resolved.		
	•	t he would seal these			• •		
	penetrations with an a sealant, immediately.	approved fire retardant			Include dates when corrective action be completed	n will	
	The deficient practice	affected two of five smoke		·	6/15/2021		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/26/2021 FORM APPROVED

OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	·			OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 1 - CLARA BALDWIN STOCKER HOME	(X3) DATE COMPI	
		555832	B. WING			05/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
CI ADA DA	ALDWIN STOCKER HOM	ıe		52	27 S VALINDA AVENUE		
CLARA DI	ALDWIN STOCKER HOM			W	/EST COVINA, CA 91790		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1	(X5) COMPLETION DATE
K 331	acknowledged during	e above findings were the survey process and ence, with the administrator	K	331			
K 346 SS=F	and the maintenance	supervisor.	к	346	K 346 FIRE ALARM SYSTEM – OUT OF SERVICE		
	services for more that period, the authority is notified, and the build an approved fire water parties left unprotected fire alarm system has 9.6.1.6 This REQUIREMENT by: Based on interview a failed to establish a dwhen the fire alarm symore than 4 hours in event the fire alarm so fire watch policy wou emergency procedure. Findings: On May 12, 2021, at facility's fire watch policy would notify the fire of that this policy did not notify the authority has a service of the servic	larm system is out of in 4 hours in a 24-hour naving jurisdiction shall be ling shall be evacuated or ich shall be provided for all ed by the shutdown until the sheen returned to service. This not met as evidenced and record review, the facility letailed fire watch policy system goes out of service for a 24-hour period. In the system goes out of service, a lid assist with the appropriate es to be implemented. 1:05 pm, a review of the olicy and procedure was y stated that the facility department. It was noticed out state that the facility would aving jurisdiction (AHJ) when it is out of service for more			The Fire Watch Policy was updated include detailed procedures and the proper notification of the Departme Health when a Fire Watch exceeds a hours on 5/12/2021 by the Administ How the facility will identify A copy of the Updated Policy is now included in the Fire Watch Policy and Procedure Binder. What measures will be put into plan During Monthly Mandatory In-service Meeting of All Staff, the Administration Designee will include a brief discuss Fire Watch including proper notification the Department of Health when a Fire Watch exceeds 4 hours.	ent of trator. d ce tor or ion on	
ORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: VWR	B21	Fa	cility ID: CA950000088 If conti	nuation she	et Page 5 of 14

PRINTED: 05/26/2021 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DESICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING A1 - CLARA BALDWIN STOCKER HOME 555832 B. WING 05/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **527 S VALINDA AVENUE CLARA BALDWIN STOCKER HOME** WEST COVINA, CA 91790 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 346 Continued From page 5 K 346 How the facility plans to monitor than 4 hours in a 24-hour period. The Maintenance Supervisor will report At 3:30 pm. an interview was conducted with the Summary of Any Fire Alarm Watch to the administrator and the maintenance supervisor **QAPI** Committee during monthly meeting regarding this fire watch policy and procedure. It for resolution and recommendation for was pointed out that there were no detailed three (3) months or until resolved. procedures, regarding the fire watch being implemented after the fire alarm system goes out Include dates when corrective action will of service for more than 4 hours in a 24-hour be completed period, and to notify the AHJ. The administrator stated that the fire watch policy would be revised. 6/15/2021 The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor. K 351 K 351 Sprinkler System - Installation K 351 SPRINKLER SYSTEM -SS≃E CFR(s): NFPA 101 INSTALLATION Spinkler System - Installation Corrective actions 2012 EXISTING The 10 Candy Packages stored in the Nursing homes, and hospitals where required by construction type, are protected throughout by an Social Service Department's Closet 5 approved automatic sprinkler system in inches from the deflector were accordance with NFPA 13, Standard for the immediately removed on 5/12/2021 by Installation of Sprinkler Systems. the Maintenance Supervisor. In Type I and II construction, alternative protection measures are permitted to be The three packages of clean towels in the substituted for sprinkler protection in specific linen Closet on the top shelf at 6 inches areas where state or local regulations prohibit from the deflector were immediately sprinklers. removed on 5/12/2021 by the In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area Maintenance Supervisor. of the closet does not exceed 6 square feet and

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING A1 - CLARA BALDWIN STOCKER HOME 555832 B. WING 05/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **527 S VALINDA AVENUE CLARA BALDWIN STOCKER HOME WEST COVINA, CA 91790 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 351 Continued From page 6 K 351 A cardboard box stored on the top shelf sprinkler coverage covers the closet footprint as inside the Central Supply Closet which required by NFPA 13, Standard for Installation of was 8 inches from the deflector was Sprinkler Systems. immediately removed on 5/12/2021 by 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, the Maintenance Supervisor. 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced The 4 packages of Styrofoam cups in the by: dietary storage room on the top shelf Based on observation, interview and record which were 12 inches from the deflector review, the facility failed to ensure and maintain were immediately removed on 5/12/2021 18-inch clearances below the sprinkler deflectors in storage areas throughout the facility. by the Maintenance Supervisor. Unobstructed areas below the sprinkler deflectors The ten cardboard boxes stored on the will ensure an effective response of the fire sprinklers to provide water discharge in a top shelf at 7 inches from the deflector of horizontal plane and will function as designed, in the PPE Storage Closet were immediately case of fire emergencies. removed on 5/12/2021 by the Maintenance Supervisor. Findings: An In-service was given by the On May 12, 2021, between 8:30 am and 11:25 Administrator to Department Heads and am, the evaluators and the maintenance Central Supply on 5/14/2021 on supervisor conducted a Life Safety Code (LSC) Standards for Installation of Sprinkler tour of the facility. During the LSC tour, the Systems. following was observed: How the facility will identify 1. At 10:15 am, there was 10 candy packages (of various sizes) stored on the top shelf, inside the In the late afternoon of 5/12/2021 all social services office closet. These packages Department Heads inspected their own were 5 inches from the deflector. units for items stored closer to 18-inch 2. At 10:20 am, there were three packages of clearances below the sprinkler deflector clean towels (measuring 10 inches by 14 inches and removed them all after which the by 14 inches each) stored on the top shelf, inside Administrator and Maintenance the clean linen closet (by Room 20). These Supervisor found no more storage is packages were 6 inches from the deflector. affected by the deficient practice. 3. At 10:45 am, there was one cardboard box

		(X3) DATE : COMPI					
		555832	B. WING			05/·	12/2021
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	52 W	REET ADDRESS, CITY, STATE, ZIP CODE 7 S VALINDA AVENUE EST COVINA, CA 91790 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLETION	
K 351	stored on the top she closet (by Room 12). the deflector. 4. At 10:55 am, there Styrofoam cups (measurings) stored on the storage room (across packages were 12 inc. 5. At 10:57 am, there (measuring 8 inches stored on the top she closet. These boxes deflector. During the LSC tour, was informed that the clearance between the objects. The maintenthese items would be At 1:40 pm, a review prevention check list heads should be under the deficient practice compartments. On May 12, 2021, the acknowledged during the exit confeand the maintenance Sprinkler System - Compartments.	s by 16 inches by 18 inches) If, inside the central supply This box was 8 inches from were four packages of asuring 4 inches by 30 top shelf, inside the dietary from the kitchen). These ches from the deflector. were ten cardboard boxes by 8 inches by 10 inches) If, inside the PPE storage were 7 inches from the the maintenance supervisor ere should be an 18-inch and deflectors and the nearest hance supervisor stated a removed, immediately. of the facility's fire indicated that sprinkler obstructed with an 18-inch or all areas of storage. e affected four of five smoke e above findings were g the survey process and rence, with the administrator e supervisor.		351	What measures will be put into place Maintenance Supervisor will make visual Checks for any items stored to the 18-inch clearance below the Sp Deflector and will remove when for Department Heads will comply with Standards for Installation of Sprinkl System. How the facility plans to monitor The Maintenance Supervisor will resummary of Noncompliance with the Standards of Sprinkler System to the Committee during monthly meeting resolution and recommendation for (3) months or until resolved. Include dates when corrective active completed 6/15/2021	daily within rinkler und. All the er eport he und QAPI g for r three	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - CLARA BALDWIN STOCKER HOME	(X3) DÄTE COMP	SURVEY LETED
		555832	B. WING		05/1:		12/2021
	ROVIDER OR SUPPLIER ALDWIN STOCKER HOM	E	STREET ADDRESS, CITY, STATE, ZIP CODE 527 S VALINDA AVENUE WEST COVINA, CA 91790		27 S VALINDA AVENUE		
(X4) IU PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 354	extent and duration of determined, areas or inspected and risks a recommendations are or designated represedepartment and other jurisdiction have been sprinkler system is or 10 hours in a 24-hour portion of the building an approved fire water sprinkler system has 18.3.5.1, 19.3.5.1, 9. This REQUIREMENT by: Based on interview a failed to establish a dwhen the automatic service for more than period. In the event is system goes out of sewould assist with the procedures to be important of the fire of that this policy did not notify the automatic sprinkler automatic sprinkler sprinkler system goes out of sewould notify the fire of that this policy did not notify the automatic sprinkler sprinkler system goes out of sewould notify the automatic sprinkler sprinkler sprinkler sprinkler system goes out of sewould notify the automatic sprinkler	aut of Service rystem is impaired, the if the impairment has been buildings involved are re determined, e submitted to management entative, and the fire r authorities having n notified. Where the aut of service for more than r period, the building or graffected are evacuated or ch is provided until the been returned to service. 7.5, 15.5.2 (NFPA 25) T is not met as evidenced and record review, the facility letailed fire watch policy sprinkler system goes out of a 10 hours in a 24-hour the automatic sprinkler ervice, a fire watch policy appropriate emergency	K	354	Corrective actions The Fire Watch Policy was updated Administrator on 5/12/2021 to inclunotification to the Fire Department jurisdiction when the sprinkler syster goes out of service for more than 10 hours in a 24-hour period. How the facility will identify A copy of the updated Policy is now included in the Fire Watch Policy an Procedure Binder. What measures will be put into plan During the Monthly Mandatory Inserting of All Staff, the Administration Designee will include a brief discuss Automatic Sprinkler System including proper notification of the Fire Depair when the sprinkler system goes out service for more than 10 hours in a shour period.	de having em	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A1 - CLARA BALDWIN STOCKER HOME		(X3) DATE SURVEY COMPLETED			
		555832	B. WING		05/1	2/2021
	ROVIDER OR SUPPLIER ALDWIN STOCKER HOM	E	ŀ	STREET ADDRESS, CITY, STATE, ZIP CODE 527 S VALINDA AVENUE WEST COVINA, CA 91790		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 354	period (as indicated in Inspection, Testing ar Water-Based Fire Produced in Inspection, Testing ar Water-Based Fire Produced in Inspection in	n NFPA 25, Standard for the and Maintenance of the otection Systems). ew was conducted with the maintenance supervisor the policy and procedure. It there were no detailed by the fire watch being automatic sprinkler system or more than 10 hours in a	K 35	How the facility plans to monitor The Maintenance Supervisor will rep Summary of Any Out- of- Service of Sprinkler System to the QAPI Comm during monthly meeting for resoluti and recommendation for three (3) months or until resolved. Include dates when corrective action be completed 6/15/2021	ittee on	
K 912 SS=D	during the exit confer- and the maintenance Electrical Systems - F CFR(s): NFPA 101 Electrical Systems - F Power receptacles hat highly dependable gramaintaining low-conta- plug. In pediatric local rooms, bathrooms, placed rooms, bathrooms, placed rooms, other than nur- tamper-resistant or ending the second rooms of the seco	the survey process and ence, with the administrator supervisor. Receptacles Receptacles are at least one, separate, bunding pole capable of act resistance with its mating tions, receptacles in patient ay rooms, and activity reries, are listed mploy a listed cover. The room, ground-fault circuit re listed.	K 912	K 912 ELECTRICAL SYSTEMS - RECEPTACLES Corrective actions Room 6's Power Receptacle was ren by Maintenance Supervisor on 5/12, How the facility will identify Out of 26 sinks in 26 resident bathro throughout the facility. No other receptacle was found having affecte the same deficient practice.	/2021.	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING A1 - CLARA BALDWIN STOCKER HOME (X3) DATE SUR COMPLETION						
	;	555832	B. WING_			05/	12/2021
	ROVIDER OR SUPPLIER ALDWIN STOCKER HOM	E		52	TREET ADDRESS, CITY, STATE, ZIP CODE 27 S VALINDA AVENUE /EST COVINA, CA 91790		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 912	by: Based on observation failed to ensure that it near resident bathrood circuit interrupters (Gothat water accidentall electrical power outled could sustain an elect prevent the possibility residents and staff from hazards. Findings: On May 12, 2021, became, the evaluators are supervisor conducted tour of the facility. Durobserved that there we bathrooms throughout the staff of the staff o	n and interview, the facility he electrical power outlets, sms sinks, were ground-fault FCI) protection. In the event y entered one of twenty-six ts, the residents or staff tric shock hazard. GFCIs of serious harm to om any electric shock tween 8:30 am and 11:25 and the maintenance I a Life Safety Code (LSC) ring the LSC tour, it was overe 26 sinks in 26 resident at the facility. Intering Room 6, it was vas a bathroom sink in the to the door. Closer that there was an electrical inches above the sink. This bactacle was not GFCI. (GFCIs ctrical receptacles with disconnect an electric possibility of serious harm k.). an interview was conducted e supervisor regarding the bacte above the residents' as pointed out that the	KS	912	What measures will be put into place Maintenance Supervisor and Design make daily visual rounds to see any noncompliant electrical receptacle is residents' rooms and consequently remove them. How the facility plans to monitor The Maintenance Supervisor will rep Summary of Any out- of- compliant electrical receptacles to the QAPI Committee during monthly meeting resolution and recommendation for (3) months or until resolved. Include dates when corrective action be completed 6/15/2021	ee will ort for three	
		otacle was not a GFCI, in					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - CLARA BALDWIN STOCKER HOME	(X3) DATE SURVEY COMPLETED	
		555832	B. WING			05/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			ŀ	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA B	ALDWIN STOCKER HOM	E			27 S VALINDA AVENUE VEST COVINA, CA 91790		
PREFIX TAG	(EACH DEFICIENC	RTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
K 920 SS=E	staff or visitor. The mastated he would correrestated he would correrestated he would correstated he would correstated, immediated. The deficient practice compartments. On May 12, 2021, the acknowledged during during the exit conferred and the maintenance Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a patient extension cords patient extension extension extension extension extension extension extension cords used	aintenance supervisor ct this electrical power ely. affected one of five smoke above findings were the survey process and ence, with the administrator supervisor. Power Cords and Extens Power Cords and Extens Power Cords and ent care vicinity are only of movable electrical equipment that have been assembled and meet the conditions of in the patient care vicinity on-PCREE (e.g., personal long-term care resident PCREE. Power strips for 3A or UL 60601-1. Power in the patient care rooms eet UL 1363. In non-patient ips meet other UL strips are used with general on cords are not used as a ing of a structure. temporarily are removed		912	K 920 ELECTRICAL EQUIPMENT- POY CORDS AND EXTENSIONS Corrective actions All electrical equipments in the Media Records that were plugged into adap and secondary power strips were removed by the Maintenance Supervimmediately on 5/12/2021. How the facility will identify No other electrical equipments found having affected by the same deficient practice. What measures will be put into place Maintenance Supervisor and Designed make daily visual rounds to see any noncompliant electrical receptacle in	ical oters visor d t	
		npletion of the purpose for and meets the conditions of			residents' rooms and consequently	:	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION - CLARA BALDWIN STOCKER HOME	(X3) DATE SURVEY COMPLETED	
		555832	B. WINGSTREET ADDRESS, CITY, STATE, ZIP CODE		05/	12/2021	
	ROVIDER OR SUPPLIER ALDWIN STOCKER HOM	E		STREET ADDRESS, CITY, STATE, ZIP CODE 527 S VALINDA AVENUE WEST COVINA, CA 91790			
(X4) IU PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	- 1	PROVIDER'S PLAN OF GORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
K 920	10.2.3.6 (NFPA 99), 1 (NFPA 70), 590.3(D) This REQUIREMENT by: Based on observation failed to plug electrical electrical outlets with electrical extension of electrical extension of possibility of an electrical extension of possibility of an electrical extension of possible fire. In additicant are not to be suring of a structure. Findings: On May 12, 2021, be am, the evaluators are supervisor conducted tour of the facility. At 9:50 am, upon entroffice, the following with the following with the supervisor conducted tour of the facility. 2. a computer, a monoplugged into a power a 6-prong adaptor, with electrical wall outlet, and the supervisor conducted tour of the facility.	(NFPA 70), TIA 12-5 is not met as evidenced in and interview, the facility al equipment directly into out the use of domestic ords. The use of domestic ords could create the rical overload and/or on, electrical extension abstituted for fixed electrical was plugged into one power d into a second power strip, that was plugged into an and	K 9	20	remove them. All electrical equipme are only plugged directly into the electrical outlet without the use of domestic electrical extension cords. Extension cords are not used as a substitute for fixed wiring of a struct How the facility plans to monitor. The Maintenance Supervisor will resummary of Any out- of- compliant electrical equipment to the QAPI Committee during monthly meeting resolution and recommendation for (3) months or until resolved. Include dates when corrective action be completed 6/15/2021	oort for three	
	domestic extension c	ctric fan were plugged into a ord, that was plugged into a as plugged into an electrical					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING A1 - CLARA BALDWIN STOCKER HOME			(X3) DATE SURVEY COMPLETED	
555832		B. WING			05/12/2021		
NAME OF PROVIDER OR SUPPLIER CLARA BALDWIN STOCKER HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 527 S VALINDA AVENUE WEST COVINA, CA 91790			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
K 920	REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				