STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR	610 NORTH GARFIELD AVENUE MONTEREY PARK, CA 91754

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a) Life Safety Code NFPA 101, 2000 Edition, Chapter 19 Existing Health Care Occupancies and other applicable codes. The following represents the findings of the Department of Public Health Services during the Life Safety Code Survey. Representing the Department of Public Health: [redacted], REHS, HFE-I Census: 97 Highest Scope and Severity = E	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907. (_____)	
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD 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 wall and ceiling by having unsealed penetration through the ceiling and wall, therefore compromising the fire rating and containment of	K 015		

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INSPECTION DIVISION
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenny J. Chen-Campos	Administrator	4/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 015	Continued From page 1 smoke and/or fire by the fire rated surface. The deficiency affected one of three smoke compartments. Findings: On 4/7/11, at between 9:55 and 10:30 a.m., during the Life Safety Code tour, in the presence of the maintenance supervisor, the following were observed: 1. Two penetrations, each measuring one inch wide around the base of the sprinkler heads, that extended through the ceiling inside Room 58. 2. A large penetration measuring five inches in diameter in the wall inside the medical equipment room located next to shower Room C. 3. A two inch wide penetration on the wall adjacent to wood cabinet, located inside Nurses' Station 2. In an interview, on the same date at 10:30 a.m., the maintenance supervisor stated he was not aware of the penetrations. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 4/11/11.	K 015	1. Penetration in #1,2, & 3 area as indicated were sealed immediately after noticed by Maintenance supervisor. 2. Maint. supervisor was instructed by Administrator to check throughout the building to ensure no penetration is found. 3. Maintenance supervisor to monitor monthly of all areas to ensure the above compliance. 4. Administrator and QA team members will monitor by random check of the interior building during the daily rounds. 5. The above deficiency was corrected on 4/13/11.	4/13/11
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6	K 018		

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K 018	Continued From page 2 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the exit corridor door in a resident sleeping room was able to resist the passage of smoke by having the door impeded from closing freely. In the event of fire emergency, rapid closure with a means suitable for keeping the door closed without any impediments or penetrations are essential component in the containment of smoke and/or fire. The deficiency affected one of three smoke compartments. Findings: On 4/7/11, during the environmental tour of the facility, in the presence of the maintenance supervisor, the exit fire door in Room 33-A was impeded from closing by the resident's wheelchair. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 4/11/11.	K 018	1. The care taker for rm.#33A was instructed to remove wheelchair from the exit door immediately after the finding. She was instructed to maintain exit door free of blockage at all times. 2. Inservice to all staff to observe the exit doors without any impediments/blockage. All staff to monitor care-takers/visitors daily. Instruction was given to all care-takers re. compliance of exit doors to be free from any blockage. 3. All staff to monitor exit doors at all times to ensure the above compliance. 4. Floor supervisors/charge nurses and QA team members will monitor daily during frequent rounds. 5. The deficiency was corrected on 4/27/11.	4/27/11
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 3 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: NFPA 101, Sect. 19.3.2.1 states that any hazardous areas shall have smoke-resisting doors that are self-closing or automatic-closing. 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 ft 2 (9.3 2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft 2 (4.6 2), 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. This requirement is not met as evidenced by: Based on observation, the facility failed to ensure	K 029	1. The self-closing device was installed for the boiler room. 4/8/11 2. Maintenance supervisor was instructed to review all hazadous areas to ensure closing device is installed as required. 3. Maintenance supervisor to monitor periodically whenever rooms changes is made & becomes hazadous, closing device will be installed. 4. Administrator and Maintenance supervisor will monitor monthly to ensure the above compliance. 5. The deficiency was corrected on 4/8/11. 4/8/11	

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K 029	Continued From page 4 the boiler room had a corridor door that was self-closing and positively latching. In the event of a fire, containment of smoke and fire would not be achieved with non-latching self closing doors in a hazardous use area. The deficiency affected one of three smoke compartments. Findings: On 4/7/10, at 11 a.m., during a tour of the facility, in the presence of the maintenance supervisor, the boiler room fire door that opens to corridor in the basement was not equipped with a self-closing device. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 4/11/11.	K 029		
K 066 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover	K 066	1. 2 metal containers with self-closing devices were ordered for the 2 designated smoking area to replace the existing metal containers. 2. Maintenance supervisor was instructed to purchase the appropriate containers for smoking areas according to the facility policy requirement. 3. Maintenance supervisor to monitor whenever a new purchase is becoming necessary to ensure the above compliance. 4. Administrator will monitor whenever the purchase is made to ensure the correct container is obtained. (cont.—)	

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K 066	Continued From page 5 devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	(cont.--) 5. The deficiency will be corrected before 5/31/11 when the ordered containers are delivered.	5/2/11 ~~5/31/11~~

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to adopt a smoking policy that included the provision that metal containers with self-closing cover device into which ashtrays can be emptied shall be readily available to all areas where smoking was permitted. The effective implementation of smoking regulations, policies, and procedures, which included the provision of metal container with a self-closing cover device, is an essential component in the prevention of fires that are caused by smoking. The deficiency affected two of three smoke compartments.

Findings:

On 4/11/11, at 11:45 a.m., during the fire alarm inspection in the presence of the maintenance supervisor, two of two metal containers that were provided in the designated smoking areas had no self-closing cover devices into which ashtrays and cigarette butts could be emptied.

In an interview at the time of observation, the maintenance supervisor stated he was unaware of the requirement and would provide the needed equipment right away.

The facility's Smoking Policy and Procedures indicated that ashtrays of non combustible

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K 066	Continued From page 6 material and safe design shall be provided in all areas where smoking is permitted along with metal containers with self-closing devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 4/11/11.	K 066		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that the oxygen cylinders storage rooms was properly maintained. Empty cylinders stored with full oxygen cylinders could result in staff choosing an empty cylinder and cause delay in a medical emergency. The deficiency affected two of three smoke compartments. Findings:	K 076	1. 2 oxygen storage rooms were posted with signs to indicate only full tanks will be stored. Empty tanks will be only stored in another designated area. 2. Inservice to all nursing/rehab staff to observe the arrangement of full/empty tanks storage in the appropriate designated areas. 3. Designated staff to monitor each shift to ensure the prostorge of oxygen tanks. 4. Floor supervisors/charge nurses and QA team members will monitor daily through frequent rounds. 5. The deficiency was corrected on 4/25/11.	4/8/11 4/25/11

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K 076	Continued From page 7 On 4/8/11, at 3:30 p.m., during the environmental tour of the facility in the presence of the maintenance supervisor, the oxygen storage rooms, one of which was located in the Nurses' Station 1 area near the rehabilitation room and the other located next to Room 39 did not have segregated oxygen tanks. There were no signs or labels indicating the empty and full oxygen cylinders were segregated. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 4/11/11. Actual NFPA Standards: NFPA 99, Sect. 4-3.5.2.2 (b) 2 stated that, if stored within the same enclosure, empty oxygen cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.	K 076		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 edition 400-8. Uses Not Permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors	K 147		

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K 147	Continued From page 8 (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8 (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this code 400-9. Splices. Flexible cord shall be used only in continuous lengths without splice or tap where initially installed in applications permitted by section 400-7(a). The repair of hard-service cord and junior hard-service cord (see Trade Name column in Table 400-4) No. 14 and larger shall permitted if conductors are spliced in accordance with Section 110-14-(b) and the completed splice retains the insulation, outer sheath properties, and usage characteristics of the cord being spliced. 410-56(e) Position of Receptacle Faces. After installation, receptacle faces shall be flush with or project from faceplates of insulating material and shall project a minimum of 0.015 in. (0.381 mm) from metal faceplates. Faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. The standard was not met as evidenced by: Based on observation and interview, the facility failed to provide electrical wiring in accordance with NFPA 70. Hazards often occur because of electrical wiring methods or usage not in conformity with this code. To meet power supply	K 147	1. The elelctrical extension cords used in room 3C, 5B,7C, 11C, 37C,58B,61B & 62B as mentioned will be removed as soon as new electrical sockets are installed. 2. All resident rooms will be re-evaluated for appropriate electrical sockets to prevent the usage of the extension cords. 3. Maintenance supervisor will monitor weekly through rounds to ensure no extension cord is used in any resident room. Resident/family will be advised when electrical appliance is used in rooms, no extension cord is allowed. 4. QA team members will randonly check rooms weekly to ensure the above compliance. 5. The deficiency will be corrected by 5/31/11.	~~5/31/11~~ 6/2/11 MS

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K 147	Continued From page 9	K 147		

needs in buildings with an inadequate supply of readily available electrical receptacles, extension cords and/or surge protected power-strips are often interconnected ("daisy chained") to provide more receptacles and/or reach greater distances. Interconnecting these devices can cause them to become overloaded, leading to their failure and a possible fire. Extension cords are sometimes used to energize power strips in locations far from receptacles. Because electrical resistance increases with increased power cord length, interconnecting cords increases the total resistance and resultant heat generation. This creates an additional risk of equipment failure and fire, particularly when paper and other combustible materials are in contact with the wires. Damaged electrical receptacle faceplates can expose energized electrical parts creating a risk of electric shock or burn injuries and fire. The deficiency affected four of six smoke compartments.

Findings:

On 4/7/11, between 9:45 and 10:15 a.m., during the life safety code survey, in the presence of the maintenance supervisor, the television sets, converter boxes and radio in Room 5-B; the electric beds in Rooms 3-C, 7-C, 11-C, 37-C, 58-B, 61-B and 62-B were connected through power-strips, (extension cords) that in turn were connected to the wall electrical receptacle. The power-strips were in use providing power to the residents electrical appliances.

The facility was using the extension cords as a permanent electrical socket.

The deficiency was brought to the attention of the

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K 147	Continued From page 10 administrator and the maintenance supervisor during the exit conference on 4/11/11.	K 147		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, the facility install alcohol based hand rub dispensers, adjacent to ignition sources, in the physical therapy room and the activity room. Alcohol based hand rub dispensers are not to be installed adjacent or above an ignition source. Failure to properly install alcohol based hand rub dispensers as required, could lead to a fire/smoke emergency. This deficiency affected two of three smoke compartments. Findings: On 4/8/11, during the environmental tour of the	K 211	1. Alcohol based hand rub dispenser inside the physical therapy room was relocated to the proper, ignition free area after the observation. 4/8/11 2. Maintenance supervisor was instructed to follow the direction of installation of such dispenser. 3. All other dispensers were reviewed and found in appropriate locations. 4. Maintenance supervisor to monitor whenever a new dispenser is installed. Administrator and QA team members will monitor such through regular rounds to ensuer the compliance. 5. The deficiency was corrected on 4/8/11. 4/8/11	

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K 211	Continued From page 11 facility, in the presence of the maintenance supervisor, the surveyor observed one of the alcohol based hand rub (ABHR) dispensers was installed over the light switch inside the physical therapy room. During the general observation of the activity room another ABHR dispenser was installed adjacent to the wall mounted thermostat switch box. In an interview on the same date the maintenance supervisor stated the dispensers will be relocated to ignition free areas. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on 4/11/11.	K 211		