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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050220	A. BUILDING 01 - MAIN BUILDING [redacted] B. WING	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 90201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under 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: Evaluator ID #14040 - REHS, HFE-I	K 000	By submitting this POC, Briarcrest Nursing Center does not admit nor concede the existence or scope and severity of the deficiencies and conditions cited in CMS-2567 or all of the facts and conclusions as described in the summary statement. However, even as to alleged facts, conclusions, determinations or issues which Briarcrest Nursing Center may question or dispute, Briarcrest Nursing Center respects the concerns raised thereby. Briarcrest Nursing Center acknowledges there is always room for improvement and will endeavor to improve where all concerns are raised, whether Briarcrest Nursing Center agrees or not. This POC is submitted in compliance with Federal and State law and Briarcrest Nursing Center is aggressively implementing actions to improve operations and resident care in accordance with this POC.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour 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: Based on observation and interview, the facility failed to provide self closing devices to the door to the transfer switch room. Failure to provide the required equipment to hazardous areas, could provide fuel and locomotion during a fire/smoke emergency. This deficiency had the potential to affect 1 of 3 smoke compartments.	K 029	**K029** **How corrective actions are accomplished:** A self closing device has been installed on to the door of the transfer switch room. **Identifying residents/area potentially affected:** The self closing device on the door of the transfer switch room has been installed	5/2/14

LABORATORY DIRECTOR'S [redacted] SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE ADMINISTRATOR (X6) DATE 6/16/14

Any [redacted] 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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	056220	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/02/2014

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K 029	Continued From page 1 Findings: On 4/25/14 at 1:22 pm, during an inspection of the fire alarm system, in the presence of the maintenance supervisor, it was observed that the door to the transfer switch room lacked a self closing device. On 4/25/14 at 1:25 pm, during an interview with the maintenance supervisor, she stated that she would have a self closing device installed right away. On 4/28/14, during the exit conference and in the presence of the administrator and maintenance supervisor, this deficiency was discussed.	K 029	and access to this transfer switch room has been securely locked. **Systematic changes to avoid recurrence:** The Director of Environmental Services has been in serviced by the Administrator concerning the need to maintain compliancy of routine monitoring of the security of the transfer switch room during scheduled rounds. **Monitor so solutions are sustained:** The functionality and security of the self closing device on the door of the transfer switch room will be monitored for compliancy. Any problems will be immediately brought to the attention of the Administrator, who will be involved in getting the problem resolved. This plan of correction has been integrated into the quality assurance system, and is reviewed quarterly by the quality assurance committee as appropriate for its effectiveness and compliance.	
K 061 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 061	<u>K051</u> **How corrective actions are accomplished:** The smoke detector adjacent to the fire alarm system has been successfully connected to the fire alarm system.	4/26/14

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K 051	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to initiate the fire alarm system, by having a smoke detector not connected to the fire alarm system. Failure to initiate the fire alarm system during a fire/smoke emergency can lead to a medical emergency. This deficiency had the potential to affect 3 of 3 smoke compartments. Findings: On 4/25/14 at 1:22 pm, during an inspection of the fire alarm system, in the presence of the maintenance supervisor, it was observed that the smoke detector, located at the nurse's station supervising the fire alarm control panel, failed to activate the fire alarm system, when activated. On 4/25/14 at 1:30 pm, during an interview with the fire alarm contractor, he said that the smoke detector was hooked up to the dialer and therefore would not activate the fire alarm. At 1:35 pm, during an interview with the maintenance supervisor, she stated that the fire alarm contractor would be at the facility "today to fix the problem." On 4/28/14 during the exit conference in the presence of the administrator and maintenance supervisor, this deficiency was discussed.	K 051	**Identifying residents/area potentially affected:** The smoke detector located in the central nursing station is isolated to detect and monitor the presence of smoke in that specific zone. The zone monitor linked to the smoke detector has been tested for full functionality. **Systematic changes to avoid recurrence:** The Director of Environmental Services has been in serviced by the Administrator concerning the need to maintain compliancy of routine maintenance and service logs for the fire alarm system. **Monitor so solutions are sustained:** The fire alarm system and smoke detectors will be serviced on schedule for compliancy. Any problems will be immediately brought to the attention of the Administrator, who will be involved in getting the problem resolved. This plan of correction has been integrated into the quality assurance system, and is reviewed quarterly by the quality assurance committee as appropriate for its effectiveness and compliance.	
K 066	NFPA 101 LIFE SAFETY CODE STANDARD	K 066	<u>K066</u> **How corrective actions are accomplished:** Metal containers with self-closing cover devices into which ashtrays can be	5/2/14

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K 066 SS=D	Continued From page 3 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 devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to adopt smoking regulations that required a metal container with a self closing cover into which ash trays could be emptied, and to provide National Fire Protection Agency (NFPA) 701 approved furniture. Failure to adopt smoking regulations that prohibit the use of flammable furniture, and provide the required equipment, can lead to a fire/smoke emergency.	K 066	emptied have been purchased and have been placed in the designated smoking area of the facility. The umbrella has been permanently removed from the facility. **Identifying residents/area potentially affected:** The absence of the metal container with self-closing cover devices into which ashtrays can be emptied, and the use of an umbrella were specific to this area. There is only one (1) designated smoking area in this facility. **Systematic changes to avoid recurrence:** The Director of Environmental Services and team have been in serviced by the Administrator concerning the need to properly identify metal containers with self-closing devices into which ashtrays can be emptied, and to ensure that umbrellas used must have an NFPA 701 approved label prior to designation as safety equipment in the designated smoking area. **Monitor so solutions are sustained:** The facility's smoking policy has been revised to include monitoring of metal containers with self-closing devices into which ashtrays can be emptied in the designated smoking area. All requests to purchase furniture will require Administrator approval and the NFPA 701 approved label. Any problems will be	

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K 066	Continued From page 4 Findings: On 4/25/14 at 2 pm, during an inspection of the fire alarm system and an inspection of the designated smoking area, in the presence of the maintenance supervisor, it was noted that there was an umbrella, that had no label to indicate if the material met the NFPA 701 standard. Further investigation determined that there was no metal container with a self closing cover into which ash trays could be emptied available at the designated smoking area. On 4/25/14 at 2:10 pm, during an interview with the maintenance supervisor, she stated she would remove the umbrella at once and would obtain a metal container with a self closing cover so that the ash trays could be emptied in a proper manner. On 4/28/14 at 1 pm, during the exit conference in the presence of the administrator and maintenance supervisor, this deficiency was discussed.	K 066	brought to the attention of the Administrator, who will be involved in getting the problem resolved. This plan of correction has been integrated into the quality assurance system, and is reviewed quarterly by the quality assurance committee as appropriate for its effectiveness and compliance.	