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

POC ACCEPTABLE 3/26/19 #16279

PRINTED: 03/01/2019
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
	056417	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW HEIGHTS CONV HOSP	12819 S. AVALON BLVD LOS ANGELES, CA 90061

(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 42 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following reflects the findings of the California Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: Evaluator #: 16279, REHS, HFE I Resident census: 153 Bed capacity: 163 Highest Severity & Scope: E	K 000	View Heights Convalescent Hospital submits this Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. By submitting this POC, View Heights Convalescent Hospital does not admit or concede the facts and contentions cited, or the existence or scope or severity of the deficiencies and conditions cited in the 2567. The POC is submitted to comply with federal and state law. View Heights Convalescent Hospital respects the allegations made in the 2567, have acted and will continue to act to implement this POC.	03/19/19
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 18.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: NFPA 101, Life Safety Code Handbook, 2012 Edition, Door Leaf Swing Direction, 7.2.1.4.2 Door leaves required to be of the single-hinged or pivoted swinging type shall swing in the direction of egress travel where: (2) the door assembly is used in an exit enclosure.	K 211	The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or it employees, agents, officers, directors or shareholders.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John E. Jones — TITLE: Admin. — (X6) DATE: 3/14/19

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 211	Continued From page 1 Based on observation, interview and record review, the facility failed to maintain gates to swing in the direction of the egress. In the event of a fire emergency, an emergency exit is to be free from impediments, and allow occupants to safely evacuate the facility. One of five fire exit gates did not swing in the direction of the egress. Findings: On February 26, 2019, at 8:30 a.m., a review of the facility's evacuation plan revealed that there were six evacuation fire exits; 1) at the lobby, 2) next to Room 22, 3) next to Room 36, 4) next to the staff lounge, 5) next to Room 44, and 6) next to Room 51. Between 8:35 a.m. and 11:40 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, it was observed that there were five exit gates; 1) at the south side, next to 127th Street, 2) outside of Room 22 near the first gate, 3) outside of Room 36, 4) at the north side next to 126th Street, and 5) one next to the fourth gate on the north side. At 11:10 a.m., it was observed that the exit gate, outside of Room 22 consisted of two gates; each measuring 6 feet long and 8 feet high. a closer observation revealed these two gates opened inward, against the direction of the egress. The other four exit gates either opened outward, in the direction of the egress, or would slide to one side along the fence, to allow the occupants to evacuate off of the facility grounds. At 11:15 a.m., an interview was conducted with	K 211	CORRECTIVE ACTION: Iron works came to the facility and replaced the metal exit gates located outside of Room 22 and ensure that the gates swing/open outward, in the direction of the egress on March 4, 2019. IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS: Environmental Services Director (ESD) made environmental rounds on February 25, 2019 and reviewed all other areas that may have the potential to be affected by the alleged deficient practice. There were no similar findings identified. MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE: Director of Staff Development (DSD) and Environmental Services Director (ESD) will ~~provide in-service and training to environmental~~ staff from 2/25/2019 to 3/25/2019 regarding NFPA 101, Life and Safety Code fire exit door requirements with an emphasis on maintaining gates to swing in the direction of the egress. Environmental Services Director (ESD) or designee will make environmental rounds monthly to ensure compliance. Any identified issues will be corrected immediately and reported to the Administrator.	3/19/19 3/19/19 3/19/19

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K 211	Continued From page 2 the maintenance supervisor regarding the exit gate next to Room 22. The maintenance supervisor was informed that in case of a fire emergency, the occupants would have difficulty opening this gate to evacuate the facility grounds because it opens inward. During this interview, the maintenance supervisor stated that he would correct the problem so that the occupants could safely evacuate the facility grounds. The deficient practice affected one of five smoke compartments. On February 22, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 211	MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM: Environmental Services Director (ESD) will monitor facility compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	3/19/19
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321	CORRECTIVE ACTION: 1. Maintenance staff patched the 1-and-1/2-inch penetration on the ceiling of the boiler room with a fire retardant seal on February 22, 2019. 2. Environmental Services Director (ESD) ordered a fire-rated door with a self-closing device on March 15, 2019 to replace the Medical records office door.	3/19/19

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K 321	Continued From page 3 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous areas were maintained with a one-hour fire rated construction, regarding a hole on a ceiling and an unapproved door at two rooms. In the event of a fire, the separation of these two rooms would not be achieved, which would allow smoke and/or fire to travel from one area to another. Findings: On February 22, 2019, between 8:35 a.m. and 11:40 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, the following were observed: 1. At 10:17 a.m., the boiler room was located at the rear of the facility. Upon entering the boiler room, it was noted that there were three 100-gallon gas fueled hot water heaters inside. A closer observation revealed that there was a 1-and-1/2-inch penetration on the ceiling. 2. At 10:40 a.m., it was noted at the medical records office: a) there was a Dutch door [a door	K 321	IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS: Environmental Services Director (ESD) made environmental rounds on February 25, 2019 and reviewed all other areas that may have the potential to be affected by the alleged deficient practice. There were no similar findings identified. MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE: Director of Staff Development (DSD) and Environmental Services Director (ESD) will provide in-service and training to maintenance staff from **2/25/2019 to 3/25/2019** regarding NFPA 101, Life and Safety Code hazardous areas requirements with an emphasis on maintaining hazardous areas with one-hour fire rated construction and ensure the utilization of approved doors. Environmental Services Director (ESD) or designee will make environmental rounds monthly to ensure compliance. Any identified issues will be corrected immediately and reported to the Administrator. MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM: Environmental Services Director (ESD) will monitor facility compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	3/19/19 3/19/19 3/19/19

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K 321	Continued From page 4 divided horizontally which the bottom half can remain shut and the top half can open], and b) this same door did not have a self-closing device to automatically close, latch and maintain the door in the closed position. During a brief interview with the maintenance supervisor, it was determined that the office was about 160 square feet [sq. ft.]. According to NFPA 101, Life Safety Code Handbook, 2012 Edition, Protection from Hazards, 19.3.2.1.5, all hazardous areas are rooms and spaces larger than 50 sq. ft., used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction, and shall have doors that are self-closing. During this LSC tour, the maintenance supervisor was informed that because the two rooms are considered hazardous areas, the penetration needed to be sealed to prevent the possibility of fire and/or smoke from spreading, and the door should be the approved type and function properly. At the end of the interview, the maintenance supervisor stated he would seal the penetration with an approved fire retardant seal and install an approved fire-rated door with a self-closing device. The deficient practice affected two of five smoke compartments. On February 22, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 321		
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101	K 331		

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K 331	Continued From page 5 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). 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 and ceilings by having penetrations at three rooms, thereby compromising the fire rated surfaces. In the event of a fire, the separation of these areas would not be achieved because these penetrations would allow smoke and/or fire to travel from one area to another. Findings: On February 22, 2019, between 8:35 a.m. and 11:40 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 10:13 a.m., there were four 1/2-inch penetrations with two cables going through two of the penetrations, which extended through the ceiling, inside the MDS office. 2. At 10:15 a.m., there was a 4-inch penetration which extended through one wall under an	K 331	**CORRECTIVE ACTION:** Maintenance staff caulked the four 1/2-inch penetrations inside the MDS office with 3M-fire barrier caulking on February 22, 2019. Maintenance staff patched the 4-inch penetration, which extended through one wall under an electrical wall outlet, next to the vending machine, inside the staff lounge on February 22, 2019. Maintenance staff caulked the three 3/4-inch penetrations, which extended through one wall next to the flat screen TV, inside the South dining room #2 with 3M-fire barrier caulking on February 22, 2019. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** Environmental Services Director (ESD) made environmental rounds on February 25, 2019 and reviewed all other areas that may have the potential to be affected by the alleged deficient practice. There were no similar findings identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Director of Staff Development (DSD) and Environmental Services Director (ESD) will provide in-service and training to maintenance staff from 2/25/2019 to 3/25/2019 regarding NFPA 101, Life and Safety Code interior wall and ceiling finish requirement with emphasis on maintaining a Class A, B, or C flame spread rating finish of walls and ceilings free from penetrations as not to compromise the fire rating and containment of smoke and/or fire by the fire rated surfaces.	3/19/19 3/19/19 3/19/19

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K 331	Continued From page 6 electrical wall outlet, next to the vending machines, inside the staff lounge. 3. At 10:20 a.m., there were three 3/4-inch penetrations which extended through one wall next to the flat screen TV, inside the South dining room #2. During this LSC tour, the maintenance supervisor was informed that these penetrations need to be sealed to prevent the possibility of fire and/or smoke from spreading. At the end of the interview, the maintenance supervisor stated he would seal these penetrations with an approved fire retardant seal. The deficient practice affected two of five smoke compartments. On February 22, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 331	Environmental Services Director (ESD) or designee will make environmental rounds weekly to ensure compliance. Any identified issues will be corrected immediately and reported to the Administrator. MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM: Environmental Services Director (ESD) will monitor facility compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	3/19/19
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351	CORRECTIVE ACTION: Dietary staff immediately removed the eight plastic quart containers and eight 28-ounce cans of food that were stored on the top shelves, inside the emergency food storage closet, by room 46 to ensure an 18" clearance below the fire sprinkler deflectors on February 22, 2019. Dietary staff immediately removed the three packages of disposable trays measuring 12 inches by 12 inches by 18 inches that were stored on the top shelves, inside the emergency food storage closet, by room 44 to ensure an 18" clearance below the fire sprinkler deflectors on February 22, 2019.	3/19/19

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K 351	Continued From page 7 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure and maintain an 18 inch clearance below the sprinkler deflectors at storage areas throughout the facility. Unobstructed areas below the sprinkler deflectors will ensure an effective response of the fire sprinklers to provide water discharge in a horizontal plane and function as designed, in case of fire emergencies. Findings:	K 351	Activity staff immediately removed the two cardboard folders stored on the top shelf, inside the activity storage closet, by room 37 to ensure an 18" clearance below the fire sprinkler deflectors on February 22, 2019. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** Environmental Services Director (ESD) made environmental rounds on February 25, 2019 and reviewed all other areas that may have the potential to be affected by the alleged deficient practice. There were no similar findings identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Maintenance staff painted a blue line inside the emergency food storage closet and activity storage closet to show a distinct demarcation of the required 18" sprinkler head clearance between the deflectors and the nearest objects on February 22, 2019. Director of Staff Development (DSD) and Environmental Services Director (ESD) will provide in-service and training to all facility staff from 2/25/2019 to 3/25/2019 regarding NFPA 13, Standards for Installation of Sprinkler systems with emphasis on maintaining an 18" sprinkler head clearance below the sprinkler deflectors at storage areas throughout the facility and the purpose of the blue demarcation line painted inside the emergency food storage closet and activity storage closet storages. Environmental Services Director (ESD) or designee will make environmental rounds weekly to ensure compliance. Any identified	3/19/19 3/19/19
	On February 22, 2019, between 8:35 a.m. and 11:40 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 10:05 a.m., eight plastic quart containers and eight 28 ounce cans of food were stored on the top shelves, inside the emergency food storage closet, by Room 46. These items were 10 inches from the deflector. 2. At 10:10 a.m., three packages of disposable trays measuring 12 inches by 12 inches by 18 inches, were stored on the top shelves, inside the emergency food storage closet by Room 44. These disposable trays were 1 inch from the deflector.			

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K 351	Continued From page 8 3. At 10:12 a.m., there were two cardboard folders stored on the top shelf, inside the activity storage closet, by Room 37. These folders were 12 inches away from the deflector. During the LSC tour, the maintenance supervisor was informed that there should be an 18-inch clearance between the deflectors and the nearest objects. The maintenance supervisor stated these items would be removed. The deficient practice affected one of five smoke compartments. On February 22, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 351	issues will be corrected immediately and reported to the Administrator. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Environmental Services Director (ESD) will monitor facility compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	3/19/19
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.	K 741	**CORRECTIVE ACTION:** Environmental Services Director (ESD) immediately posted a "No Smoking" sign outside the supply closet next to room 53 where a crash cart was stored with two 25 cubic feet oxygen tanks on February 22, 2019. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** Environmental Services Director (ESD) made environmental rounds on February 25, 2019 and reviewed all other areas that may have the potential to be affected by the alleged deficient practice. There were no similar findings identified.	3/19/19 3/19/19

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K 741	Continued From page 9 (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to post "No Smoking" signs in areas where oxygen is stored or in use. Areas where oxygen tanks and oxygen equipment are stored or in use without the proper signs could lead to accident hazards and/or fire emergencies. Findings: On February 22, 2019, between 8:35 a.m. and 11:40 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 9:50 a.m., there was a supply closet next to Room 53. A closer observation revealed that there was a "crash" cart with two 26 cubic feet oxygen tanks inside. But a "No Smoking" sign was not posted outside of this closet. At 2:20 p.m., an interview was conducted with a charge nurse regarding the missing "No Smoking" sign. The charge nurse stated that "No Smoking" signs should be posted at all areas where oxygen is stored or is being used. At the	K 741	**MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Director of Staff Development (DSD) and Environmental Services Director (ESD) will provide in-service and training to all facility staff from 2/25/2019 to 3/25/2019 regarding VHCH Oxygen policy and procedure with emphasis on correct posting of "No Smoking" signs. Environmental Services Director (ESD) or designee will make environmental rounds weekly to ensure compliance. Any identified issues will be corrected immediately and reported to the Administrator. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Environmental Services Director (ESD) will monitor facility compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	3/19/19 3/19/19

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056417	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW HEIGHTS CONV HOSP	12619 S. AVALON BLVD LOS ANGELES, CA 90061

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K 741	Continued From page 10 end of the interview, the charge nurse stated that a "No Smoking" sign would be posted at this supply closet. At 3:30 p.m., a review of the facility's oxygen policy and procedure stated that all warning signs and NO SMOKING signs are correctly posted. The deficient practice affected one of five smoke compartments. On February 22, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 741		