POC ACCEPTABLE 11/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING 01 #16279 B. WING	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK BEHAVIORAL HEALTH CENTER	1425 LAUREL AVENUE POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The facility is in substantial compliance with 42 Code of Federal Regulations 483.73, Requirement for Long Term Care Facilities, during an Emergency Preparedness recertification survey. Representing the Department of Public Health: Evaluator #: 16279, REHS, HFE I Highest scope and severity = E	E 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Laurel Park Behavioral Health Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide documentation that the facility's battery-operated exit directional signs were tested and maintained on a monthly basis. The periodic testing of the battery-operated exit directional signs will ensure that they will be functioning properly, in the event of a fire emergency.	K 293	2019 OCT 25 PM 3:3 **K293 Exit Signage CFR(s): NFPA 101** **A. Corrective action for condition(s) found to be deficient** On 10/4/19 maintenance director: * Visually checked facility's batter-operated exit directional signs for illumination. * Tested battery operation by pushing TEST button for 30 seconds * Found no repairs needed	10/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/25/19

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 293	Continued From page 1 Findings: On October 2, 2019, between 9:15 a.m. and 10:45 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 directional signs. Two of these exit directional signs were battery-operated and the other three signs were connected to the emergency generator. At 1:30 p.m., a review of the facility's fire inspection reports and documentation was conducted. During this review, it was noticed that there was no documentation to show that the exit directional signs were tested and maintained on a monthly basis. According to NFPA 101, 2012 Edition, Life Safety Code Handbook, 7.10.9 Testing and Maintenance exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3 and exits signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. At 2:45 p.m., an interview was conducted with the administrator and the maintenance supervisor regarding the exit directional signs. During this interview, it was mentioned that the exit directional signs 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 directional signs and record it on a log. The deficient practice affected two of three	K 293	**K293 continued:** **B. Scope of deficient practice that was identified** Facility has 2 batter operated exit signs **C. What measure were put in place to ensure that deficient practice does not reoccur** On 10/23/19 maintenance director received training on NFPA requirement for testing and maintenance of exit signs to be visually inspected for operation of the illumination sources at 30 days or less intervals. **D. How facility will monitor to make sure corrections are sustained** An audit for exit sign testing will be conducted for 4 consecutive weeks, and then for 2 consecutive months. Audit findings will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee who will, dependent upon audit results, determine if audits need to continue. E. Date corrective actions completed: 10/24/19	

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K 293	Continued From page 2 smoke compartments. On October 2, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 293	**K324 Cooking Facilitie CFR(s): NFPA 101** **A. Corrective action for condition(s) found to be deficient** On 10/2/19 Fire Protection Inc. inspected facility cooking equipment.	10/24/19
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	K 324	**B. Scope of deficient practice that was identified** Facility has one stove, oven and hood in the facility kitchen. **C. What measure were put in place to ensure that deficient practice does not reoccur** On 10/23/19 maintenance director received training on NFPA requirement for cooking operations to be serviced every six months by a qualified person to ensure ventilation control and fire protection. **D. How facility will monitor to make sure corrections are sustained** An audit for cooking operations service schedule and completion will be conducted at 5 months and then again at 6 months. This way the facility will be certain that the service is scheduled to be completed by the 6th month and then follow up to ensure that the service occurred. Audit findings will be reviewed by the facility Quality Assurance	

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K 324	Continued From page 3 review, the facility failed to provide documented evidence that the cooking facilities were protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, and serviced every six months by a qualified person. The six-month service of the kitchen fire extinguishing system helps prevent accumulation of grease building up and decreases the possibility of a fire inside the hood and flue. Findings: On October 2, 2019, between 9:15 a.m. and 10:45 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 the kitchen hood had a service sticker with a date of March 27, 2019 (indicating when it was serviced). At 1:40 p.m., a review of the facility's latest service of the kitchen's hood cleaning service was conducted. The service receipt showed that the last service was done, on March 27, 2019 (6 months and 5 days earlier). At 2:30 p.m., an interview was conducted with the maintenance supervisor regarding the kitchen's hood cleaning service. The maintenance supervisor stated that the cleaning service should have cleaned the hood, sometime at the end of September. The maintenance supervisor stated that he called the hood cleaning service and that they would be at the facility, on October 3, 2019. The deficient practice affected one of three smoke compartments.	K 324	**K324 continued:** Performance Improvement (QAPI) committee who will, dependent upon audit results, determine if audits need to continue. E. Date corrective actions completed: 10/24/19	

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K 324	Continued From page 4 On October 2, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 324	**K741 Smoking Regulations CFR(s): NFPA 101** **A. Corrective action for condition(s) found to be deficient** On 10/2/19 No Smoking sign was posted atop the door into nursing station where facility "crash" cart, which contains a 25 cubic foot oxygen, tank is located. **B. Scope of deficient practice that was identified** Facility has 2 oxygen tanks on premise. One is the previously identified 25 cubic foot tank located in the nursing station. The other is another 25 cubic foot tank that is located in the closet between resident rooms 16 and 17. **C. What measure were put in place to ensure that deficient practice does not reoccur** On 10/23/19 maintenance director received training on NFPA requirement for smoking to be prohibited in any room, ward, or compartment where flammable liquids, combustible gasses, or oxygen is stored and in any other hazardous location. Such areas must be posted with signs that read no smoking or with the international symbol for on smoking.	10/24/19
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. (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"	K 741		

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K 741	Continued From page 5 signs in areas where oxygen is used or stored. Areas where oxygen tanks and oxygen equipment are used or stored without the proper signs could lead to accident hazards and/or fire emergencies. Findings: On October 2, 2019, between 9:15 a.m. and 10:45 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 10:15 a.m., a "crash" cart (which was not in use), with a 25 cubic foot oxygen tank, was stored in the enclosed nurses station. Closer observation showed that a "No Smoking" sign was not posted, outside of the nurses station. At 1:30 p.m., an interview was conducted with the Director of Nursing (DON) regarding the missing "No Smoking" sign, outside of the nurses station with the "crash" cart. The DON stated that "No Smoking" signs should be posted at all areas where oxygen is stored or is being used. At the end of the interview, the DON stated that a "No Smoking" sign would be posted at the nurses station. The deficient practice affected one of three smoke compartments. On October 2, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 741	**K741 Continued:** **D. How facility will monitor to make sure corrections are sustained** An audit for no signs outside of rooms at the facility which contain flammable liquids, combustible gasses, or oxygen will be conducted for 4 consecutive weeks, and then for 2 consecutive months. Audit findings will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee who will, dependent upon audit results, determine if audits need to continue. E. Date corrective actions completed: 10/24/19	