POC accepted 05275 7/6/18

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

PRINTED: 06/18/2018
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
	056084	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(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 CFR Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: 07598 Highest scope and severity= F Total licensed beds: 210 Total resident census: 159	K 000	This Plan of Correction constitutes the facility's (Astoria Nursing & Rehabilitation Center) written credible allegation of compliance for the deficiencies noted. This Plan of Correction was completed/ corrected on 6/28/18. . Submission of this Plan of Correction does not constitute admission or agreement by the facility of the truth of the findings, conclusions and/or deficiencies alleged, or if these deficiencies were cited correctly. .	
K 331 SS=D	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). 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 ceiling by having unsealed penetrations through the ceiling, therefore, compromising the fire rating and the	K 331	This Plan of Correction is solely prepared and executed because it is required by provisions of the Health & Safety Code Section 1280 & 42 C.F.R. 48370 of the California Health and Safety Code. . Abbreviations: ANRC: Astoria Nursing & Rehabilitation Center ADM: Administrator It is the policy of ANRC to maintain a class A, B, C flame spread rating finish walls and ceiling. . How corrective action will be accomplished for those residents affected by the deficient practice: . On 6/1/18, the maintenance supervisor removed the wire that was found going	

2018 JUN 28 AM 10:36
LOS ANGELES COUNTY HEALTH FACILITIES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin Tech — (X6) DATE: 06-28-2018

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 331	Continued From page 1 containment of smoke and/or fire by the fire rated surface. In the event of smoke and/or fire, unsealed penetrations would not be able to resist the passage of smoke and/or fire, and allow smoke to travel to an adjacent room and/or smoke compartment. Findings: On May 31, 2018, at 11:37 a.m., during a life safety code tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed a penetration in the wall of the office of the business manager assistant. The penetration was 2 inches in diameter with a wire going through the wall. Further observation revealed the wire was not connected to anything. During an interview with the maintenance staff person at the time of the observation, he stated he would seal the penetration with approved material. The deficiency affected one out of eight smoke compartments. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on May 31, 2018.	K 331	the wall inside the business manager assistant's room as it was not connected to any active wiring. The maintenance supervisor also sealed the 2 inches diameter penetration using an approved fire resistant material. . How the facility will identify other residents having the potential to be affected by the same deficient practice: . After the corrective action, there was no resident that would be affected by the deficient practice. . Measure and systemic changes to be in place to ensure the deficient practice does not recur. . The maintenance supervisor and staff were in-serviced by the ADM on 6/1/18 at 2:00pm and a follow-up in-service on 6/6/18 at 10:00am to ensure there are no existing penetration in the building and no visible wiring that is not connected to anything. . How facility plans to monitor its performance to make sure that solutions are sustained: . The maintenance supervisor and his staff will conduct daily routine rounds of the building to ensure there are no penetrations in any wall and to inspect any wiring that not connected to	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the	K 341	anything. . Any findings will be discussed with the ADM for immediate corrective action for compliance. . The facility QAPI will monitor compliance during quarterly review. . Corrective action date / compliance date:	6/28/18

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K 341	Continued From page 2 building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that there was a remote annunciation system for the facility fire alarm devices to an approved central station to provide effective warning of fire in any part of the building. The central station received a total of 1 of 20 fire alarm signals from the building during the first alarm test and 1 of 12 fire alarm signals during a second alarm test. In the event of smoke and/or fire, a central monitoring station is required to provide continuous monitoring of the entire fire alarm system, including annunciation of all devices activated in all parts of the facility, and contact the fire department, as required, during a fire emergency. Findings: On May 31, 2018, a fire alarm test was conducted by the maintenance supervisor in the presence of the evaluator from 9:40 a.m., till 10:55 a.m. The fire and sprinkler system was tested and the maintenance supervisor activated 10 smoke	K 341	It is the policy of ANRC to ensure there was a remote annunciation system for the facility fire alarm devices to an approved central station to provide effective warning of fire in any part of the building. . Immediately after the facility was notified of the findings, the ADM contacted the facility's contracted fire alarm monitoring company to correct the findings of the surveyor. Meanwhile, the facility was put on every 30 minutes fire watch, led and monitored by the ADM, maintenance supervisor and RN supervisors. After the correction was made by the facility's contracted fire alarm monitoring company, the ADM provided the corrective action to the surveyor on 6/1/18 at 7:00pm and was then instructed to discontinue the fire watch. . How the facility will identify other residents having the potential to be affected by the same deficient practice: . There was no affected resident during the fire watch. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM in-serviced the maintenance supervisor and staff on 6/1/18 at 2:30pm regarding the correct process on how to communicate with the fire alarm monitoring company when the system is in test mode.	

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K 341	Continued From page 3 detectors, 10 manual alarm boxes, 2 inspector test valves, and 2 tamper switches. A review of the fire alarm activity report provided by the facility's monitoring station indicated that no signals were received from the building from 9:42 a.m., to 10:22 a.m. The only signals received were from the first manual alarm box, the 2 inspector test valves, and the 2 tamper switches. On May 31, 2018, a second fire alarm test was conducted by the maintenance supervisor in the presence of the evaluator from 3:03 p.m. till 3:29 p.m. The fire and sprinkler system was tested and the maintenance supervisor activated 6 smoke detectors and 6 manual alarm boxes. A review of the second fire alarm activity report provided by the facility's monitoring station indicated that only one signal was received from the building from 3:04 p.m., till 3:34 p.m. A review of the facility service records indicated the last annual fire alarm service by the contracting company was done on January 2, 2018, with no problems identified. During an interview with the administrator after reviewing the results of the second alarm test, he stated that a fire watch will be conducted immediately and continued till the alarm service company repairs the problem with the signals that was not received by the monitoring station. This deficiency affected 8 out of 8 compartments. The deficiency was discussed with the administrator and the maintenance supervisor during the exit conference on May 31, 2018.	K 341	The fire alarm will be checked by the fire alarm monitoring company quarterly. . How the facility plans to monitor its performance to make sure that solutions are sustained: . An in-house testing will be done monthly by the maintenance supervisor and his staff and will notify the ADM for any findings for immediate corrective action. . The facility QAPI will monitor compliance during the quarterly review. . Corrective action date / compliance date	6/28/18

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K 343 SS=D	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire alarm chime produced an audible notification. In the event of a fire/emergency, the notification devices would alert the occupants of a fire emergency and to evacuate the building. Findings: On May 31, 2018, at 10:20 a.m., during a test of the fire alarm system, the evaluator, in the presence of the maintenance supervisor, observed that a fire alarm chime in the kitchen failed to emit an audible sound when the fire alarm system was activated. The maintenance supervisor also confirmed that the fire alarm chime did not activate when the inspector test valve was tested. During an interview with the administrator at the time of the observation, he stated he would call the fire alarm company to repair the fire alarm	K 343	It is the policy of ANRC to ensure the fire alarm chime produced an audible notification. . How corrective action will be accomplished for those residents affected by the deficient practice: . The ADM immediately called the fire alarm monitoring company to ensure the fire alarm chime found in the kitchen produced an audible notification. After ordering the needed parts for repair, the job was completed on 6/27/18. . How the facility will identify other residents having the potential to be affected by the same deficient practice: . There was no resident affected during the process of correcting the audible system of the fire alarm. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM in-serviced the maintenance supervisor and staff on 6/1/18 at 3:00pm regarding ensuring the fire alarm chimes produced an audible notification during the monthly in-house test. . How facility plans to monitor its performance to make sure solutions are sustained: . Monthly monitoring of the fire alarm system for its audible sound will be conducted by the maintenance department to ensure all systems are in good working condition. Any findings will be discussed with the ADM for immediate corrective action to ensure compliance.	

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K 343	Continued From page 5 chime. The deficiency affected one out of eight smoke compartments. The deficiency was discussed with the administrator and the maintenance supervisor during the exit conference on May 31, 2018.	K 343	The facility QAPI will monitor the result of compliance during quarterly review and for further intervention as needed. . Corrective action date / compliance date:	6/28/18
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: NFPA 25 2011 Edition Water Based Fire Protection Systems Chapter 5 Maintenance Section 5.4.8. Sprinklers shall not be altered in any respect or have any type or ornamentation,	K 353	It is the policy of ANRC to ensure the sprinkler heads are not altered at any time. . How corrective action will be accomplished for those residents affected by the deficient practice. . On 6/1/18, the maintenance supervisor removed the masking tape that was covering the sprinkler head. . How the facility will identify other residents having the potential to be affected by the same deficient practice: . There was no resident affected by the deficient practice. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM in-serviced the maintenance supervisor and staff on 6/5/18 at 10:00am to inspect all sprinkler head to ensure there	

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K 353	Continued From page 6 paint, or coatings applied after shipment from the place of manufacturer. Paint, tape, or other types of ornamentation placed on a sprinkler head can adversely affect the performance of the sprinkler head during an actual fire. Based on observation, and interview, the facility failed to ensure that one sprinkler head in Room 262 was not altered after being installed. The deficient practice could result in the ineffective operation of the automatic fire sprinkler system in the event of a fire. Findings: On May 31, 2018, at 12:25 p.m., during a life safety code tour of the facility with the maintenance supervisor, the closet in Room 262 was observed with a sprinkler head that was entirely covered with a masking tape. During an interview with the maintenance supervisor, he stated that the sprinkler head was covered with a masking tape to protect it from paint because the closet was painted a long time ago. The maintenance supervisor concluded that the painters forgot to remove the tape from the sprinkler head after the paint dried up. The deficient practice affected one out of eight smoke compartments. The deficiency was discussed with the administrator and the maintenance supervisor on May 31, 2018.	K 353	are no alteration in the sprinkler heads' function. . How facility plans to monitor its performance to make sure that solutions are sustained: . During routine rounds, the maintenance supervisor and staff will inspect all sprinkler heads especially when there are painting done on the ceiling of the facility to ensure there are no alterations in any of the sprinkler heads that would alter the function of the system. . Any findings will be discussed to the ADM for immediate corrective action. . The facility QAPI will monitor compliance during quarterly review. . Corrective action date / compliance date:	6/28/18
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363	It is the policy of ANRC to ensure the corridor and resident's doors do not	

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K 363	Continued From page 7 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363	impede closure of the doors during an emergency and will provide full fire and smoke containment in the building. . How corrective action will be accomplished for those resident's affected by the deficient practice: . The beds in Room 106 and 108 were moved further away from the wall which created an allowable space for the door to close unimpeded. . The door latch of Room 251 was adjusted to assure a positive latch when the door is shut. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . An in-service was conducted by the ADM to the maintenance supervisor and staff on 6/5/18 at 10:30am regarding monitoring of the residents room and inspection of the latch on all fire doors to ensure there is no alteration to the closure doors in case of fire or disaster. . How facility plans to monitor its performance to make sure that solutions are sustained:	

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K 363	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to keep three corridor doors free of impediments and or allow the door to positively latch. Equipment and kick-down door holders used to hold corridor doors open impede the door from closing. In the event of a fire emergency, rapid closure of doors, without any impediments, is an essential component in the containment of smoke and/or fire. Findings: On May 31, 2018, during a life safety code tour of the facility, the evaluator, in the presence of the maintenance supervisor, observed the following deficiencies with the corridor doors: 1. At 11:47 a.m., there was a bed that impeded the door from closing in resident room 106. 2. At 11:50 a.m., there was a bed that impeded the door from closing in resident room 108. 3. At 12:38 p.m., the door to resident room 251 did not positively latch when closed shut. During an interview with the Maintenance Supervisor at the time of the observation, he stated he would maintain the doors to close and latch at all times without any impediments in the doorway. The deficiency affected 2 out of 8 smoke compartments. The deficiency was brought to the attention to the administrator and the maintenance supervisor	K 363	The maintenance supervisor and staff will conduct routine rounds to ensure no bed impedes the door from the resident's room from positively latching. Any alteration and finding will be brought to the attention of the ADM for immediate corrective action. The facility QAPI will continue to monitor compliance during quarterly review and implement corrective action if needed. Corrective action date / compliance date:	6/28/18

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K 363	Continued From page 9 during the exit conference on May 31, 2018.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a fire resistive rating of at least one-half hour by having unsealed penetrations through 2 of 9 smoke barrier walls. Penetrations of smoke barrier walls may compromise the integrity of the smoke compartments, thereby, allowing smoke to travel easily between smoke compartments and other openings such as the ceiling vents during an emergency. Findings: On May 30, 2018, at 3:52 p.m., the evaluator observed a penetration through the smoke barrier wall in the attic space above the cross-corridor door next to Room 111. The penetration was 3 inches in diameter.	K 372	It is the policy of ANRC to maintain a fire resisting rating of at least one half hour and sealed walls free of any penetrations. . How corrective action will be accomplished for those residents affected by the deficient practice: . The maintenance supervisor immediately sealed the 3 inch penetration in the attic space near Room 111 using an approved fire resistant material. . How the facility will identify other residents having the potential to be affected by the same deficient practice: . During the corrective action plan, no resident was affected by the deficient practice. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM conducted an in-service with the maintenance supervisor and staff on 6/5/18 at 11:00am regarding the inspection of the smoke barrier walls for any penetration in order to prevent fire from spreading. . How facility plans to monitor its to make sure that solutions are sustained: . The maintenance supervisor and staff will conduct routine rounds to ensure there are	

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K 372	Continued From page 10 During an interview, the maintenance supervisor stated he would seal the penetration with approved fire rated material. The deficient practice affected 2 out of 8 smoke compartments. The deficiency was brought to the attention of the administrator and the maintenance supervisor during the exit conference on May 31, 2018.	K 372	no penetrations in the walls, ceiling or cross ceiling attic in the facility that would compromise the one and a half smoke barrier. Any findings will be discussed with the ADM for immediate corrective action. . The facility QAPI will monitor compliance during quarterly review. . Corrective action date / compliance date:	6/28/18
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: National Electrical Code 2011 Edition (NFPA 70) Article 400, Section 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, or floors. The use of power cords running through holes in walls are not allowed as they create a potential for fire as well as a penetration for smoke to pass	K 511	It is the policy of ANRC to ensure a power cord is not running though a hole in the wall. . How corrective action will be accomplished for those residents affected by the deficient practice: . The maintenance supervisor removed the extension cord and sealed the penetration on the wall using an approved fire resistant material. . How facility will identify other residents having the potential to be affected by the same deficient practice: . During the corrective action, no resident was affected by the same deficient practice. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM conducted an in-service to the maintenance supervisor and staff on 6/5/18 at 11:30am regarding proper installation of power cords.	

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K 511	Continued From page 11 through. Based on observation and interview, the facility failed to ensure that a power cord was not running through a hole in the wall in the office of the business manager's assistant. Findings: On May 31, 2018, at 11:37 a.m., during a life safety code tour of the facility, the evaluator observed the use of a power cord running through the wall of the office of the business manager's assistant. During an interview with the maintenance supervisor, he stated the power cord ran through a hole in the wall to connect to an electrical outlet outside the room which powered a coffee maker and a paper shredder. This deficiency practice affected one out of eight smoke compartments. The deficiency was discussed with the administrator and the maintenance supervisor during the exit conference on May 31, 2018.	K 511	How facility plans to monitor its performance to make sure that solutions are sustained: . The maintenance supervisor and staff will do routine rounds to ensure there are no power cords running through the walls. . Any finding will be reported to the ADM for immediate corrective action. . The facility QAPI will monitor compliance during the quarterly review. . Corrective action date / compliance date:	6/28/18
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521	It is the policy of ANRC to comply with the NFA 90A to inspect, service and maintain the dampers with fusible links at least every 4 years to prevent the passage of smoke and/or fire from spreading. . Immediately after the receipt of the notice, the ADM contacted the facility alarm monitoring company to service the dampers with fusible links. Services were provided on 6/1/18, 6/2/18, 6/5/18, 6/12/18, and 6/13/18.	

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K 521	Continued From page 12 This REQUIREMENT is not met as evidenced by: NFPA 90A, 2010 Edition, Standard for the Installation of Air-Conditioning and Ventilating Systems Section 19.4.1.1 Maintenance At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Based on observation, interview, and record review, the facility failed to comply with NFPA 90A by failing to inspect, service, and maintain the damper and fusible links at least every four years. In the event of fire, fusible links are designed to melt, which in turn will result in the dampers closing, to interrupt migratory airflow or assure the restriction and passage of smoke and/or fire from one compartment to another. Findings: On May 30, 2018, during a review of the facility's fire protection equipment records, the evaluator could not find documented evidence that the fire dampers with fusible links were serviced at least every four years. A review of document for maintenance of motorized dampers indicated they were serviced on January 2, 2018. Further review of the document indicated that the facility had no the fire dampers with fusible links. However, during a tour of the facility at 3:00 p.m., the evaluator, in the presence of the maintenance supervisor, observed at least two fire dampers with fusible links in the facility corridors.	K 521	How the facility will identify other residents having the potential to be affected by the same deficient practice: . During the corrective action, no resident was identified to be affected by the same deficient practice. . Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM in-serviced the maintenance supervisor and staff on 6/7/18 at 10:00am to maintain and monitor a log to ensure the facility's contracted fire alarm monitoring company will service the dampers with fusible links every 4 years. . How the facility plans to monitor its performance to make sure that solutions are sustained: . The maintenance supervisor will maintain and monitor the log to ensure the dampers with fusible links are serviced every 4 years and the scheduled year will not be missed. . Corrective action date / compliance date:	6/28/18

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K 521	Continued From page 13 During an interview at the time of the observation with the maintenance supervisor assistant from another building, he stated he could identify at least 25 other fire dampers with fusible links in the facility corridors. The deficiency affected eight out of eight smoke compartments. The deficiency was brought to the attention to the administrator and the maintenance supervisor during the exit conference on May 31, 2018.	K 521		
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	K 741	It is the policy of ANRC to ensure the facility has a metal container with self closing cover device or an ash-tray of non-combustible material and safe design for residents who smoke. . How corrective action will be accomplished for those residents affected by the deficient practice: . The ADM immediately purchased an ash tray of non-combustible material and safe design. (See attached). . How the facility will identify other residents having the potential to be affected by the same deficient practice: . The facility did not have any resident who smokes during the time of survey. Therefore, no resident was affected by the deficient practice.	

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K 741	Continued From page 14 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 ensure metal containers with self-closing cover devices into which ashtrays can be emptied were provided in the back patio where smoking was permitted. The effective implementation of the provision of metal containers with self-closing cover devices into which ashtrays can be emptied, is an essential component in the prevention of fires that are caused by smoking. Findings: On May 30, 2018, at 2:57 p.m., during a life safety code tour of the building, the evaluator observed two metal ashtrays at the back patio where smoking is allowed. One was missing a metal cover while the other was overflowing with cigarette ashes that were within reach of residents. A review of the facility's smoking policy and procedures revealed that there was no provision for metal containers with self-closing cover devices into which ashtrays can be emptied to be readily available to all areas where smoking is permitted. During an interview, the maintenance supervisor stated he would replace the existing ash trays with ones that are in good repair. The deficiency did not affect any smoke	K 741	Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM in-serviced the maintenance supervisor and staff on 6/7/18 at 10:30am regarding maintaining the ash tray found in the designated smoking area is in working order. . How facility plans to monitor its performance to make sure that solutions are sustained: . The maintenance supervisor will monitor the ash tray is in good condition in case the facility admits a resident who smokes. . The maintenance supervisor will report to the ADM any findings which will be discussed during the facility's QAPI quarterly review for compliance. . Corrective action date / completion date:	6/28/18

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K 741	Continued From page 15 compartments. On May 31, 2018, during the exit conference, the deficiency was brought to the attention of the administrator, and the maintenance supervisor.	K 741		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to connect electrical devices directly into electrical receptacles and instead, used non-UL (Underwriter Laboratories) approved power strip	K 920	It is the policy of ANRC to connect electrical devices directly into electrical receptacles and use UL approved power strip cords in residents rooms. . How corrective action will be accomplished for those residents affected by the deficient practice: . The maintenance supervisor immediately removed the non-UL approved power strip cord in Room 202 after explaining the regulation to the resident and family. . The ADM immediately purchased federally approved power strip cords to be used in residents rooms (UL 1363A). . How the facility will identify other residents having the potential to be affected by the same deficient practice: . No other resident's room was found to be using a federally non-approved UL power strip cord during the maintenance inspection.	

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K 920	Continued From page 16 cords. Federally approved over-current (surge) protection devices are designed to protect equipment and structures from fire. Findings: On May 31, 2018, at 12:52 p.m., during a life safety code tour of the facility, the evaluator observed a non-UL (Underwriter Laboratories) approved power strip cord in Room 202. The non-UL (Underwriter Laboratories) approved power strip was connected to an electric fan, a computer, a monitor screen, a clock, a separate air-conditioning fan, and a phone charger. On May 31, 2018, during an interview with the maintenance supervisor, he stated that he would replace the non-UL approved power cord with a UL approved power cord. The deficient practice affected one out of eight smoke compartments. The deficiency was brought to the attention to the administrator and the maintenance supervisor at the exit conference on May 31, 2018.	K 920	Measure and systemic changes to be in place to ensure the deficient practice does not recur: . The ADM in-serviced the maintenance supervisor and staff on 6/7/18 at 11:00am regarding the use of only federally approved UL power strip cords in residents rooms. . How facility plans to monitor its performance to make sure that solutions are sustained: . The maintenance supervisor will conduct routine rounds to ensure that only federally approved UL power strip cords are used in residents rooms. . Any findings will be discussed with the ADM for corrective action and the facility QAPI will monitor compliance during the quarterly review. . Corrective action date / compliance date:	6/28/18

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 07598 Bed capacity: 218 Census: 159	E 000	This Plan of Correction constitutes the facility's (Astoria Nursing and Rehabilitation Center) written credible allegation of compliance for the deficiencies noted. This Plan of Correction was completed/corrected on 6/28/18. . Submission of this Plan of Correction does not constitute admission or agreement by the facility of the truth of the finding, conclusions and/or deficiencies alleged, or if these deficiencies were cited correctly.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based	E 039	. This Plan of Correction is solely prepared and executed because it is required by provisions of the Health & Safety Code Section 1280 & 42 C.F.R. 483.70 of the California Health and Safety Code. . Abbreviations: ANRC: Astoria Nursing & Rehabilitation Center ADM: Administrator	

2018 JUN 28 AM 10:35

LOS ANGELES COUNTY HEALTH FACILITIES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 06-28-2018

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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E 039	Continued From page 1 full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a table top exercise that includes a group discussion led by a facilitator	E 039	It is the policy of ANRC to ensure that a table top exercise is conducted as preparation for Emergency Disaster Operation Plan for the facility. . How corrective action will be accomplished for those residents affected by the deficient practice: . A full scale emergency and disaster table top exercise was conducted by the ADM from 6/25-27/18. . How the facility will identify other residents having the potential to be affected by the same deficient practice: . No resident was affected while the table top exercise was being conducted. . Measures and systemic changes to be in place to ensure the deficient practice doe not recur: . The ADM will schedule a routine annual table top exercise. . Training and exercise will be scheduled yearly.	

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E 039	Continued From page 2 using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages or prepared questions designed to challenge an emergency plan. The lack of this table top exercise could affect the performance of staff in providing care and services to the residents, during an actual emergency. Findings: On May 30, 2018, a review of the facility's emergency preparedness plan revealed no documentation to verify a tabletop exercise (including analyzing the facility's response during these exercises), had been conducted. On May 30 2018, at 4:00 p.m., an interview was conducted with the administrator regarding facility's emergency preparedness documentation, specifically for emergency preparedness testing. The administrator stated that the facility will schedule an emergency preparedness full-scale exercise in the near future in accordance with the regulatory requirement. The deficiency was discussed with the administrator during the exit conference on May 31, 2018.	E 039	How the facility plans to monitor its performance to make sure that solutions are sustained: . The ADM will monitor compliance yearly and will be addressed with the facility QAPI for compliance. . Corrective action date / compliance date:	6/28/18