STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/13/2016

9/13/16 #16279

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(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, 2000 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: Evaluator #: 16279, REHS, HFE I Resident census: 38 Bed capacity: 43 Highest Scope & Severity: D	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 ensure that hazardous areas were maintained with a one hour fire rated construction, by failing to maintain one of two soiled linen room doors to close automatically. In the event of a fire, the separation of this room would not be achieved, which would allow smoke	K 029	• On August 12, 2016, the Maintenance Supervisor checked all the doors of the facility. He did not find a similar deficiency except for one of the two doors of the soiled linen room in the basement which did not have an automatic self-closing device.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Armando Yu	ADMINISTRATOR	9-2-16

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 029	Continued From page 1 and/or fire to travel from one area to another. Findings: On August 12, 2016, between 8:50 a.m. and 11:05 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 9:50 a.m., it was observed that the soiled linen room (in the basement) that was over 50 square feet (sq. ft.). Upon closer observation, it was noticed that this soiled linen room was slightly over 50 square feet (sq. ft.) and one of the two doors (near the washing machines) did not have a self-closing device to automatically close, latch and maintain the door in a closed position. (According to NFPA 101, Life Safety Code, 2000 Edition, 19.3.2.1, 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 all doors to the soiled linen room must have self-closing devices on the doors. He stated that he would provide a self-closing device on this door, as soon as possible. The deficient practice affected one of three smoke compartments. On August 12, 2016, and August 13, 2016, the above finding was acknowledged during the survey process and during the exit conference, with the administrator and the maintenance	K 029	• The Administrator in-serviced the Environmental Director and Maintenance Supervisor regarding the importance of separating the soiled linen area from the adjoining rooms with doors equipped with self-closing gadget. This would ensure that in the event of a fire, the closed doors would not allow smoke and/ or fire to travel from the room to adjoining areas or vice versa. • The Maintenance Supervisor during his daily rounds will check to ensure that hazardous areas are separated from other spaces by doors that are equipped with self-closing devices. •The Environmental Director will monitor to ensure compliance and the findings will be discussed with the QAA Committee for further recommendation if needed. • Date of compliance 08/31/16	8/31/16

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K 029	Continued From page 2 supervisor.	K 029	• On August 13, 2016, a "NO SMOKING" sign was immediately posted outside of the door of the Rehab room.	
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) This STANDARD 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 tanks are stored in accordance with 19.3.2.4 NFPA 99 8.6.4.2. Areas where oxygen is being stored without a "No Smoking" sign may increase the risk for fire emergencies. Findings: On August 13, 2016, between 8:55 a.m. and 10:50 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 9:10 a.m., it was observed that a "crash" cart (which was not in use), with a 25 cubic foot oxygen tank, was inside the rehab room, next to Room 117. Upon closer observation, it was observed that a "No Smoking" sign was not posted, outside of this room. At 9:18 a.m., an interview was conducted with the director of nursing regarding the missing "No Smoking" sign. During this interview, the director	K 141	• On August 13, 2016 the DSD inspected all the areas of the Facility where oxygen is used or stored and found all the areas are conspicuously posted with "NO SMOKING" signs to decrease the risk of potential fire emergencies. • The Director for Staff Development in-serviced all staff on 8/15/18, 8/17/16 and 8/29/16 regarding the need to post "NO SOMKING" sign where oxygen is used of stored. Bi-Annual follow-up in services will be included in the yearly in-service calendar to ensure continued compliance y the Facility. • The Department Heads during their daily rounds will monitor that there are "NO SMOKING" signs posted in areas where oxygen are in use or stored. Findings will be discussed during the daily stand-up meetings and will be reported during the quarterly QAA Committee meetings for corrective actions as needed. • Date of compliance 08/31/16	8/31/16

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K 141	Continued From page 3 of nursing stated that a "No Smoking" sign should be posted outside this room and that a sign would be posted, immediately. At 9:55 a.m., a review the facility's oxygen safety policy and procedure (dated August 2002) was conducted. The policy stated that "No Smoking" signs must be clearly visible in areas where oxygen is stored or in use. The deficient practice affected one of three smoke compartments. On August 13, 2016, the above finding was acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 141		