Department of Public Health
Barbara A. Garcia, MPA, Director of Health

Edwin M. Lee
Mayor

Laguna Honda Hospital and Rehabilitation Center
Mivic Hirose, RN, CNS, Executive Administrator

VIA US POSTAL SERVICE AND FAX: (909) 383-4452

October 3, 2016

Ms. Marian De Meire, Chief
California Department of Public Health
Licensing and Certification Program
Life Safety Code Unit
464 W. 4th Street, Suite 454A
San Bernardino, CA 92401

RE: Annual Life Safety Code Recertification Survey
Laguna Honda Hospital and Rehabilitation Center D/P SNF
Provider Number: 555020

Dear Ms. De Meire:

Please find enclosed Laguna Honda Hospital's response to the above referenced Form CMS 2567 Statement of Deficiencies and Plan of Correction Form.

If additional information is required, please call Regina Gomez, Director of Quality Management, at (415) 759-3053.

Sincerely,

Mivic Hirose, RN, MSN, CNS
Executive Administrator

MH:sn

Enclosures

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

PRINTED: 09/22/2016
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
	555020	A. BUILDING 03 B. WING	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 12/2010 K7 SURVEY UNDER: 2000 NEW STRUCTURE TYPE: CONSTRUCTION TYPE I (443), FULLY SPRINKLERED. North Tower: 7 Story Building South Tower: 6 Story Building Pavilion: 4 Story Building. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 Edition, New codes. Representing the California Department of Public Health: 31201 31203 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 749	K 000	This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("Laguna Honda" or "facility") as required by regulation, to the Statement of Deficiencies (Form CMS-2567) issued by the CA Department of Public Health on September 22, 2016, and received by the facility on September 22, 2016, during an annual recertification Life Safety Code Survey which began on September 12, 2016 and concluded on September 15, 2016. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on this Form CMS-2567 or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the integrity of the building	K 012	The facility is designed, constructed and maintained to prevent the passage of smoke or fire from one location of the building to another.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Hume | TITLE: Executive Administrator | (X6) DATE: 10/3/2016

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 012	Continued From page 1 construction as evidenced by unsealed penetrations in the ceilings and walls. This affected two of four floors in the Pavilion Building, and two of seven floors in the North Tower. This could result in the passage of smoke or fire to other locations in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition 18.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on	K 012	North Tower: 1. The wall penetration in Room N2021 was sealed by Facility Services staff. 2. The wall penetration in Room N1014 was sealed by Facility Services staff. Pavilion Building: 3. The ceiling penetration in Room PG158 was actually a 12 inch by 12 inch ceiling tile that was replaced by Facility Services staff. 4. The two wall penetrations in Room M023 were sealed by Facility Services staff. 5. The ceiling tile in Room P2141 was replaced by Facility Services staff. A read and sign review of educational slides will be provided to neighborhood staff reminding them to complete a work order if they observe any unsealed wall or ceiling penetrations in any of the rooms on the North and South Towers and the Pavilion Building. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material.	9/15/16 9/15/16 9/27/16 9/27/16 9/27/16 10/15/16

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K 012	Continued From page 2 either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) *Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier.	K 012	Facility Services supervisors are responsible for tracking the work order system weekly to verify completion of repair work. Director of Facility Services is responsible for compliance. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor for unsealed wall and ceiling penetrations. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 10/15/16 and on-going

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K 012	Continued From page 3 b. The material shall be protected by an approved device that is designed for the specific purpose. Findings: During a tour of facility Engineering Staff on 9/14/16 and 9/15/16, the ceilings and walls were observed. North Tower - 9/14/16 1. At 10:21 a.m., there were two approximately ¼ inch in diameter unsealed penetrations in the wall in Room N2021 located on the Second floor. This finding was confirmed by Engineering Staff. 2. At 10:54 a.m., there was an approximately 8 inch by 1 inch unsealed penetration in the wall in Room N1014 located on the first floor. This finding was confirmed by Engineering Staff. PAVILION Building - 9/14/16 3. At 2 p.m., there was an approximately 12 feet by 12 feet penetration in the ceiling, in Room PG158 located on the ground floor. This finding was confirmed by Engineering Staff. 4. At 2:35 p.m., there were two wall penetrations measuring approximately 6 inch by 2 inch behind a bed, in Room M023 located on the Mezzanine floor. When interviewed, Engineering Staff stated that the rubber bumpers were missing on both side of the bed. Pavilion Building - 9/15/16 5. At 10:25 a.m., there was an approximately 4 inch by 6 inch penetration in the ceiling from a broken ceiling tile in Room P2141 on the second	K 012		

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K 012	Continued From page 4 floor. When interviewed, the Engineering Staff stated that the staff must have hit and broke the ceiling tile by a broom.	K 012		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors to resist the passage of smoke and/or fire. This was evidenced by a door that was obstructed from closing and by a door that required force to open. This affected one of seven floors in the North Tower, and one of four floors in the Pavilion Building. This could result in the passage smoke and flames in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition 18.2.3.6.3 Doors shall be provided with latches or other mechanisms suitable for keeping the doors closed. No doors shall be arranged to prevent the occupant from closing the door. 18.2.3.6.4 Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Exception: Door-closing devices shall not be required in buildings protected throughout by an	K 018	The facility is designed, constructed, equipped and maintained with doors that are intact and latch completely to resist the passage of smoke. North Tower: 1. Facility Services staff readjusted the door to Room N325 so that the door opens easily and closes completely to resist the passage of smoke. Pavilion Building: 2. Facility Services staff cut and removed the airline tube from the door lever to Room P1176. In addition Facility Services staff checked on the operability of the door to Room P1176, making sure that the door with the self-closing device is fully functional. A read and sign review of educational slides will be provided to neighborhood staff reminding them to complete a work order when they find a door that does not easily open or does not completely close in any of the rooms on the North and South Towers and the Pavilion Building. Staff will also be reminded not to tie or prop doors open. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material.	9/15/16 9/15/16 10/15/16

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K 018	Continued From page 5 approved automatic sprinkler system in accordance with 19.2.3.5.2. 7.2.1.8 Self-Closing Devices. 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the holdopen mechanism is released and the door becomes selfclosing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be	K 018	Facility Services supervisors are responsible for tracking the work order system weekly to verify completion of repair work. Director of Facility Services is responsible for monitoring compliance. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor the condition of doors that they open easily and fully latch when closed, and with staff compliance in not propping or tying doors to keep them open. Reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 10/15/16 and on-going

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K 018	Continued From page 6 located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1:* Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. Findings: During a tour of the facility and interview with Engineering Staff on 9/14/16 and 9/15/16, the corridor doors were observed. North Tower - 9/14/16 1. At 10:10 a.m., the door to Room N325 required force to open once in the closed position. The Engineering Staff acknowledged the finding and stated that the door needs to be adjusted.	K 018		

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K 018	Continued From page 7 Pavilion Building- 9/15/16 2. At 10:30 a.m., the door to Room P1176 was equipped with a self-closing device that was held open by an airline tube that was tied from the door lever and the storage rack. The Engineering Staff confirmed the finding and cut the airline tube to release the door.	K 018		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non- rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire doors. This was as evidenced by a fire door that failed to latch. This could result in the passage of smoke or fire in an emergency and affected one of six floors in the South Tower. NFPA 101, Life Safety Code, 2000 Edition 18.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 18.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027	The facility is designed, constructed, equipped, and maintains fire doors to continuously serve as a barrier to prevent the spread of smoke and /or fire. South Tower: 1. Facility Services stff adjusted the door latching mechanism to the right leaf of the double fire doors to the Marina Suite household to positively latch when closed. Monthly inspections will be conducted by the carpenters to identify fire doors that do not fully latch when closed upon activation of the fire alarm system and to adjust the door and the door latching mechanism to positively latch when closed. Director of Facility Services is responsible for monitoring compliance.	9/15/16 10/15/16

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K 027	Continued From page 8 18.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair. 8.2.3.2 Fire Protection-Rated Opening Protectives.	K 027	A read and sign review of educational slides will be provided to neighborhood staff reminding them to complete a work order when they find a fire door that does not fully close when released by the activation of the fire alarm system. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Facility Services supervisors are responsible for tracking the work order system weekly to verify completion of the repair work. Director of Facility Services is responsible for compliance. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor that fire doors fully close upon activation of the fire alarm system. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 10/15/16 10/15/16 and on-going

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K 027	Continued From page 9 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) *Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. NFPA 80 Standard for Fire Doors and Fire Windows, 1999 Edition 1-5.1 Listed items shall be identified by a label. Labels shall be applied in locations that are readily visible and convenient for identification by the authority having jurisdiction after installation of the assembly. 2-4.1.2* A closing device shall be installed on every fire door. Exception: With approval by the authority having jurisdiction, where pairs of doors are provided for mechanical equipment rooms to allow the movement of equipment, the device shall be permitted to be omitted on the inactive leaf. 2-4.1.3 All components of closing devices used shall be attached securely to doors and frames by steel screws or through-bolts. 2-4.1.4* All closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation.	K 027		

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	555020	A. BUILDING 03 B. WING _____	09/15/2016

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K 027	Continued From page 10 Findings During fire alarm testing with the Engineering Staff on 9/15/16, the fire doors were observed. At 11:41 a.m., the right leaf of the double fire doors near the Marina Suite did not latch when released from its magnetic hold-open device upon activation of the fire alarm system. The Engineering Staff acknowledged the finding and stated that the top latch didn't retract all the way.	K 027		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all staff were familiar with procedures during fire drills. This was evidenced by failure to provide fire drill document and staff participation document during one of twelve quarterly fire drills. This affected three of six floors in the South Tower. This could result in staff not being familiar with fire and emergency procedures in the event of an emergency.	K 050	Fire drills are conducted at least quarterly on every shift at unexpected times under varying conditions. Drills will include the transmission of fire alarm signals when conducted between the hours of 6 am to 9 pm. Facility Services staff assigned to conduct fire drills has been trained to review the Fire Drill Participation forms and analyze staff responses for completeness and if review criteria are met. If a neighborhood Fire Drill Participation record is not submitted to Facility Services within 1 hour of the drill, the Safety Engineer is responsible for notifying the designated neighborhood Nurse manager and requesting that the Fire Drill Participation form be completed and submitted by the end of the shift. If the Fire Drill Participation form is not received by end of shift from the neighborhood Nurse Manager, the Safety Engineer will request that a repeat fire drill be conducted. The Nurse Manager is responsible for completing the Fire Drill Participation form and the Safety Engineer is responsible for monitoring compliance.	10/15/16

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K 050	Continued From page 11 NFPA 101, Life Safety Code, 2000 Edition 18.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 18.7.2 Procedure in Case of Fire. 18.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 18.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 18.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must	K 050	The Senior Stationery Engineer and the Chief Stationery Engineer are responsible for reviewing and analyzing the Fire Drill Participation forms monthly, assessing and following up on any issues with the fire drills. Director of Facility Services is responsible for monitoring staff compliance with facility procedures. A read and sign review of educational slides will be provided to neighborhood staff reminding them of the importance of fire drill participation, documenting their participation and submitting the Fire Drill Participation forms to the Safety Engineer. The Nurse Educator is responsible for developing the educational slides. Nurse Managers are responsible for monitoring staff compliance with review of the instructional material. Neighborhood submission of the Monthly Fire Drill Participation reports will be aggregated monthly and submitted to the Performance Improvement and Patient Safety (PIPS) Committee quarterly by the Director of Facility Services. Chief Operating Officer is responsible for reporting compliance.	10/15/16 10/15/16 10/15/16 and on-going

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K 050	Continued From page 12 immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. 18.7.1.2* Fire drills in health care occupancies shall include the transmission of fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours)and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. Findings: During document review and interview with Engineering Staff on 9/13/16, the fire drill records were reviewed. At 12:07 p.m., the facility failed to provide documentation for one fire drill and documentation that staff participated during the fourth quarter (October/November/December) NOC shift fire drill that was conducted on 10/16/15; for floors four, five, and six in the South Tower.	K 050		

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K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its automatic sprinkler system. This was evidenced by the failure to provide an annual sprinkler test and inspection, by sprinklers that did not have at least 18 inch clearance between the deflector and the top of the storage, and by an escutcheon ring that was not flush with the ceiling. This could result in a sprinkler malfunction in the event of a fire and affected the North Tower, South Tower and the Pavilion Building. NFPA 101, Life Safety Code, 2000 Edition SECTION 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 062	The facility has installed and maintained an automatic sprinkler system in reliable operating condition that is periodically inspected and tested. 1. Director of Facility Services will request for the 2016 annual maintenance and testing report of the automatic sprinkler system from the assigned alarm vendor. Chief Operating Officer is responsible for monitoring compliance. The Chief Engineer will be assigned responsibility for tracking the vendor's completion of the 2017 annual maintenance and testing report of the automatic sprinkler system by the assigned alarm vendor. Director of Facility Services will be responsible for monitoring compliance. North Tower: 2. Facility Services staff removed the box that was placed on the top shelf in Room N1064 to provide the required 18 inch clearance.	10/15/16 10/15/16 and on-going 9/14/16

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K 062	Continued From page 14 NFPA 25 Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection System; 1998 Edition 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.1.3 The supply of spare sprinklers shall be inspected annually for the following: (a) The proper number and type of sprinklers (b) A sprinkler wrench for each type of sprinkler 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	Pavilion Building: 3. The box that was placed on the top shelf was removed to provide the required clearance between the sprinkler and #5 refrigerator in the Kitchen. 4. The escutcheon ring in Freezer # 1 in the kitchen has been re-installed flush to the ceiling by Facility Services staff. A read and sign review of educational slides will be provided to neighborhood and Kitchen staff reminding them not to place items on the top shelf of storage areas or on top of refrigerators and freezers that may impede the 18 inch clearance from sprinkler heads. Hospital-wide staff will also be reminded to promptly submit a Facility Services work order when they observe that an escutcheon ring in their work area is not flush with the ceiling and there is a gap noted. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material.	9/14/16 9/14/16 10/15/16

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K 062	Continued From page 15 2-2.3* Hangers and Seismic Braces. Sprinkler pipe hangers and seismic braces shall be inspected annually from the floor level. Hangers and seismic braces shall not be damaged or loose. Hangers and seismic braces that are damaged or loose shall be replaced or refastened. Exception No. 1: *Hangers and seismic braces installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Hangers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.5 Buildings. Annually, prior to the onset of freezing weather, buildings with wet pipe systems shall be inspected to verify that windows, skylights, doors, ventilators, other openings and closures, blind spaces, unused attics, stair towers, roof houses, and low spaces under buildings do not expose waterfilled sprinkler piping to freezing and to verify that adequate heat [minimum 40°F (4.4°C)] is available. 9-2.6* Main Drain Test. A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. 9-3.4.1* Each control valve shall be operated annually through its full range and returned to its normal position. Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter	K 062	Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor compliance with 18 inch clearance between the deflector and the top of shelves, refrigerators and freezers; and escutcheon rings that are not flush with the ceiling. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 and on-going

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K 062	Continued From page 16 turn from the fully open position to prevent jamming. Exception: This test shall be conducted every time the valve is closed. 9-3.4.2 A main drain test shall be conducted annually and any time the valve is closed at each system after the control valve has been closed to determine whether there has been a change in the condition of the water supply piping and control valves. 9-3.5 Maintenance. The operating stems of outside screw and yoke valves shall be lubricated annually. The valve then shall be completely closed and reopened to test its operation and distribute the lubricant. 9-5.5.1.2 During the annual fire pump test, it shall be verified that the circulation relief valve closes in accordance with the manufacturer ' s specifications. 9-5.5.2.2 During the annual fire pump flow test, it shall be verified that the pressure relief valve is correctly adjusted and set to relieve at the appropriate pressure and to close below that pressure setting. 9-6.2.1* All backflow preventers installed in fire protection system piping shall be tested annually in accordance with the following: (a) A forward flow test shall be conducted at the system demand, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. (b) A backflow performance test, as required by the authority having jurisdiction, shall be conducted at the completion of the forward flow	K 062		

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K 062	Continued From page 17 test. Exception No. 1: For backflow preventers sized 2 in. (50.8 mm) and under, it shall be acceptable to conduct the forward flow test without measuring flow, where the test outlet is of a size to flow the system demand. Exception No. 2: Where water rationing shall be enforced during shortages lasting more than 1 year, an internal inspection of the backflow preventer to ensure the check valves will fully open shall be acceptable in lieu of conducting the annual forward flow test. Exception No. 3: Where connections of a size sufficient to conduct a full flow test are not available, tests shall be completed at the maximum flow rate possible. Exception No. 4: The forward flow test shall not be required where annual fire pump testing causes the system demand to flow through the backflow preventer device. 9-6.2.2* All backflow devices installed in fire protection water supply shall be tested annually at the designed flow rate of the fire protection system, including hose stream demands, if appropriate. Exception: Where connections of a size sufficient to conduct a full flow test are not available, tests shall be conducted at the maximum flow rate possible. CHAPTER 5 FIRE PUMPS (if applicable) 5-3.3 Annual Tests. 5-3.3.1* An annual test of each pump assembly shall be conducted under minimum, rated, and peak flows of the fire pump by controlling the quantity of water discharged through approved test devices. This test shall be conducted as described in 5-3.3.1(a), (b), or (c).	K 062		

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K 062	Continued From page 18 Exception:* If available suction supplies do not allow flowing of 150 percent of the rated pump capacity, the fire pump shall be operated at maximum allowable discharge. This reduced capacity shall not constitute a noncompliant test. (a) Use of the pump discharge via the hose streams; pump suction and discharge pressures and the flow measurements of each hose stream shall determine the total pump output. Care shall be taken to prevent water damage by verifying there is adequate drainage for the high-pressure water discharge from hoses. (b) Use of the pump discharge via the bypass flowmeter to drain or suction the reservoir; pump suction and discharge pressures and the flowmeter measurements shall determine the total pump output. (c) Use of the pump discharge via the bypass flowmeter to pump suction (closed-loop metering); pump suction and discharge pressures and the flowmeter measurements shall determine the total pump output. Where the annual test is conducted periodically in accordance with 5-3.3.1(c), a test shall be conducted every 3 years in accordance with 5-3.3.1(a) or (b) in lieu of the method described in 5-3.3.1(c). Where 5-3.3.1(b) or (c) is used, the flowmeter shall be adjusted immediately prior to conducting the test in accordance with the manufacturer ' s instructions. If the test results are not consistent with the previous annual test, 5-3.3.1(a) shall be used. If testing in accordance with 5-3.3.1(a) is not possible, a flowmeter calibration shall be performed and the test shall be repeated. 5-3.3.2 The pertinent visual observations, measurements, and adjustments specified in the following checklist shall be conducted annually	K 062		

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K 062	Continued From page 19 while the pump is running and flowing water under the specified output condition. During a tour of the facility, interview, and document review with Engineering Staff on 9/13/16 to 9/14/16, the automatic sprinkler systems were observed and document reviewed. 1. On 9/13/16, at 10:30 a.m., the facility failed to provide the annual maintenance and testing of the automatic sprinkler system upon request. The facility's alarm vendor conducts the waterflow test quarterly. When interviewed, Engineering Staff stated the alarm vendor only conducts the alarm device on the waterflow and nothing else. North Tower - 9/14/16 2. At 11:12 a.m., the sprinkler in Room N1064 on the first floor located in the North Tower had approximately 6 inch clearance between the deflector and a box placed on top of the shelve. This finding was acknowledged by Engineering Staff and they removed the box from the shelf. Pavilion Building - 9/14/16 3. At 9:59 a.m., the sprinkler in #5 refrigerator in the Kitchen on the second floor located in the Pavilion had approximately 10 inch clearance between the deflector and a box placed on top of the shelve. This finding was confirmed by the Engineering Staff. 4. At 10:02 a.m., the escutcheon in #1 freezer in the Kitchen on the second floor located in the Pavilion was not flushed with ceiling. The escutcheon dropped approximately ½ inch from the ceiling. This finding was confirmed by the Engineering Staff.	K 062		

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K 064 K 064 SS=D	Continued From page 20 NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their portable fire extinguisher. This was evidenced by a portable fire extinguisher that was not securely mounted. This could result in a damaged portable fire extinguisher, in the event of a fire emergency. This affected one of three floors in the Pavilion Building. NFPA 101, Life Safety Code, 2000 Edition 9.7.4 Manual Extinguishing Equipment 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition 1-7.7* Portable fire extinguishers other than wheeled types shall be securely installed on the hanger or in the bracket supplied or placed in cabinets or wall recesses. The hanger or bracket shall be securely and properly anchored to the mounting surface in accordance with the manufacturer's instructions. Wheeled type fire extinguishers shall be located in a designated location. Findings: During a tour of the facility with the Engineering	K 064 K 064	The facility provides and maintains portable fire extinguishers in accordance with 9.7.4. NFPA 10, 18.3.5.6 Pavilion Building: 1. The fire extinguisher observed in Room 251, Fire Protection Room, was removed and discarded. A read and sign review of educational slides will be provided to hospital-wide staff on the standards of maintaining fire extinguishers in the work area, including checking that the inspection tag is current and has been inspected by Facility Services staff during the past month. Staff will be instructed to submit a Facility Services work order if they find a fire extinguisher with a past due inspection date. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. The Safety Engineer is responsible for reviewing the log of monthly fire extinguisher inspections. The Senior Stationary Engineer is responsible for verifying that the annual fire extinguisher inspections has been performed by contracted services. The Chief Stationary Engineer is responsible for monitoring compliance.	9/13/16 10/15/16 10/15/16

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K 064	Continued From page 21 Staff on 9/13/16, the portable fire extinguishers were observed. At 2:21 p.m., a 20 pound portable fire extinguisher in Room 251, Fire Protection Room was sitting unsecured on the floor. The last annual inspection conducted by a vendor was dated 4/26/2006. When interviewed, Engineering Staff stated that the fire extinguisher has been sitting on the floor for a week, is not in use, and they will call their vendor.	K 064	Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor that fire extinguishers are securely placed, visually inspected monthly, and undergoes an annual hydrostatic test. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 and on-going
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the kitchen range hood suppression system (ANSUL system). This was evidenced by a nozzle cap that was missing. This affected one of four floors in the Pavilion Building and could result in a failure to extinguish fire in the kitchen. NFPA 101, Life Safety Code, 2000 Edition 18.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3 9.2.3 Commercial cooking equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protecting of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction NFPA 96, Standard for Ventilation Control and Fire Protecting of Commercial Cooking	K 069	The facility provides and maintains the kitchen range hood suppression system (ANSUL system) in good working condition including the provision of kitchen nozzle blow caps to prevent the entrance of grease vapors, moisture and other foreign materials into the piping. The missing nozzle blow cap for the ANSUL system sprinkler head above the grille in the Cafeteria was replaced by Facility Services staff. A read and sign review of educational slides will be provided to Kitchen staff on the standards of maintaining the kitchen nozzle blow caps for the ANSUL system sprinkler heads. Staff will be instructed to submit a Facility Services work order when they find that the nozzle blow cap for the ANSUL system sprinkler head is missing. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff	9/27/16 10/15/16

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K 069	Continued From page 22 Operations, 1998 Edition 7-2.2.1 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer 's instructions, and the following standards where applicable. (a) NFPA 12, Standard on Carbon Dioxide Extinguishing Systems (b) NFPA 13, Standard for the Installation of Sprinkler Systems (c) NFPA 17, Standard for Dry Chemical Extinguishing Systems (d) NFPA 17A, Standard for Wet Chemical Extinguishing Systems NFPA 17A, Standard for Dry Chemical Extinguishing Systems, 1998 Edition 2-3.1.4 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. Findings: During a tour of the facility with Engineering Staff on 9/15/16, the kitchen nozzle caps were observed. At 10:49 a.m., one of seven nozzle blow caps for the ANSUL system sprinkler heads above the grille was missing in the Cafeteria. The previous maintenance service was conducted on 8/26/16. This finding was acknowledge by Engineering Staff.	K 069	compliance with review of the instructional material. Life Safety Code (LSC) rounds are conducted in the Kitchen by Facility Services staff and the Industrial Hygienist to monitor the condition of sprinkler heads and the nozzle blow caps for the ANSUL system. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 and on-going
K 071	NFPA 101 LIFE SAFETY CODE STANDARD	K 071		

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K 071 SS=E	Continued From page 23 Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the required protective separation features for the laundry chute. This affected two of seven floors in the North Tower and one of six floors in the South Tower. This could result in the spread of fire and smoke in the event of a fire in the chute. NFPA 101, Life Safety Code, 2000 Edition SECTION 9.5 RUBBISH CHUTES, INCINERATORS, AND LAUNDRY CHUTES 9.5.1 Enclosure. Rubbish chutes and laundry chutes shall be separately enclosed by walls or partitions in accordance with the provisions of Section 8.2. Inlet openings serving chutes shall be protected in accordance with Section 8.2. Doors of such	K 071	The facility maintains a linen chute system that has protective separation features to prevent the spread of fire and smoke in the event of a fire in the chute. North Tower: 1. The self-closing laundry chute door in Room N1012 was repaired by Facility Services staff. 2. Facility Services staff removed the bags of soiled linen that was preventing the linen chute door from closing and checked that the laundry chute door fully latched when released. South Tower: 3. The self-closing laundry chute door in Room S4012 was repaired by Facility Services staff. A read and sign review of educational slides will be provided to Nursing and Environmental Services staff on the importance of maintaining a linen chute system that is free from obstruction and has protective separation features to prevent the spread of fire and smoke in the event of a fire in the chute. Staff will be instructed to submit a Facility Services work order when they find that the laundry chute door does not fully latch when released. The Nurse Educator is responsible for developing the educational slides. Managers are	9/26/16 9/14/16 9/21/16 10/15/16

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K 071	Continued From page 24 chutes shall open only to a room that is designed and used exclusively for accessing the chute opening. The room shall be separated from other spaces in accordance with Section 8.4. Exception No. 1: Existing installations having properly enclosed service chutes and properly installed and maintained service openings shall be permitted to have inlets open to a corridor or normally occupied space. Exception No. 2: Rubbish chutes and laundry chutes shall be permitted to open into rooms not exceeding 400 ft2 (37 m2) in area used for storage, provided that the room is protected by automatic sprinklers. 9.5.2 Installation and Maintenance. Rubbish chutes, laundry chutes, and incinerators shall be installed and maintained in accordance with NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Findings: During a tour of the facility and interview with Engineering Staff on 9/14/16, the laundry chutes were observed and staff interviewed. North Tower 1. At 10:54 a.m., the laundry chute door in Room N1012 located on the First floor failed to latch when fully opened and released. The laundry chute door was tested three times. This finding was confirmed by Engineering Staff. 2. At 11:35 a.m., the laundry chute door tied into the fire alarm system was obstructed by piles of soiled linen bags which will prevent the door from	K 071	responsible for monitoring staff compliance with review of the instructional material. Facility Services supervisors are responsible for tracking the work order system weekly to verify completion of repair work. Director of Facility Services is responsible for compliance. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor that linen chute doors positively latch when opened and released and that the linen chute system is free from obstruction. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 10/15/16 and on-going

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K 071	Continued From page 25 closing in the event the fire alarm system is activated. The Engineering Staff acknowledged the finding and stated, the door would not close if fire alarm was activated and removed the bags of soiled linen. South Tower 3. At 2:08 p.m., the laundry chute door in Room S4012 located on the Fifth floor failed to latch when fully opened and released. The laundry chute door was tested three times. This finding was confirmed by Engineering Staff.	K 071	The facility maintains an environment free of combustible decorations to reduce the risk of spread of fire. North Tower: Nursing staff explained to the resident in room N147 the findings of the Life Safety Code Surveyor. The stuffed that were toys hung on the wall in Room N147 were removed and placed inside resident's dresser per the resident's preference.	9/15/16
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their facility free of combustible decorations. This was evidenced by flammable decorations attached to the wall. This could lead to an increased spread of fire and affected one of seven floors in the North Tower NFPA 101, Life Safety Code, 2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.	K 073	The Chief Nursing Officer sent a memo to Nursing staff reminding them that combustible decorations are not permitted to be attached to walls as they pose an increased risk to the spread of fire. A limited number of stuffed animals may be placed on the resident's hutch or they may be kept inside the cabinet or dresser drawers. Neighborhood Charge Nurses were instructed to check other resident rooms for compliance with the Life Safety Code rules on flammable decorations. The Nurse Manager is responsible for monitoring compliance. A read and sign review of educational slides will be provided to neighborhood staff on the importance of maintaining an environment free of combustible decorations to reduce the risk of fire development or spread of fire. Only decorations that are certified as flame retardant may be used. The Nurse Educator is responsible for developing the	9/30/16 10/15/16

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K 073	Continued From page 26 Findings: During a tour of the facility and interview with Engineering Staff and Charge Nurse on 9/14/16, the flammable decorations in the facility were observed and staff interviewed. At 11:04 a.m., there were eleven medium sized stuffed toys hung on the wall with push pins in Suite A in Room N147 located on the first floor. When interviewed, the Charge Nurse stated that the staff are aware of the issue and there is a care plan to minimize combustibles in the resident's room. This finding was confirmed by Engineering Staff.	K 073	educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor for the presence of combustible decorations in the resident rooms and the environment. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 and on-going
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the storage of oxygen gas cylinders as evidenced by failure to mark and segregate empty cylinders from full cylinders. This affected two of seven floors in the North Tower and could result in confusion and delay in the event of an emergency.	K 076	The facility maintains medical gas storage and administration areas in accordance with NFPA 99, Standard for Health Care Facilities. North Tower: 1. The two unmarked empty E-cylinders in the oxygen storage cabinet in Room N3053 were tagged with "Empty" signs and separated from the full E-cylinders. 2. The one unmarked empty E-cylinders in the oxygen storage cabinet in Room N1053 was tagged with "Empty" signage and separated from the full E-cylinders.	9/14/16 9/14/16

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K 076	Continued From page 27 NFPA 101, Life Safety Code, 2000 Edition 18.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 18.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.	K 076	Charge Nurses on Pavilion Mezzanine, South 2, South 4 and South 6 neighborhoods were instructed to check on the segregation of full and empty oxygen cylinders, and that the oxygen cylinders had the proper signage on them. Nurse Managers are responsible for monitoring compliance. The Chief Nursing Officer sent a memo to Nursing staff on the revised procedure for E-cylinder oxygen storage and signage. The E-cylinder oxygen storage cabinet/slots are to be segregated from "Full/Ready to Use" oxygen cylinders and "Empty" oxygen cylinders. The first 2 left side slots will be designated for "Full/Ready To Use" oxygen cylinders, and the 2 right side slots will be designated for "Empty" oxygen cylinders. Full oxygen cylinders will be delivered and tagged with "FULL/Ready To Use" signage by Central Supply staff and placed on the first this left side/slots of the oxygen storage cabinet. Nursing staff who return an empty oxygen cylinder is responsible for replacing the "FULL/Ready To Use" tag with an "EMPTY" tag. The "Empty" tags will be kept hanging on the oxygen storage cabinet doors. The empty oxygen cylinders will be placed on the designated 2 right side oxygen slots. Licensed Nurses on the Day shift are responsible for checking the proper storage of oxygen cylinders. Charge Nurses are responsible for monitoring compliance with the revised procedure.	9/14/16 9/30/16

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K 076	Continued From page 28 NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 16 Nursing Home Requirements 16-3.8 Gas Equipment Requirements. 16-3.8.1 Patient. Equipment shall conform to requirements for patient equipment in Chapter 8. Chapter 8 Gas Equipment 8-3.1.11.1 Storage Requirements 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft.3 (85 m3) shall comply with 4-3.1.1.2 and 4-3.5.2.2. Chapter 8 Gas Equipment 8-3-1.11.1 Storage Requirements 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft.3 (85 m3) shall comply with 4-3.1.1.2 and 4-3.5.2.2. NFPA 99, Standard for Health Care Facilities, 1999 Edition. 4-3.5.2.2 (2) If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.	K 076	A read and sign review of educational slides will be provided to neighborhood staff on the importance of segregating empty oxygen cylinders from full oxygen cylinders, and to mark them accordingly to avoid confusion and delay if a full oxygen cylinder is needed hurriedly. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor the proper storage of oxygen cylinders, the segregation of empty oxygen cylinders from full oxygen cylinders, and to have them marked accordingly. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 10/15/16 and on-going

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K 076	Continued From page 29 (h) Cylinder or container restraint shall meet 4-3.5.2.1 (b) 27 4-3.5.2.1 Gases in Cylinders and Liquefied Gases in Containers- Level 1 (b) Special Precautions- Oxygen Cylinders and Manifolds. Great care shall be exercised in handling oxygen to prevent contact of oxygen under pressure with oils, greases, organic lubricants, rubber, or other materials of an organic nature. The following regulations, based on those of the CGA Pamphlet G-4, Oxygen, shall be observed: 27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Findings: During a tour of the facility with the Engineering Staff on 9/14/16, the oxygen storage room were observed. 1. At 10:03 a.m., there were two unmarked empty E-cylinders stored in the same rack with seven full E-cylinders in the oxygen storage cabinet in Room N3053 located on the third floor. This finding was confirmed by the Engineering Staff. 2. At 11:15 a.m., there was one unmarked empty E-cylinder stored in the same rack with eight full E-cylinders in the oxygen storage cabinet in Room N1053 located on the third floor. This finding was confirmed by the Engineering Staff.	K 076		
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are	K 104	The facility is designed, constructed and maintains smoke barrier walls to prevent the passage of smoke or fire from one location of the building to another.	

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	555020	A. BUILDING 03 B. WING	09/15/2016

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K 104	Continued From page 30 protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke integrity of the smoke barrier walls as evidenced by an unsealed penetration in the smoke barrier wall. This could result in the spread of smoke and fire and increase the risk of injury to residents and staff in the event of a fire; and affected one of seven floors in the North Tower. NFPA 101, Life Safety Code, 2000 Edition 18.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2:* Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.	K 104	North Tower: The penetration on top of the electrical conduit near Room N3022 (location identified as N320 on the work order) was caulked and sealed by Facility Services Staff. Facility Services supervisors are responsible for verifying the completion of construction activities within the hospital according to facility standards and that wall penetrations are properly sealed and caulked. Director of Facility Services is responsible for monitoring compliance. A read and sign review of educational slides will be provided to hospital-wide staff on facility standards for maintaining the integrity of smoke barrier walls and to submit a work order when they observe any unsealed wall penetrations in their work area. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Facility Services supervisors are responsible for tracking the work order system weekly to verify completion of the repair work. Director of Facility Services is responsible for compliance.	9/22/16 10/15/16 10/15/16 10/15/16

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K 104	Continued From page 31 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings: During a tour of the facility with Engineering Staff on 9/12/16, the smoke barrier walls were observed.	K 104	Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor for wall penetrations that have not been sealed. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	10/15/16 and on-going

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K 104	Continued From page 32 At 1:05 p.m., there was an approximately 1 inch unsealed penetration on top of an electrical conduit that went through the smoke barrier wall near Room N3022 located on the third floor. This finding was confirmed by Engineering Staff.	K 104		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to maintain the generators. This was evidenced by the documented transfer times that were greater than 10 seconds and by the failure to perform 3 of 12 monthly full load tests. This affected the North Tower, South Tower and Pavilion Building and could result in the failure of the generator in the event of a power outage. NFPA 99, Health Care Facilities, 1999 Edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 3-4.1.1.8 + Load Pickup. The generator set(s)	K 144	The facility has 2 generators that are inspected weekly and exercised under load for 30 minutes monthly in accordance with NFPA 99. 3.4.4.1 1 -3. The Director of Facility Services will revise the Department's policy and procedure on the emergency power generator systems to include annual testing, maintenance and servicing of the emergency generators and Automatic Transfer Switches by the designated vendor. Chief Operating Officer is responsible for monitoring compliance with Department policies and procedures. 4. The missing monthly load documentation for October-December 2015 has been located; and submitted to the Life Safety Code Unit. The Chief Engineer will scan and keep an electronic back-up copy of monthly load test documentation for future annual inspections.	10/15/16 9/28/16

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K 144	Continued From page 33 shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. [110: 3-4.1] 3-4.3.1 Source. The branches of the emergency system shall be installed and connected to the alternate power source specified in 3-4.1.1.2 and 3-4.1.1.3 so that all functions specified herein for the emergency system shall be automatically restored to operation within 10 seconds after interruption of the normal source. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. NFPA 110, 1999 Edition 6-3 Maintenance and Operational Testing. 6-3.4 A written record for the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel	K 144	A retest of the generator will be conducted if the transfer time is greater than 10 seconds. If the retest transfer time is again greater than 10 seconds, the Chief Engineer will contact the vendor to evaluate and repair the Automatic Transfer Switch (ATS). The Senior Stationary Engineer is responsible for monitoring compliance with NFPA 110 Testing. Weekly inspection and monthly test reports will be submitted to the Chief Stationary Engineer every month for follow-up as necessary. Director of Facility Services is responsible for monitoring compliance. Documentation of weekly inspections, monthly generator test results, and timely follow-up will be evaluated quarterly and submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Director of Facility Services. Chief Operating Officer is responsible for reporting compliance.	10/15/16 10/15/16 and on-going

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K 144	Continued From page 34 (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer. 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4 Operational Inspection and Testing. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. Findings: During document review with Engineering Staff on 9/13/16, the generator maintenance records were reviewed. 1. At 11:03 a.m., the documents for the diesel generators were requested. The document titled "Laguna Honda Hospital Engineering, Emergency Diesel Generator Test" indicated that the diesel generators took more than 10 seconds to turn on	K 144		

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K 144	Continued From page 35 during two monthly loads. 2. At 11:05 a.m., two July monthly loads were conducted. The transfer time for Edg#1 noted that it took 18 seconds for the generator to turn on 7/20/16 and 14 seconds for the generator to turn on 7/21/16. 3. At 11:12 a.m., the transfer times for Edg#2 noted that it took 18 seconds for the generator to turn on 7/20/16, and 14 seconds for the generator to turn on 8/3/16. When interviewed, Engineering Staff confirmed the findings and stated that generators were serviced on 9/6/16 for the problem with the transfer switch to resolve time issues. The September monthly load document, 9/7/16 indicated that the transfer time was below 10 seconds. 4. At 11:36 a.m., the facility failed to provide documentation for monthly loads conducted during the months of October, November and December of 2015. When interviewed, Engineering Staff confirmed the findings and stated that they were not able to locate the monthly load documentation.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1; 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their electrical wiring and equipment. This was evidenced by the use of a surge protector and an extension cord as a substitute for fixed wiring. This affected one of seven floors in the North Tower and one of six	K 147	The facility maintains electrical wiring and equipment in accordance with NFPA 70, National Electrical Code.9.1.2 North Tower: 1. 1. Facility Services staff removed the extension cord in Room NM023 and plugged the Electrical Amprobe Data Logger/Recorder Machine directly into a wall outlet.	9/14/16

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K 147	Continued From page 36 floors in the South Tower. This could result in an increased risk of an electrical fire and/or shock. NFPA 101, Life Safety Code, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 400-7 Uses Permitted (a) Uses. Flexible cords shall be used only for the following: 1) Pendants 2) Wiring of fixtures 3) Connection of portable lamps, portable and mobile signs or appliances 4) Elevator cables 5) Wiring of cranes and hoists 6) Connection of stationary equipment to facilitate their frequent interchange 7) Prevention of the transmission of noise or vibration 8) Appliances where the fastening means and mechanical connections are specifically designed to permit ready removal for maintenance and repair, and the appliance is intended or identified for flexible cord connection 9) Data processing cables as permitted by Section 645-5 10) Connection of moving parts 11) Temporary wiring as permitted in Sections 305-4 b) & 305-4 c) 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	K 147	South Tower: 2. Facility Services staff unplugged the fan from the surge protector and plugged it directly into a wall outlet in Room S3064. A read and sign review of educational slides will be provided to hospital-wide staff on the following facility standards: a) electrical devices must be plugged directly into the wall outlet, b) extension cords or power strips may not be used, c) a facility approved surge protector may be used for small electrical devices if approved by Facility Services and the surge protector must be placed flat on the floor. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Life Safety Code (LSC) rounds are conducted quarterly in the North, South and Pavilion buildings by Facility Services staff and the Industrial Hygienist to monitor the use of surge protectors, placement of power strips and the condition of electrical wiring and equipment. Quarterly reports from LSC rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Industrial Hygienist. Chief Executive Officer is responsible for reporting compliance.	9/14/16 10/15/16 10/15/16 and on-going

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K 147	Continued From page 37 structure (2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. Findings: During a tour of the facility with Engineering Staff on 9/14/16, the electrical wiring and equipment was observed. North Tower 1. At 11:18 p.m., an Electrical Amprobe Data Logger/Recorder Machine was plugged into an extension cord, in Room NM023 located on the Mezzanine floor. The finding was confirmed by Engineering Staff. South Tower 2. At 1:13 p.m., a fan was plugged into a power strip, in Room S3064, File Room located on the third floor.	K 147		