STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055374	A. BUILDING 02 B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLAND REHABILITATION AND CARE CENTER	1221 EAST ARROW HWY UPLAND, CA 91786

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 192	E 000		
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 206 Resident Census: 192 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 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j),	K 000		

RECEIVED
By CDPH LSC at 12:13 pm, Jun 09, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Miller — TITLE: Administrator — (X6) DATE: 6/6/25

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.

6/9/25 POC approved by Brian Fenton, SSM-I

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K 000	Continued From page 1 National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story	K 161	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is submitting this document in order to comply with its obligations as a provider participating in Medicare/Medicaid program(s). **K161 NFPA 101** **Building Construction type and height.** ***How corrective action will be accomplished for those residents found to have been affected by the identified practice. Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:*** The Penetration in Room 203 was immediately fixed. No residents were affected by this finding. ***How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken.*** All residents have the potential to have been affected by the practice.	

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K 161	Continued From page 2 sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by a penetration in the building walls. This could result in the passage of smoke and gases from one part of the building to another. This affected 32 of 192 residents in one of six smoke compartments. NFPA 101: Life Safety Code, 2012 Edition 19.1.3.3 * Sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (2) They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. 8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved	K 161	Maintenance director and assistant checked all other drain caps in all restrooms and no issues were identified. *What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.* Maintenance Staff were in serviced on June 2, 2025 by administrator regarding the policy penetrations in the facility. Maintenance Director or designee will check all storage rooms and hallways to ensure there are no penetrations weekly for the next 3 months. Dept heads or designee will check their Guardian Angel rooms weekly for any penetrations for the next 3 months. *How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.* The Administrator or designee will do rounds weekly for the next 3 months to monitor for compliance. Any issues will be reported to the Quality Assurance committee for review and recommendations. *Completion date of corrective actions:* *June 9, 2025.*	

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K 161	Continued From page 3 existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 5/21/25, the building construction was observed. At 10:45 a.m., there was a drain cap underneath the restroom sink in Room 203 that was not flush with the wall and created an approximate seven-inch crescent shape penetration. Upon interview, the MD stated that he was not sure how long the penetration had been there.	K 161		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced	K 223	**K223 NFPA 101 Doors with self closing devices** *How corrective action will be accomplished for those residents found to have been affected by the identified practice. Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:* The door with self-closing device that did not latch when released was immediately fixed by maintenance staff. No residents were affected by the finding. *How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken.* All residents have the potential to be affected by this practice. Maintenance director and assistant conducted a sweep of all self-closing doors to ensure they latch upon release. No other findings identified. *What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.*	

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K 223	Continued From page 4 by: Based on observation and interview, the facility failed to maintain the doors with self-closing devices. This was evidenced by a door equipped with a self-closing device that did not latch when released. This could result in the passage of smoke and gases from one part of the building to another. This affected 32 of 192 residents in one of six smoke compartments. Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 5/21/25, the doors equipped with self-closing devices were observed. At 1:03 p.m., the corridor kitchen door that was equipped with a self-closing device did not latch when tested. Upon interview, the MD stated he just realized that the door was not latching.	K 223	Maintenance staff were in serviced on June 2, 2025 by the administrator regarding policy on Self closing devices. Maintenance Director or Designee will check all self-closing devices biweekly to ensure compliance for the next 3 months. *How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.* The Administrator or Designee will do rounds monthly for the next 3 months to monitor for compliance. Any issues will be reported to the Quality Assurance committee for review and recommendations. *Completion date of corrective actions:* *June 9, 2025*	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353	**K353 NFPA 101** **Sprinkler System- Maintenance and Testing** *How corrective action will be accomplished for those residents found to have been affected by the identified practice. Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:* The automatic fire sprinkler system inspection and testing was immediately scheduled and completed on 5/27/25. The auxiliary Drain Information sign was replaced on 5/27/25. No residents were affected by the finding.	

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K 353	Continued From page 5 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the automatic fire sprinkler system. This was evidenced by missing automatic fire sprinkler system inspection and testing record, and by an identification sign that was not legible. This could result in the malfunction of the fire sprinkler system. This affected staff and 192 of 192 residents in six of six smoke compartments. NFPA 101: Life Safety Code, 2012 Edition 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 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. 5.2* Inspection. 5.2.1 Sprinklers.5.2.4 Gauges. 5.2.1.1 Sprinklers shall be inspected from the floor level annually. 5.2.4.1 * Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure	K 353	The automatic fire sprinkler system inspection and testing was immediately scheduled and completed on 5/27/25. The auxiliary Drain Information sign was replaced on 5/27/25. No residents were affected by the finding. *How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken.* All residents have the potential to have been affected by this finding. Maintenance director completed audit to ensure all inspections and testing are up to date. *What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.* Maintenance staff were in serviced on 5/27/25 by the Administrator regarding policy on ensuring that all sprinkler inspections and testing are completed to ensure compliance. Maintenance director will ensure that all logs are reviewed monthly for the next 3 months. *How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.* The Administrator or designee will review inspection and testing records for the next 3 months to monitor for compliance. Any issues will be reported to the Quality Assurance committee for review and recommendations. *Completion date of corrective actions:* *June 9, 2025.*	

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K 353	Continued From page 6 is being maintained. 5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. 5.2.6* Hydraulic Design Information Sign. The hydraulic design information sign for hydraulically designed systems shall be inspected quarterly to verify that it is attached securely to the sprinkler riser and is legible. 5.2.8* Information Sign. The information sign shall be inspected annually to verify that it is securely attached and is legible. Findings: During document review and interview with the Maintenance Director (MD) and Administrator on 5/21/25, the automatic fire sprinkler maintenance records were reviewed, and the system was observed. 1. At 9:49 a.m., the Auxiliary Drain information sign on the west outside wall near the generator was faded and illegible. Upon interview, the MD stated that he had informed the contractor who replaces the sprinkler system signs during the semi-annual inspection about two months ago that the sign needed to be replaced. 2. At 2:03 p.m., the facility failed to provide the annual sprinkler system inspection/test records. The date of the last inspection records provided was during the five-year sprinkler inspection/test on 4/5/22. Upon interview, the MD stated that he would have to follow up with the sprinkler company because they were under a contract and are supposed to automatically conduct the	K 353		

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K 353	Continued From page 7 annual, but they were unable to locate any records for the annual.	K 353		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoking area. This was evidenced by cigarette butts on the ground in the smoking area. This could result in a fire. This	K 741	**K741 NFPA 101** **Smoking Regulations** *How corrective action will be accomplished for those residents found to have been affected by the identified practice.* *Immediate Corrective action(s) for resident(s) found to have been affected by the deficient practice:* All Cigarette butts were immediately picked up from the smoking area ground. No residents were affected by the finding. *How the facility will identify other residents having the potential to be affected by the same identified practice and what corrective action will be taken.* All residents have the potential to have been affected by the practice. Housekeeping staff will ensure that all smoking areas are cleaned daily, Ash trays are emptied out and any cigarette butts picked up daily. *What measures will be put into place or what systemic changes will the facility make to ensure that the identified practice does not recur.* Housekeeping Staff were in serviced on 5/27/25 by the Administrator regarding keeping smoking areas free of smoking debris on the floor. Housekeeping supervisor or designee will check smoking area to ensure compliance weekly for the next 3 months.	

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K 741	Continued From page 8 affected 192 of 192 residents in six of six smoke compartments. During facility tour and interview with the Maintenance Director (MD) on 5/21/25, the smoking area was observed. At 9:45 a.m., there were approximately five cigarette butts on the ground near the smoking area. Upon interview, the MD stated that he had not realized the butts were on the ground and did not know how long they were there.	K 741	*How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.* The Administrator or Designee will do rounds weekly and for the next 3 months to monitor for compliance. Any issues will be reported to the Quality Assurance committee for review and recommendations. *Completion date of corrective actions:* *June 9, 2025.*	