STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055093	A. BUILDING **02** B. WING _____	**06/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MARIN HEALTH & WELLNESS CENTER	**1220 SOUTH ELISEO DRIVE** **GREENBRAE, CA 94904**

(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 Surveyor: 31201 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 62	E 000		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in	E 015	**E-015** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility adopted a policy and procedure specifically for sewage and waste disposal in the event of an emergency. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All current residents have the potential to be affected, facility adopted a policy and procedure for sewage and waste disposal in the event of an emergency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/16/22

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.

7/7/22: approved by Brian Fenton, SSM-I

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E 015	Continued From page 1 place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to provide policies and procedures	E 015	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility adopted a specific policy and procedure for sewage and waste disposal in the event of an emergency and added the section to its facility Emergency Operating Plan (EOP) effective 6/18/22. Facility staff in-serviced on sewage and waste disposal policy and procedure as of 6/30/22. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Administrator will review the Sewage and Waste Disposal policy and procedure with the Quality Assurance & Performance Improvement Committee Members at Quality Assurance & Performance Improvement Meeting for one Month. The Facility Emergency Operating Plan will be reviewed at Quality Assurance & Performance Improvement Meeting for one month, and then annually thereafter to ensure plan contains a Sewage and Waste Disposal policy and procedure.	Completion Date: 6/30/22

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E 015	Continued From page 2 (P&P) for providing subsistence needs. This was evidenced by the absence of a policy and procedure for sewage and waste disposal. This affected 62 of 62 residents. This could result in unsafe conditions due to waste in the event of an emergency. Findings: During document review and interview with the Administrator on 6/2/22, the Emergency Preparedness (EP) policies and procedures were requested. At 12:32 p.m., the facility failed to provide a policy and procedure for sewage and waste disposal during a disaster. Upon interview, the Administrator confirmed the finding.	E 015		
K 000	INITIAL COMMENTS Surveyor: 31201 K3 BUILDING: 01 K6 PLAN APPROVAL: 11/1/1967 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 72 Resident Census: 62 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		

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K 000	Continued From page 3 National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Abbreviations: Staff 1 (Maintenance Staff) Staff 2 (Administrator)	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	K 161	**K-161** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility Maintenance Director completed the repair of the penetration of the wall in Resident Room 7 (Bed A) by re-installing the face plate as of 6/24/22. Maintenance Director completed the repair of the penetration of the wall in the Kitchen Closet area as of 6/24/22. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** No other residents identified as having the potential to be affected by deficient practice.	

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K 161	Continued From page 4 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story 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: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by penetrations in the wall. This affected 62 of 62 residents and could result in the spread of smoke in the event of a fire. Findings: During a tour of the facility and interview with the Staff on 6/2/22, the walls and ceilings were observed. 1. At 10:11 a.m., there was a wall penetration observed behind Bed A in Resident room 7. The phone jack faceplate detached from the wall leaving a penetration measuring approximately four inch in diameter. Upon interview, Staff 1	K 161	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility Maintenance Director will review work orders through TELs (the facility's mechanism for staff to report needed repairs) on a weekly basis to identify needed repairs in regards to penetrations. Wall Penetration observations will be added to the Environmental Maintenance Rounds conducted on a monthly basis by Environmental Services Personnel. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Maintenance Director will report to Quality Assurance & Performance Improvement Meeting the Monthly Environmental Maintenance Rounds and the findings of such for three months for Committee member review.	Completion Date: 6/30/22

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K 161	Continued From page 5 confirmed the finding and stated will screw the faceplate back to the wall. 2. At 10:39 a.m., a closet in the kitchen containing the Inspector's Test Valve (ITV) was observed. There was a wall penetration on the right bottom side of the pipe measuring approximately ¾ inches. Upon interview, Staff 1 confirmed the finding.	K 161		
K 343 SS=E	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, document review, and interview, the facility failed to maintain their fire alarm system. This was evidenced by the loss of the fire alarm communication system with the outside monitoring company. This affected 62 of 62 residents and could result in delayed notification of a fire. NFPA 101, Life Safety Code, 2012 Edition	K 343	**K-343** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents have the potential to be affected by deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Facility initiated its Fire Watch protocol effective 6/2/22 which serves as a plan of action for providing continuous facility wide fire detection and alarm capabilities on a 30 minute interval, 24 hours a day. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility has contracted with a vendor to install a new Dialer to connect to the central station using a cell dialer. Once the installation of the new dialer is complete, the vendor will provide a monthly monitoring service for the facility to ensure the fire alarm system is communicating to the outside monitoring company.	

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K 343	Continued From page 6 19.3.4 Detection, Alarm, and Communication Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6 Fire Detection, Alarm, and Communications Systems. 9.6.1 General. 9.6.1.1 The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. 9.6.1.2 Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 9.6.1.4 All systems and components shall be approved for the purpose for which they are installed. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm Code, 2010 Edition Chapter 14 Inspection, Testing, and Maintenance 14.1 Application.	K 343	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The Administrator will be responsible for monitoring compliance of the new dialer being installed and the new monitoring company being set up. The Maintenance Director will report to Monthly Quality Assurance & Performance Improvement Committee the facility fire watch status until the project is completed.	Completion Date: 6/30/22

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K 343	Continued From page 7 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. 14.1.2 The inspection, testing, and maintenance of single and multiple-station smoke and heat alarms and household fire alarm systems shall comply with the requirements of this chapter. 14.2 General. 14.2.1 Performance. 14.2.1.1 Performance Verification. To ensure operational integrity, the system shall have an inspection, testing, and maintenance program. 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. 14.2.1.1.2 Inspection, testing, and maintenance programs shall verify correct operation of the system. 26.6.3 Communications Methods. 26.6.3.2 Digital Alarm Communicator Systems. 26.6.3.2.1 Digital Alarm Communicator Transmitter (DACT). 26.6.3.2.1.1 Public Switched Network. A DACT shall be connected to the public switched telephone network upstream of any private telephone system at the protected premises. (A) The connections to the public switched telephone network shall be under the control of the subscriber for whom service is being provided by the supervising station alarm system. (B) Special attention shall be required to ensure that this connection is made only to a loop start telephone circuit and not to a ground start telephone circuit.	K 343		

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K 343	Continued From page 8 Exception: If public cellular telephone service is used as a secondary means of transmission, the requirements of 26.6.3.2.1.1 shall not apply to the cellular telephone service. 26.6.3.2.1.2 Signal Verification. All information exchanged between the DACT at the protected premises and the digital alarm communicator receiver (DACR) at the supervising or subsidiary station shall be by digital code or some other approved means. Signal repetition, digital parity check, or some other approved means of signal verification shall be used. 26.6.3.2.1.3 Requirements for DACTs. (A) A DACT shall be configured so that, when it is required to transmit a signal to the supervising station, it shall seize the telephone line (going off-hook) at the protected premises and disconnect an outgoing or incoming telephone call and prevent use of the telephone line for outgoing telephone calls until signal transmission has been completed. A DACT shall not be connected to a party line telephone facility. (B) A DACT shall have the means to satisfactorily obtain a dial tone, dial the number(s) of the DACR, obtain verification that the DACR is able to receive signals, transmit the signal, and receive acknowledgment that the DACR has accepted that signal. In no event shall the time from going off-hook to on-hook exceed 90 seconds per attempt. (C) A DACT shall have means to reset and retry if the first attempt to complete a signal transmission sequence is unsuccessful. A failure to complete connection shall not prevent subsequent attempts to transmit an alarm where such alarm is generated from any other initiating device circuit or signaling line circuit, or both. Additional attempts shall be made until the signal	K 343		

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K 343	Continued From page 9 transmission sequence has been completed, up to a minimum of 5 and a maximum of 10 attempts. (D) If the maximum number of attempts to complete the sequence is reached, an indication of the failure shall be made at the premises. Findings: During testing of the fire alarm system, document review and interview with Staff on 6/2/22, the fire alarm panel was observed, staff was interviewed, and the fire alarm reports were requested. Between 1:26 p.m. to 1:36 p.m., a smoke detector, pull station and Inspectors Test Valve and a Post Indicator Valve were tested. The devices all activated during test. At 2:14 p.m., Staff 1 called their monitoring company to verify signals. He was informed that they did not receive any signals from the facility. At 2:20 p.m., Staff 1 called the technician and was informed that the issue was with the dialer in the fire alarm panel. The internal alarm was working but alarm signal will not go out to the monitoring company. Upon interview, Staff 1 stated that the issue with the monitoring company not receiving signals has been going on for a month. Staff 1 was asked what their interim life safety measure would be while they are having issues with the dialer. He stated that they will go on fire watch until the issue with the panel is resolved. And that a technician was currently on-site troubleshooting the issue.	K 343		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353	**K-353**	

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K 353	Continued From page 10 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by storage of items less than 18 inches beneath a sprinkler deflector. This affected 30 of 62 residents and could result in obstruction of the sprinkler spray pattern in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 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. NFPA 25, Standard for the Inspection, Testing,	K 353	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility Maintenance Director removed items less than 18 inches from the fire sprinkler system to remove the obstruction of the fire sprinkler system as of 6/10/22. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Facility Maintenance Director conducted observation rounds of fire sprinklers in closets throughout the facility as of 6/10/22, no other residents identified as being affected by deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Maintenance Director provided an in-service to dietary personnel on facility policy and procedure regarding storing of items 18 inches beneath fire sprinklers. Facility reapplied a visual line on the closet walls showing maximum height of needed storage space to provide at minimum 18 inches below the fire sprinkler. Maintenance Director audited all closets with fire sprinklers and ensured each had a visual line that could be seen by staff when storing items at minimum 18 inches below fire sprinklers.	

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K 353	Continued From page 11 and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition 8.5.6* Clearance to Storage. 8.5.6.1* Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Finding: During a tour of the facility and interview of Staff on 6/2/22, the automatic sprinkler system was observed. At 10:27 a.m., there were two boxes in the Kitchen storage closet that were stored at approximately seven inches beneath the sprinkler deflector. Upon interview, Staff 1 confirmed the finding.	K 353	**How the facility plans to monitor its performance to make sure that solutions are sustained:** Maintenance Director will report to the Quality Assurance & Performance Improvement Committee for one month the status of each closet with fire sprinklers having a visual line showing 18 inches of space below closet fire sprinklers.	Completion Date: 6/30/22
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 31201	K 355	**K-355** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility Maintenance Director posted a warning sign by the Class K Fire Extinguisher as of 6/17/22.	

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	055093	A. BUILDING **02** B. WING _____	**06/02/2022**

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K 355	Continued From page 12 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by the failure to post a warning sign near the Class K Fire Extinguisher to direct staff to use it as a secondary back-up to the kitchen hood suppression system. This affected 30 of 62 residents and could result in delay in containment in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 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 selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher. Findings: During a tour of the facility and interview with Staff on 6/2/22, the fire extinguisher was observed. At 10:37 a.m., the facility failed to post a sign near the Class K fire extinguisher that directed staff to activate the hood extinguishing system prior to using the Class K fire extinguishers in the	K 355	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** No other residents identified as being affected by deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility Maintenance Director will include fire extinguisher observations on the Monthly Maintenance Environmental Rounds observation checklist for proper signage of Class K Fire Extinguishers. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Maintenance Director will report to Quality Assurance & Performance Improvement Meeting the Monthly Environmental Maintenance Rounds and the findings of such for three months for Committee member review.	Completion Date: 6/30/22

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K 355	Continued From page 13 Kitchen. Upon interview, Staff 1 confirmed the finding and stated that he was not aware that the sign he posted for the Class K fire extinguisher was missing.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363	**K-363** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility Maintenance Director installed a new self closing device on the Kitchen Pantry Door to correct the deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Facility Maintenance Director checked self closing devices of all other doors in the facility, no other residents identified as being affected by deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility Maintenance Director will include Self Closure Door Device tests on the Monthly Maintenance Environmental Rounds observation checklist for proper door closures. **How the facility plans to monitor its performance to make sure that solutions are sustained:**	

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K 363	Continued From page 14 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a door with self-closing device that was not maintained. This affected 30 of 62 residents and could result in the inability to contain smoke and/or fire to a room. Findings: During a tour of the facility and interview with Staff on 6/2/22, the corridor doors were observed. At 10:41 a.m., the door to the Kitchen Pantry room did not latch when tested by Staff 1. The door was equipped with a self-closing device. The door was tested three times and failed. Upon interview, Staff 1 confirmed the finding.	K 363	Maintenance Director will report to Quality Assurance & Performance Improvement Meeting the Monthly Environmental Maintenance Rounds and the findings of such for three months for Committee member review.	Completion Date: 6/30/22
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO	K 741	**K-741** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Social Services Director provided education to its current residents who smoke about the facility policy of using the facility provided ash tray in the smoking area as of 6/30/22.	

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K 741	Continued From page 15 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: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the designated smoking area. This was evidenced by cigarette butts discarded on the ground. This could result in the increased risk of fire and affected the designated smoking area. Findings: During a tour of the facility and interview with Staff on 6/2/22, the designated smoking area was observed. At 9:45 a.m., the designated smoking area of the facility near the parking lot was observed. There were approximately over a dozen cigarette butts on the ground. There was a safety-type smoke	K 741	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** No other residents identified as being affected by deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility Maintenance Director in-serviced environmental services personnel on facility smoking area observations and cleaning of area/ash tray disposing. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Administrator will be responsible for monitoring solutions are sustained. Any findings of non compliance will be reported to the monthly Quality Assurance & Performance Improvement Meetings with actions taken to correct non-compliance to the facility smoking area for 3 months and as needed.	Completion Date: 6/30/22

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K 741	Continued From page 16 pole ashtray provided. Upon interview, Staff 1 confirmed the finding.	K 741		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the electrical system and its components. This was evidenced by an obstructed electrical panel. This affected 30 of 62 residents and could result in an increased risk of an electrical fire. NFPA 101 Life Safety Code, 2012 Edition 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70 National Electrical Code, 2011 Edition 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance	K 919	**K-919** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Facility Maintenance Director removed the 24 gallon garbage container obstructing the electrical panel. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Facility Maintenance Director conducted rounds of all other facility electrical panels, no other electrical panels identified as being obstructed, and no other residents identified as being affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility Maintenance Director removed the 24 gallon garbage container, and replaced it with a lower profile container that was relocated away from the electrical panel so that the electrical panel was unobstructed. **How the facility plans to monitor its performance to make sure that solutions are sustained:**	

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K 919	Continued From page 17 of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. (2) Width of Working Space. The width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90 degree opening of equipment doors or hinged panels. Findings: During a tour of the facility and interview with Staff on 6/2/22, the electrical system and its components were observed. At 11:50 a.m., the electrical panel located in the Kitchen was observed. The electrical panel was obstructed by a 24-gallon garbage container that was stationed directly in front of the electrical panel. Upon interview, Staff 1 confirmed the finding.	K 919	The Administrator will be responsible for monitoring solutions are sustained. Any findings of non compliance will be reported to the monthly Quality Assurance & Performance Improvement Meetings with actions taken to correct non-compliance of electrical panel obstructions for 3 months and as needed.	Completion Date: 6/30/22