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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555066	A. BUILDING 02 B. WING _____	02/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FILLMORE, LLC	118 B ST FILLMORE, CA 93015

(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: 40596 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: 40596 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 78	E 000	**RECEIVED** **By CDPH-LSC at 12:21 pm, Feb 22, 2019**	
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) (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 at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C Rodrigues | TITLE: Administrator | (X6) DATE: 2/22/19

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.

2/22/19 Accepted by Cynthia Luc

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E 013	Continued From page 1 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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 at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on record review and interview, the facility failed to develop and implement policies and procedures that support the execution of the emergency plan. This was evidenced by missing policies and procedures on the use of volunteers or other emergency staffing strategies. This could result in not having the necessary planning and preparation in place to adequately protect the health and safety of 78 of 78 residents. § 483.475 Emergency Preparedness	E 013		

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E 013	Continued From page 2 The facility 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 at least annually. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in 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 resident 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. (2) A system to track the location of on-duty staff and sheltered residents in the facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the facility must document the specific name and location of the receiving facility or other location. (3) Safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 013		

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E 013	Continued From page 3 (4) A means to shelter in place for residents, staff, and volunteers who remain in the facility. (5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. (7) The development of arrangements with other facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to the facility's residents. (8) The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings: During record review and interview with staff on 2/4/19, the facility's emergency preparedness policies and procedures were reviewed. 1. At 2:46 p.m., the facility failed to provide emergency preparedness policies and procedures on the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Upon interview, Staff 1 stated that she was aware that the facility needed to have a policy, but they did not have a written policy available at the time of survey.	E 013	The administrator started seeking resources to use for volunteers, including State and Federal health care professionals, sister facilities, RedCross, registries, and other staffing strategies to be used in the event of an emergency situation. A Policy and Procedure will be developed by the Administrator by 2-27-19. All staff will be educated on the plan and it will be available in the Emergency Operation Plan that will be located at the nurses station. Adm will do the in-service on 2-28-19 The EOP will be reviewed annually or as needed. The EOP will be presented to the QA Committee for review and recommendations.	2-5-19 2-27-19 2-28-19 2-28-19

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E 029 SS=D	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan. This was evidenced by a communication plan that did not include primary and alternate means of communication, and a method for sharing information. This could result in not having the necessary planning and preparation in place to adequately protect the health and safety of 78 of 78 residents. § 483.475 Emergency Preparedness The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Residents' physicians. (iv) Other facilities. (v) Volunteers. (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.	E 029		

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E 029	Continued From page 5 (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. (3) Primary and alternate means for communicating with the facility's staff, Federal, State, tribal, regional, and local emergency management agencies. (4) A method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii). (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). (7) A means of providing information about the facility's occupancy, needs, and its ability to provide assistance; to the authority having jurisdiction, the Incident Command Center, or designee. (8) A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Findings: During record review and interview with staff on 2/4/19, the facility's emergency preparedness communication plan was reviewed. 1. At 2:53 p.m., the facility failed to provide a communication plan that included primary and alternate means of communicating with the LTC facility's staff, and Federal, State, tribal, regional,	E 029	The Administrator will purchase a supply of walkie talkies by 2-25-19 to be used as alternate means of communication in the event that the facility phone system is not working. The majority of staff carry cell phones which is another method for communication.	2-25-19

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E 029	Continued From page 6 and local emergency management agencies. Upon interview, Staff 1 stated that the facility had primary and alternates means of communication, but they did not have a plan in writing at the time of survey. 2. At 2:54 p.m., the facility failed to provide a communication plan that included a method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health providers to maintain the continuity of care, a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii), and a means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). Upon interview, Staff 1 confirmed the finding.	E 029	The Administrator will write a plan for the use of the 2 methods of communication, including a method for sharing information and medical documentation for residents in the facility's care with other healthcare provders to maintain continuity of care as well as track their location if evacuation is necessary. The plan will also includes a means for providing general information about the resident. All staff will be educated on the plan and a copy of the plan will be placed in the EOP Manual, accessible to all staff. Adm will give the inservice on 2-28-19 The plan and the EOP Manual will be reviewed annually or as necessary by the Administrator along with any staff who should give informaion/suggestions. The plan will be presented to the QA Committee for review and recommendatiions	2-27-19 2-28-19
K 000	INITIAL COMMENTS Surveyor: 40596 K3 BUILDING: 01 K6 PLAN APPROVAL: 5/20/1977 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. 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), National Fire Protection Association (NFPA) 101, Life Safety Code, 2012 Edition, and NFPA 99 Health Care Facilities Code, 2012 Edition.	K 000		

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K 000	Continued From page 7 Representing the California Department of Public Health: 40596 The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care Facilities. Census: 78	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		

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K 321	Continued From page 8 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on observation and interview, the facility failed to maintain the hazardous areas. This was evidenced by a door to a hazardous area that was held open by a door wedge and a hazardous area that did not have a self-closing or automatic-closing door. This affected two of five smoke compartments and could result in the inability to contain a fire in a hazardous area. Findings: During a tour of the facility and interview with staff on 2/4/19, the hazardous areas were observed. 1. At 10:59 a.m., the Medical Storage door inside of the Nurses Storage Room was observed. The Medical Storage Room was approximately 90 square feet and contained shelves of medical equipment, boxes, and paper. The door was equipped with a self-closing device and was held open with a rubber wedge. Upon interview, Staff 2 confirmed the finding. 2. At 11:53 a.m., the door to the Kitchen Pantry inside of the Kitchen was observed. The door was not equipped with either a self-closing or automatic-closing device. The room measured approximately 240 square feet and contained shelves of canned and dry food items. Upon interview, Staff 2 stated that he was not aware that the door needed to have a self-closing device.	K 321	The wedge was removed from the Medical Storage Room door at once. All self closing doors were checked and no other doors were held open by a wedge or propped open on 2-6-19 All staff will be educated on-28-19 by the MaintenanceSupervisor or designee that self-closing doorscan't be propped open. A self-closing device was installed on the Kitchen Pantry door on 2-15-19 The Maintenance Supervisor will monitor the doors with self-closing devices monthly to ensure that they are not propped open. If he does not find doors propped open after 3 months he will check them on a quarterly basis. He will report his findings to the QA Committee for recommendations.	2-6-19 2-28-19 2-15-19

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K 345	Continued From page 9	K 345		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on record review and interview, the facility failed to maintain the fire alarm system. This was evidenced by missing a semi-annual fire alarm system inspection and incomplete fire alarm control panel battery tests. This affected five of five smoke compartments and could result in a malfunctioning fire alarm system. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1* General. 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 and Signaling Code, 2010 Edition. 14.3 Inspection.	K 345		

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K 345	Continued From page 10 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance. Table 14.3.1 Visual Inspection Frequencies-semiannually 3. Batteries 4. Transient suppressors 5. Fire alarm control unit trouble signals 7. In- building fire emergency voice/alarm communications equipment 8. Remote annunciators 9. Initiating devices 10. Guard's tour equipment 11. Combination systems (a) Fire extinguisher electronic monitoring device/systems (b) Carbon monoxide detectors/systems 12. Interface equipment 13. Alarm notification appliances 14. Exit marking audible notification appliances 15. Supervising station alarm systems-transmitters 16. Special procedures 17. Supervising station alarm systems-receivers 18. Public emergency alarm reporting system transmission equipment 20. Mass notification system, non-supervised systems installed prior to adoption of this edition Table 14.4.5 Testing Frequencies 6. Batteries-fire alarm systems (d) Sealed lead-acid type: (1) Charger test (Replace battery within 5 years after manufacture or more frequently as	K 345		

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K 345	Continued From page 11 needed)-annually (2) Discharge test (30 minutes)-annually (3) Load voltage test-semi-annually Findings: During record review and interview with staff on 2/4/19, the fire alarm system testing and inspection records were reviewed. 1. At 3:14 p.m., the facility failed to provide documentation indicating that a semi-annual fire alarm system inspection was completed. Upon interview, Staff 2 stated that the fire alarm system was only tested and inspected on an annual basis. 2. At 3:14 p.m., the facility failed to provide documentation indicating that one of two semi-annual load voltage tests was completed on the two sealed lead-acid type batteries in the fire alarm control panel. Upon interview, Staff 2 stated that the load voltage test was only completed on an annual basis.	K 345	The Maintenance Spv. will schedule a fire alarm test in April 2019, 6 months from the last one in Oct. 2018. The schedule has been amended to ensure the fire alarm system is inspected twice a year and appropriate documentation will be maintained. The Life Safety & Environmental Resource provided education to the Maintenance Spv. regarding all of the required testing and how to keep the records in order. This was done on 2-7-19. The Administrator will check the documentation for the required tests monthly for 2 months and if all is in order then quarterly to ensure they are done on schedule. The findings will be presented to the QA Committee for review and recommendations.	2-7-19
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on record review and interview, the facility failed to maintain the smoke detectors. This was evidenced by missing biennial smoke detector	K 347		

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K 347	Continued From page 12 sensitivity testing. This affected five of five smoke compartments, and could result in a malfunctioning smoke detector in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.4 Detection, Alarm, and Communications Systems 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.5 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 and Signaling Code, 2010 Edition. 14.4.5.3 In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7. 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between	K 347	The Maintenance Spv. will schedule a fire alarm test in April 2019, 6 months from the last one in Oct. 2018. The schedule has been amended to ensure the fire alarm system is inspected twice a year and appropriate documentation will be maintained. The Life Safety & Environmental Resource provided education on2 to the Maintenance Spv. on 2-7-19 regarding all of the required testing and how to keep the records in order. The Administrator will check the documentation for the required tests monthly for 2 months and if all is in order then quarterly to ensure they are done on schedule. The findings will be presented to the QA Committee for review and recommendations.	2-7-19

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	555056	A. BUILDING 02 B. WING	02/04/2019

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K 347	Continued From page 13 calibration tests shall be permitted to be extended to a maximum of 5 years. 14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained. 14.4.5.3.3.2 In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. 14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction 14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. 14.4.5.3.6 Smoke detectors or smoke alarms listed as field adjustable shall be permitted to either be adjusted within the listed and marked sensitivity range, cleaned, and recalibrated, or be replaced.	K 347		

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K 347	Continued From page 14 14.4.5.3.7 The detector or smoke alarm sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector or smoke alarm. 17.7.2* Sensitivity. 17.7.2.1* Smoke detectors shall be marked with their nominal production sensitivity and tolerance (percent per foot obscuration), as required by the listing. 17.7.2.2 Smoke detectors that have provision for field adjustment of sensitivity shall have an adjustment range of not less than 0.6 percent per foot obscuration. 17.7.2.3 If the means of adjustment of sensitivity is on the detector, a method shall be provided to restore the detector to its factory calibration. Findings: During record review and interview with staff on 2/4/19, the smoke detector testing and inspection records were reviewed. 1. At 2:00 p.m., the facility failed to provide documentation indicating that smoke detector sensitivity testing was completed within the last two years. The facility provided a document titled, "Panel Device Maintenance/Sensitivity Report" that indicated the smoke detector sensitivity testing was last completed on 12/6/16. Upon interview, Staff 2 confirmed the finding.	K 347	 The smoke detectors will be tested on 2-27-19. The smoke detectors will be tested as required going forward and a log will be kept by the Mainenance Spv. that shows the test date and results. The Life Safety Environmental Resource provided education on 2-7-19 to the Maintenance Spv. regarding the regulations for smoke detector testing. The Maintenance Spv. will provide a report to the QA Committee for review and recommendations if necessary on a monthly basis for the next year.	2-27-19 2-7-19
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		

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K 353	Continued From page 15 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: 40596 Based on observation, record review, and interview, the facility failed to maintain the automatic fire sprinkler system. This was evidenced by missing quarterly inspections, missing escutcheon rings, and the failure to maintain 18 inches of clearance. This affected five of five smoke compartments and could result in a malfunctioning automatic fire sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements 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 Automatic Sprinklers and other Extinguishing	K 353		

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K 353	Continued From page 16 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 one of the following: (1) 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. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition 6.2.7 Escutcheons and Cover Plates 6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. 6.2.7.2 Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly. 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. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition 4.3 Records. 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be	K 353		

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K 353	Continued From page 17 made available to the authority having jurisdiction upon request. 4.3.2 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 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. 5.3.3.2* Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Findings: During a tour of the facility, record review, and interview with staff on 2/4/19, the automatic fire sprinkler system components were observed and testing and inspection records were reviewed. 1. At 11:25 a.m., the automatic fire sprinkler system components in Room 29 were observed. One of four sprinkler heads was observed missing an escutcheon ring. Upon interview, Staff 2 stated that the facility recently had water damage that may have caused some escutcheon rings to fall. 2. At 11:29 a.m., the automatic fire sprinkler system components in the Janitor's Closet next to the Staff Development Office were observed. One of one sprinkler head was observed missing an escutcheon ring. Upon interview, Staff 2 stated that the facility recently had water damage that may have caused some escutcheon rings to fall. 3. At 11:39 a.m., the automatic fire sprinkler	K 353	The escutcheon ring will be replaced on 2-27-19 in room 29 and the Janitors Closet by the vendor who is inspecting the fire sprinklers. The Maintenance Supervisor checked all sprinkler heads on 2-11-19 and found no other missing escutcheon rings.	2-27-19 2-11-19

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K 353	Continued From page 18 system components in the Storage Room next to Room 18 were observed. One of one sprinkler head was observed with approximately 10 inches of clearance between the sprinkler deflector plate and a box. Upon interview, Staff 2 confirmed the finding. 4. At 3:15 p.m., the facility failed to provide documentation indicating that three of four automatic fire sprinkler system quarterly inspections were completed. No quarterly sprinkler reports were provided for first quarter, third quarter, and fourth quarter of 2018. Upon interview, Staff 2 stated that the automatic fire sprinkler system was only inspected on an annual basis during the second quarter of 2018.	K 353	The supplies in the Storage Room were removed by the Maintenance Spv. in order to allow for 18 inch clearance from the sprinkler head on 2-8-19 All storage closets were checked by the Maintenannce Supervisor and the supplies moved to provide the 18 inch clearance on 2-11-19 The Maintenance Supervisor will provide education to all applicable staff on 2-28-19 The Maintenance Spv. scheduled the automatic sprinkler system inspection for 2-27-19 for 1st quarter 2019. He will ensure that a quarterly inspection for this system is done every quarter	2-8-19 2-11-19 2-28-19 2-27-19
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	K 363	The Life Safety Environmental Resource provided education on 2-7-19 regarding the automatic sprinkler system testing requirements. He provided a schedule of all required tests and the frequency. A report of the test results will be presented to QA Committee for review and recommedations if necessary. The Administrator will ensure that all tests are completed as required over the course of this year.	2-7-19

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K 363	Continued From page 19 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by corridor doors that failed to latch and corridor doors that were obstructed from closing. This affected two of five smoke compartments and could result in the spread of smoke and fire in the event of a fire emergency. Findings: During a tour of the facility and interview with staff on 2/4/19, the corridor doors were observed. 1. At 11:07 a.m., the corridor door to the Small Dining Room was observed. The door was equipped with a self-closing device and failed to latch when allowed to self-close. Upon interview, Staff 2 confirmed the finding.	K 363	The Maintenance Supervisor repaired the door to ensure it would latch and close securely on 2-6-19. He will check all doors by 2-20-19 to ensure that they close and latch. Repairs will be made as necessary.	2-6-19 2-20-19

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K 363	Continued From page 20 2. At 11:16 a.m., the corridor door to Room 38 was observed. The door was obstructed from closing by a resident bed. Upon interview, Staff 2 confirmed the finding. 3. At 11:27 a.m., the corridor door to the Nursing Fax Machine Room was observed. The door was equipped with a self-closing device and failed to fully close and latch when allowed to self close. The door was observed with a white cable running next to the door frame that obstructed the door from fully closing and latching. Upon interview, Staff 2 stated that the cable was connected to a fax machine and was placed there on a permanent basis.	K 363	The Maintenance Spv.exchanged the bed in room 38 with another bed that would allow the door to close on 2-5-19. All rooms were inspected by the Maintenance Supervisor on 2-6-19 to ensure that the doors are not blocked and can close. The Maintenance Supervisor removed the cord that was obstructing the door from closing and latching on 2-6-19 All doors will be inspected to ensure they latch securely by the Maintenance Spv. by 2-20-19.	2-5-19 2-6-19 2-20-19
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918	The Maintenance Supervisor will check all doors quarterly to ensure they close and latch securely. He will inspect all rooms to ensure that the doors are not blocked on a quarterly basis. The Maintenance Spv. will provide a report of his findings to the QA Committee for recommendations each month	

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K 918	Continued From page 21 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 40596 Based on observation, record review, and interview, the facility failed to maintain the diesel generator. This was evidenced by the failure to conduct monthly battery tests, the failure to complete monthly full load tests, and the failure to complete weekly inspections. This affected five of five smoke compartments and could result in a generator malfunction due to a battery failure. NFPA 101 Life Safety Code, 2012 edition 19.5 Building Services. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Standard for Emergency and Standby	K 918		

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K 918	Continued From page 22 Power Systems, 2010 edition. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 The permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. Findings: During a tour of the facility, record review, and interview with staff on 1/2/19, the generator was observed and maintenance records were reviewed. 1. At 1:57 p.m., there were no records that indicated 12 of 12 monthly battery conductance tests were performed during the past 12 months. The diesel generator was observed with one sealed lead acid battery. Upon interview, Staff 2 stated that he was not aware that the generator battery needed to be tested monthly.	K 918	The battery tester was ordered on 2-6-19 and the battery tests started on 2-15-19 by the Maintenance Spv. He has a schedule set up to maintain the tests on a weekly basis The Life Safety Environmental Resource provided education to the Maintenance Spv. on 2-7-19 on the requirements for testing the generator battery, smoke detectors, fire alarm system and all required tests.	2-6-19 2-15-19 2-7-19

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K 918	Continued From page 23 2. At 3:03 p.m., the facility failed to provide documentation indicating that two of 12 monthly full load tests were completed on their diesel generator. The facility failed to provide documents for the month of March 2018 and August 2018. Upon interview, Staff 2 confirmed the finding. 3. At 3:08 p.m., the facility failed to provide documentation indicating that weekly inspections were completed for February 2018 and March 2018. Upon interview, Staff 2 confirmed the finding.	K 918	The full load test was set up on the "TELS" system for 2-22-19 and the test will be done on a monthly basis going forward. The Maintenance Spv. has weekly inspections for each week as of March 2018 and understands this must be done on a weekly basis. The Life Safety Environmental Resource provided education to the Maintenance Spv. on 2-7-19 regarding the importqance of making these inspections evey week. A schedule of all required inspections was provided. The Mainenance Spv. will provide a report to the QA Committee on a monthly basis and discuss the tests that were done for the last month. The QA Committee will make recommendations if necessary. The Administrator will monitor the test schedule to ensure that it is completed as required	2-22-19 2-7-19