STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING **02** B. WING _____	**07/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

(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. Representing the California Department of Public Health: 49495 The facility is not in substantial compliance with 42 CFR §483.73 for Long Term Care Facilities. Census = 114	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the	E 004		7/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/29/2024

8/07/2024: POC accepted per Jose Gonzalez, SSM-1

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E 004	Continued From page 1 following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to review and update their policies and procedures (P&P) in their Emergency Operations Plan (EOP) manual. This was evidenced by the facilities review date of the EOP that was not current within the past year. This could cause a disorganized emergency response in the case of an emergency, and result in injury to visitors, staff, and 114 of 114 residents. Findings: On 7/10/24, during a record review with the	E 004	What corrective action(s) have or will be put in place to ensure Emergency Plan meets requirements outlined as described by the California Department of Health? Emergency Operations Plan has been updated within the last 7 days, reviewed and signed by key department heads. Included along with this POC are the names and signatures of those who have reviewed this plan, as well as a screenshot of the table of contents.	

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E 004	Continued From page 2 Administrator, the emergency preparedness plan was reviewed. At 10:44 a.m., the facility's EOP failed to include an updated review date by staff. During an interview, the Administrator stated the staff was still in the process of updating the EOP manual. Recent staff turnover prevented the administration from updating and reviewing the EOP. The Maintenance Director acknowledged the finding at the exit conference.	E 004	Subsequent plans will be reviewed during Q2 of each following calendar year. A meeting notice has already been set up for Q2 2025 to revise and update this EOP Plan next year. Individual responsible: Administrator Date when corrective action will be completed: July 23, 2024	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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 every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E 030		7/23/24

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E 030	Continued From page 3 (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030		

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E 030	Continued From page 4 (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain their emergency plan. This was evidenced by the lack of the emergency names and contact information for the communication plan. The lack of maintaining an emergency response plan can result in an disorganized response during an emergency and result in injury to visitors, staff, and 114 of 114 residents. Findings: During record review and interview with the Administrator on 07/10/2024, the emergency plan	E 030	What corrective action(s) have or will be put in place to ensure Emergency Plan meets requirements outlined as described by the California Department of Health? Emergency Operations Plan has been updated within the last 7 days, to include contact information with latest staff, physicians, and other entities providing services. Included with submission are list of those contacts. Subsequent plans will be reviewed during	

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E 030	Continued From page 5 was reviewed. At 12:37 p.m., the emergency preparedness plan lacked evidence of development of the communication procedures with the names and contact information for entities providing services under arrangement. Upon interview, the Administrator stated recent staff turnover prevented the administration from completing this requirement. The Maintenance Director acknowledged the finding at the exit conference.	E 030	Q2 of each following calendar year. A meeting notice has already been set up for Q2 2025 to revise and update this EOP Plan next year. Individual responsible: Administrator Date when corrective action will be completed: July 23, 2024	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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 every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following:	E 031		7/23/24

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E 031	Continued From page 6 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to maintain their emergency plan. This was evidenced by the lack of emergency officials contact information. The lack of maintaining an emergency response plan can result in an disorganized response during an emergency and result in injury to visitors, staff, and 114 of 114 residents. Findings: During record review and interview with the Administrator on 07/10/2024, the emergency plan was reviewed. At 12:50 p.m., the emergency preparedness plan lacked evidence of development of the communication procedures with the names and contact information for federal, state, and local emergency officials. Upon interview, the Administrator stated recent staff turnover prevented the administration from completing this requirement.	E 031	What corrective action(s) have or will be put in place to ensure Emergency Plan meets requirements outlined as described by the California Department of Health? Emergency Operations Plan has been updated within the last 7 days, to include contact information for emergency personnel, including: • Federal, State, tribal, regional, and local emergency preparedness staff. • The State Licensing and Certification Agency. • The Office of the State Long-Term Care Ombudsman. Included with submission are list of those contacts. Subsequent plans will be reviewed during Q2 of each following calendar year. A meeting notice has already been set up	

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E 031	Continued From page 7 The Maintenance Director acknowledged the finding at the exit conference.	E 031	for Q2 2025 to revise and update this EOP Plan next year. Individual responsible: Administrator Date when corrective action will be completed: July 23, 2024	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.	E 036		7/23/24

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E 036	Continued From page 8 *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and	E 036		

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E 036	Continued From page 9 updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain their emergency plan's policy and procedure (P&P). This was evidenced by the lack of development of a training and testing program. The lack of maintaining an emergency response plan can result in an disorganized response during an emergency and result in injury to visitors, staff, and 114 of 114 residents. Findings: During record review and interview with the Administrator on 07/10/2024, the emergency plan was reviewed. At 12:31 p.m., the emergency response plan lacked P&P for development and maintenance of a training and testing program reflecting the risks and hazards identified within the facility's program. Upon interview and record review, the Administrator was unable to present the requested P&P. The Administrator stated recent staff turnover prevented the administration from completing the requirement The Maintenance Director acknowledged the finding at the exit conference.	E 036	What corrective action(s) have or will be put in place to ensure Emergency Plan meets requirements outlined as described by the California Department of Health? Emergency Operations Plan has been updated within the last 7 days, and includes Policies and Procedures for review with new hires and annually for common threats. Included with submission is section 3.10 of EOP manual for Training and Testing, along with log of drills and exercises to be tracked moving forward, and AAR form to document progress and those drills and exercises. Subsequent EOP plans will be reviewed during Q2 of each following calendar year. A meeting notice has already been set up for Q2 2025 to revise and update this EOP Plan next year. Individual responsible: Administrator Date when corrective action will be completed: July 23, 2024	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)	E 037		7/25/24

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E 037	Continued From page 10 §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 11 procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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E 037	Continued From page 12	E 037		

staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at

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	555323	A. BUILDING **02** B. WING _____	**07/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

(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 037	Continued From page 13 least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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E 037	Continued From page 14 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain their emergency plan. This was evidenced by the lack of documentation for the annual training of staff. The lack of maintaining an emergency response plan can result in an disorganized response during an emergency and result in injury to visitors, staff, and 114 of 114 residents. Findings: During record review and interview with the Administrator on 07/10/2024, the emergency plan was reviewed. At 12:31 p.m., the facility lacked documentation that would have shown that staff were trained annually on the emergency preparedness plan. The Administrator presented documentation for training new employee hires. The Administrator stated that he did not have the annual training on the emergency response plan completed by staff. Recent staff turnover prevented the administration from completing the requirement. The Maintenance Director acknowledged the finding at the exit conference.	E 037	What corrective action(s) will be accomplished for the deficiencies identified? Emergency Operations Plan has been updated within the last 7 days, and includes Policies and Procedures for review with new hires and annually for common threats. Included with submission is section 3.10 of EOP manual for Training and Testing, along with log of drills and exercises to be tracked moving forward, and AAR form to document progress and those drills and exercises. We've also included an attachment with signatures as evidence that EOP training took place with staff on 08/02/2024. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Subsequent EOP plans will be reviewed	

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E 037	Continued From page 15	E 037	during Q2 of each following calendar year. A meeting notice has already been set up for Q2 2025 to revise and update this EOP Plan next year. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the log quarterly during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not	E 039		7/25/24

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E 039	Continued From page 16	E 039		

accessible, conduct a facility-based functional exercise every 2 years; or

(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]

(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based

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E 039	Continued From page 17 functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise	E 039		

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E 039	Continued From page 18 following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or	E 039		

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E 039	Continued From page 19 and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 20 is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 21 community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion,	E 039		

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E 039	Continued From page 22 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039		

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E 039	Continued From page 23 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set	E 039		

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E 039	Continued From page 24 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain their emergency plan. This was evidenced by the lack of documentation for an in-house tabletop exercise and community-based drill. The lack of maintaining an emergency response plan can result in an disorganized response during an emergency and result in injury to visitors, staff, and 114 of 114 residents. Findings: During record review and interview with the Administrator on 07/10/2024, the emergency plan was reviewed. At 10:57 a.m., the emergency response plan lacked documentation for two of two emergency preparedness testing requirements. Upon interview, the Administrator stated recent staff turnover prevented the administration from completing the requirement. The Administrator stated if the documentation was found, they would send the documentation via email by the end of the day. The documentation was not received. The Maintenance Director acknowledged the finding at the exit conference.	E 039	What corrective action(s) will be accomplished for the deficiencies identified? Emergency Operations Plan has been updated within the last 7 days and includes Policies and Procedures for review with new hires and annually for common threats. Included with submission is section 3.10 of EOP manual for Training and Testing. Log of drills included to be tracked moving forward (though fire drills already tracked previously, just not disaster or tabletop drills) Aviara also completed a tabletop drill activity on 08/02 and attached documentation to prove evidence of drill. We will conduct another community-based drill within the next 6 months (prior to end of 2024) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Subsequent EOP plans will be reviewed	

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E 039	Continued From page 25	E 039	during Q2 of each following calendar year. A meeting notice has already been set up for Q2 2025 to revise and update this EOP Plan next year. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the log quarterly during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING **02** B. WING _____	**07/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

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E 041	Continued From page 26 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource	E 041		

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E 041	Continued From page 27 Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	E 041	What corrective action(s) will be	

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E 041	Continued From page 28 failed to update their policies and procedures (P&P) in the emergency plan. This was evidenced by the lack information in their emergency plan that was not current with the available emergency power source. This could cause confusion during the loss of normal power in an emergency, and result in injury to visitors, staff, and 114 of 114 residents. Findings: On 07/10/24, during a record review with the Maintenance Director (MD), the emergency preparedness plan was reviewed. At 11:28 a.m., the facility's P&P failed to include information on the emergency power system. The facility was observed with a 17.5 kilowatt (kW) diesel-powered generator connected to emergency power. The MD acknowledged the finding at the exit conference.	E 041	accomplished for the deficiencies identified? Emergency Operations Plan has been updated within the last 7 days, and includes Policies and Procedures related to alternate sources of fuel. Included in this POC is pg. 69 of our EOP Plan with those details. The P&P has also been updated and states the following: It is a Kohler fueled by Diesel with a tank that holds 50 hours worth of fuel. This generator powers the following systems in our facility: • Emergency Lighting • Every other light in hallways • Red outlets in hallways • Fridge and Freezer What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Policies and Procedures will be updated annually based on the calendar invite that has already been set up (starting in the 2025 calendar year) How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the P&P with IDT team in Q4 of each	

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E 041	Continued From page 29	E 041	calendar year, during QA meeting. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 26th.	
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1998 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, Construction Type V(000), 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. Representing the Department of Public Health: 49495 CENSUS: 114 The facility is not in substantial compliance with 42 CFR §483.90.	K 000		
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	K 223		7/23/24

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K 223	Continued From page 30 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 by: Based on observation and interview, the facility failed to maintain self-closing devices. This was evidenced by a door that did not fully close and latch when tested. This affected facility staff in one of seven smoke compartments. The lack of maintaining self-closing devices could result in the inability to prevent smoke and toxic gases from entering the space during an active fire. NFPA 101: Life Safety Code, 2012 Edition 19.2.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 19.2.2.2.8 Where doors in a stair enclosure are held open by an automatic release device as permitted in 19.2.2.2.7, initiation of a door-closing action on any level shall cause all doors at all levels in the stair enclosure to close.	K 223	What corrective action(s) will be accomplished for the deficiencies identified? The door to the boiler room, located in the laundry room, has been adjusted and now fully latches properly. (screw was missing but has since been replaced). What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? There will be a log signed monthly by Director of Maintenance to ensure that self-closing devices are checked on a regular basis. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the log quarterly during scheduled QA meetings. Any negative findings to be	

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K 223	Continued From page 31 Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 07/10/24, the door openings were observed. At 1:48 p.m., the door to the boiler room, located in the laundry room, was tested and did not close fully nor latch properly. The arm to the self-closing mechanism was observed to be detached. The MD indicated they will be adjusting the door to self-close. The MD acknowledged the findings in the exit conference.	K 223	reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain their exit signs. This was evidenced by the lack of 90-minute annual testing and the lack of testing for the 30-second monthly testing of the exit signs. This affected visitors, staff, and 114 of 114 residents in seven of seven smoke compartments. The lack of maintaining the exit signs could result in a delayed emergency response during an active fire.	K 293	What corrective action(s) will be accomplished for the deficiencies identified? Alarm Company (James Gollner) arrived on July 25th to do annual 90-minute inspection. They will continue to come annually moving forward. Included is documentation that test has been	7/25/24

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K 293	Continued From page 32 NFPA 101, Life Safety Code, 2012 Edition 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: On 7/10/24, during a record review with the Maintenance Director (MD), the exit signage inspection records were reviewed. 1. At 9:50 a.m., there was no 90-minute annual testing of the battery powered exit signs. The MD	K 293	completed. (Pages 20-22 of file - additional supporting documentation) MD reviewed all Exit signs for 30-sec test to confirm all 28 units functioning properly (see Attachment3 with signed log). Moving forward there is a monthly log that MD will fill out to confirm exit lights work properly. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Records will be signed by both Director of Maintenance and Administrator once annual 90-minute and monthly 30-second tests are completed. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review confirmed tests annually during scheduled QA meeting in Q2 each year. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	

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K 293	Continued From page 33 stated the annual 90-minute testing document for the exit signs could not be found. 2. At 9:50 a.m., there was no record to test the exit signs for 30-seconds monthly. The MD stated that staff does not test the exit signs monthly for 30-seconds. The MD acknowledged the finding at the exit conference.	K 293		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		7/26/24

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K 324	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their cooking facility. This was evidenced by the lack of record of the semi-annual kitchen hood fire suppression maintenance and missing the annual kitchen cooking equipment inspection. This affected facility staff in one of seven smoke compartments. The lack of maintaining the cooking facility can result in a delay with extinguishing a stove top fire. NFPA 101: Life Safety Code, 2012 Edition 19.3.2.5 Cooking Facilities. 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4.9.2.3 Commercial Cooking Equipment. 9.2.3 Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2014 Edition. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every six	K 324	What corrective action(s) will be accomplished for the deficiencies identified? Included is documentation for quote on company that will begin doing cleaning/inspection of kitchen equipment. (Pages 2-3 of file - additional supporting documentation) Included is documentation on inspection of fire hood suppression system (Pages 8-11 of file - additional supporting documentation) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Records will be signed by both Director of Maintenance semi-annually as inspections take place, and logged. This will be reviewed by Administrator to confirm it's taking place. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review confirmed tests semi-annually during scheduled QA meeting in Q1 and Q3 of each year. Any negative findings to be reported to the QA committee to ensure facility compliance.	

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K 324	Continued From page 35 months. 11.4* Inspection for Grease Buildup. The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. 11.5 Inspection, Testing, and Maintenance of Listed Hoods Containing Mechanical, Water Spray, or Ultraviolet Devices. Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected and tested by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. 11.7 Cooking Equipment Maintenance. 11.7.1 Inspection and servicing of the cooking equipment shall be made at least annually by properly trained and qualified persons. Findings: During a record review and interview with the facility Maintenance Director (MD) on 07/10/24, the cooking facility was observed. 1. At 3:20 p.m., there was no annual kitchen cooking equipment inspection record. 2. At 3:20 p.m., there was one of two semi-annual kitchen hood fire suppression system maintenance records missing. The semi-annual kitchen hood fire suppression system maintenance's that was completed was dated June 28th, 2024. The MD acknowledged the findings at the exit	K 324	Date when corrective action will be completed: July 25th.	

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K 324	Continued From page 36 conference.	K 324		
K 345 SS=F	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: Based on document review and interview, the facility failed to maintain the fire alarm system. This is evidenced by missing annual and semi-annual fire alarm inspection/testing records, and a missing semi-annual load voltage testing record. This could cause a disorganized emergency response in the case of an emergency, and result in injury to visitors, staff, and 114 of 114 residents in seven of seven smoke compartments. NFPA 101- Life Safety Code, 2012 Edition 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. 9.6.1.5 * 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	K 345	What corrective action(s) will be accomplished for the deficiencies identified? 1. Included is documentation from Alam Company - James Gollner - with proof of inspection. (Pages 12-19 of file additional supporting documentation) 2. Included is documentation from Alam Company - James Gollner - with proof of inspection. (Pages 12-19 of file additional supporting documentation) 3. Alarm Company (James Gollner) tested the smoke detector the following day and confirmed that the detector activated properly. 4. Included is documentation from Alam Company - James Gollner - with proof of inspection on load-voltage testing. (Pages 12-19 of file additional supporting documentation) What measures will be put into place or	7/26/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 37 Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72- National Fire Alarm and Signaling Code, 2010 Edition 14.3 Inspection. 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. Table 14.3.1 (9) Initiating Devices Subsection (e) Manual Fire Alarm Devices-Initial/Reacceptance, Semiannually Table 14.3.1 (13) Alarm Notification Devices--Supervised- Initial/Reacceptance, Semiannually 14.4.5 * Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5 (15) Initiation Devices* Subsection (f) Manual Fire Alarm Boxes-Initial/Reacceptance, Annually Table 14.4.5 (20) Alarm notification appliances Subsection (a) Audible Devices-Initial/Reacceptance, Annually Subsection (b) Audible Textual Notification Devices- Initial/Reacceptance, Annually Subsection (c) Visible Devices-Initial/Reacceptance, Annually 14.6.2.1 Records shall be retained until the next test and for 1 year thereafter. 14.6.2.3 The records shall be on a medium that will survive the retention period. Paper or electronic media shall be permitted. 14.6.2.4 * A record of all inspections, testing, and	K 345	what systemic changes the facility will make to ensure that the deficient practice does not recur? Records will be signed by Director of Maintenance semi-annually/annually as inspections take place, and logged. This will be reviewed by Administrator to confirm its taking place. How will the facility plan to monitor its performance to make sure that solutions are sustained? Administrator or designee to review confirmed tests semi-annually during scheduled QA meeting in Q1 and Q3 of each year. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	

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	555323	A. BUILDING **02** B. WING _____	**07/10/2024**

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K 345	Continued From page 38 maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) * Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device	K 345		

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K 345	Continued From page 39 abandoned in place) Findings: During a document review and interview with the Maintenance Director (MD) on 07/10/24, the fire alarm system inspection/testing records were requested and reviewed. 1. At 11:31 a.m., the semiannual fire alarm system inspection records for the manual fire alarm box, duct detectors, heat detectors, and smoke detectors were missing. The MD stated if the documentation was found, they would send the documentation via email by the end of the day. The requested documentation was not received. 2. At 11:31 a.m., the annual fire alarm system inspection records for the manual fire alarm box, duct detectors, heat detectors, and smoke detectors were missing. The MD stated if the documentation was found, they would send the documentation via email by the end of the day. The requested documentation was not received. 3. At 11:40 a.m., in the 300 hallway, a smoke detector failed to activate and did not set off the fire alarm system when tested. The MD stated the fire alarm system vendor would test the alarm system again to and fix the detector as soon as possible. 4. At 12:02 p.m., there was one of two records missing for the semi-annual load-voltage testing of batteries to the fire alarm control panel. The MD acknowledged the finding at the exit conference.	K 345		

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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 _____ 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 observation, and interview, the facility failed to maintain the sprinkler system. This was evidenced by the coating of dust and debris buildup on a sprinkler head, misplacement of the orientation of a sprinkler head, and missing inspection test records. This affected visitors, staff, and 114 of 114 residents in seven of seven smoke compartments. The lack of maintaining a sprinkler system could result in the malfunction of the sprinkler discharging and extinguishing 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,	K 353	What corrective action(s) will be accomplished for the deficiencies identified? 1. In the Biohazard Closet, there was one unconcealed sprinkler head that appeared to be covered in dust and debris: the MD has cleaned the dust and debris from the sprinkler head. 2. Sprinkler in kitchen that was not flush with the ceiling: The MD has adjusted the sprinkler head and ensured that it is flush with the ceiling as required. 3. Five-year annual sprinkler inspection test record has been included, sent as attachment called: Attachment3	7/26/24

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K 353	Continued From page 41 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25-Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.2.1 Sprinklers. 5.2.1.1 * Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1 * Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading * (6) Painting unless painted by the sprinkler manufacturer Findings: Upon observation and interview with the Maintenance Director (MD) on 07/10/2024, the sprinkler system was observed. 1. At 11:59 a.m., in the Biohazard Closet, there was one unconcealed sprinkler head that appeared to be covered in dust and debris. The MD removed the spider web immediately. 2. At 1:56 p.m., in the kitchen, a sprinkler head appeared to be broken and the ceiling around the	K 353	4. Visual inspection has been done for all sprinklers, gaugers, control valves, and tamper switches. A log has been created to manage and monitor these moving forward. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? A log has been created to monitor the sprinkler system as listed in requirements. This log will be filled out by the MD and reviewed by Administrator on a quarterly basis in QA review. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the signed logs during QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 26th.	

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K 353	Continued From page 42 sprinkler was punctured. This caused the sprinkler not to be flushed to the ceiling properly. The MD stated the pressure in the pipes inside the kitchen walls most likely caused the ceiling to open which pushed the sprinkler outwards causing it to be improperly secured and misplaced. 3. At 10:27 a.m., there was no evidence of a five-year annual sprinkler inspection test record. The MD stated the sprinkler system had not been maintained by the vendor. 4. At 11:26 a.m., there was no evidence of monthly visual inspection records of gauges, control valves, tamper switches, and valves. The MD acknowledged the findings at the exit conference.	K 353		
K 355 SS=F	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: Based on record review and interview, the facility failed to maintain their portable fire extinguishers. This was evidenced by fire extinguisher that had not been visually inspected for the last twelve months. This affected visitors, staff, and 114 of 114 residents, and seven of seven smoke compartments. The lack of maintaining the portable fire extinguishers could result in the	K 355	What corrective action(s) will be accomplished for the deficiencies identified? Fire extinguishers have been inspected monthly, however were not tracked on a log. Included in this POC is a template for a log that will be used moving forward	7/23/24

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K 355	Continued From page 43 inability to extinguish an active fire. NFPA 101, Life Safety Code, 2012 Edition 9.7.4 Manual Extinguishing Equipment. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1 * Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2 * Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Findings: On 7/10/24, during record review with the Maintenance Director (MD), the portable fire extinguishers were observed. At 10:00 a.m., the portable fire extinguisher had not been visually inspected for twelve months. Upon record review, the MD stated the fire extinguishers are not visually inspected monthly and will fulfill the requirement moving forward.	K 355	(monthly). What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Records will be signed by Director of Maintenance monthly as inspections take place, and logged. This will be reviewed by Administrator to confirm its taking place. How will the facility plan to monitor its performance to make sure that solutions are sustained? Administrator or designee to review confirmed tests during monthly Quality meeting. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	

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K 355	Continued From page 44 The MD acknowledged the finding at the end of the exit conference.	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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		7/25/24

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K 363	Continued From page 45 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: Based on observation, the facility failed to maintain the corridor doors. This was evidenced by a door that did not latch properly when tested. This affected two of 114 clients in one of seven smoke compartments. The lack of maintaining the corridor doors could result in the inability to prevent smoke and toxic gases from entering the corridor during an active fire. NFPA 101: Life Safety Code, 2012 Edition 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: 1. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. 19.3.6.3.10* Doors shall not be held open by devices other than those that release when the door is pushed or pulled. Findings: During a tour of the facility with the Maintenance Director (MD) on 07/10/24, the door openings were observed. At 11:54 p.m., in hallway 500, the door did not latch fully and the latch appeared to be stuck inside the door. The MD acknowledged the findings in the exit conference.	K 363	What corrective action(s) will be accomplished for the deficiencies identified? Corridor doors have been adjusted/fixed, so that they now latch properly when tested. For room in 500 hall, the latch was replaced and is not working/closing properly. Included is a picture of the fixed door. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? There will be a log signed monthly by Director of Maintenance to ensure that both self-closing devices, and doors are checked on a regular basis. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the log quarterly during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	

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K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their electrical system. This was evidenced through a broken electrical outlet, which affected two of 114 residents in one of seven smoke compartments. There was also a missing receptacle wall plate which affected one of seven compartments. The lack of maintaining the electrical system components could result in an electrical fire. NFPA 101, Life Safety Code, 2012 9.1 Utilities 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, Life Safety Code, 2011 406.5 Receptacle Mounting. Receptacles shall be mounted in boxes or assemblies designed for the purpose, and such boxes or assemblies shall be securely fastened in	K 511	What corrective action(s) will be accomplished for the deficiencies identified? 1. Outlet cover in room 100, bed A was replaced/repaired appropriately. Picture included in submitted material 2. In DSD office, wall receptacle replaced so that no wires protruding from the wall. Picture included in submitted material What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? There will be a log signed monthly by Director of Maintenance to ensure outlets and wall plates are in good working condition. How the facility plans to monitor its performance to make sure that solutions	7/25/24

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K 511	Continued From page 47 place unless otherwise permitted elsewhere in this Code. 406.5(C) Receptacles Mounted on Covers. Receptacles mounted to and supported by a cover shall be held rigidly against the cover by more than one screw or shall be a device assembly or box cover listed and identified for securing by a single screw. 406.6 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface. Findings: During observation, record review, and interview with the Maintenance Director (MD) on 07/10/2024, the electrical outlet was observed. 1. At 2:01 p.m., in room 100, bedroom A, the outlet's cover plate was broken. 2. At 2:15 p.m., in the DSD office, there was a missing receptacle wall plate. There was several wires protruding from the wall. Upon interview, the MD stated they were still figuring out which wires to cut in a safe manner. The MD acknowledged the finding at the exit conference.	K 511	are sustained? Administrator or designee to review the log quarterly during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	K 761		7/25/24

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K 761	Continued From page 48 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to maintain their fire doors. This was evidenced by the lack of the annual fire door inspection. This affected visitors, staff, and 114 of 114 of residents. The lack of maintaining the fire doors annually could result in the malfunction of the doors during an active fire. NFPA 80: Standard for Fire Doors and Other Opening Protectives, 2010 Edition 5.2 * Inspections. 5.2.1 * Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. Findings: Upon observation and interview with the Maintenance Director (MD) on 07/10/2024, the fire door inspection test records were observed. At 11:32 a.m., in there was no, record of the annual fire door maintenance and testing records.	K 761	What corrective action(s) will be accomplished for the deficiencies identified? Fire doors have been routinely inspected, however, were not tracked on a log annually. Included in this POC is a template for a log that will be used moving forward. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? There will be a log signed monthly by Director of Maintenance to ensure fire doors are in good working condition. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the	

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K 761	Continued From page 49 The MD stated the maintenance and testing records are not completed annually. The MD acknowledged the finding at the exit conference.	K 761	log quarterly during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	
K 918 SS=F	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 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	K 918		7/25/24

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	555323	A. BUILDING **02** B. WING _____	**07/10/2024**

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K 918	Continued From page 50 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: Based on record review and interview, the facility failed to maintain their electrical system. This was evidenced by the facility's lack of documentation of conductance testing for the generator battery, incomplete visual inspection records for the generator, and the lack of the four-hour load test for diesel engines. This affected visitors, staff, and 114 of 114 of residents and seven out of seven smoke compartments. The lack of maintaining an electrical system could result in the improper function of the generator system. NFPA 101, Life Safety Code, 2012 Edition. 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 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. 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 99, Health Care Facilities Code, 2012 Edition 6.3.2.2.10 Essential Electrical System (EES)	K 918	What corrective action(s) will be accomplished for the deficiencies identified? 1. As noted, generator has been visually inspected and logged since our current MD started working at Aviara in July 2023. This will continue to be logged moving forward. 2. Global Power Group has since come out and visited Aviara and provided backup documentation on required generator testing. (Page 8 of file: additional supporting documentation) 3. MD purchased a Mobile Battery Tester (Model TOPDON BT20) and confirmed conductance testing meets requirements. While this testing had not been done previously, Aviara now has a log to track moving forward What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? In-house logs will be signed by MD, and external testing records will be submitted. Administrator will review both on a quarterly basis to ensure testing and inspections are taking place according to	

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K 918	Continued From page 51 6.3.2.2.10.2 General care room (Category 2 Room) Shall be served by a Type I or Type II EES. 6.4.1.1.6 General. Generator sets installed as an alternate source of power for essential electrical systems shall be designed to meet the requirements of such a device. 6.4.4.1.1.3 Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8. 6.4.4.2 Record Keeping. A written record of inspection, performance, exercise period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. 6.5.1 Sources (Type 2 EES). This requirement for sources for Type 2 essential electrical systems shall conform to those listed in 6.4.1. 6.5.4 Administration (Type 2 EES). 6.5.4.1 Maintenance and Testing of Essential Electrical System. 6.5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. 6.5.4.1.1.1 Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenance parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 6.4.1.1.7 and 6.4.3.1. 6.5.4.1.1.2 Inspection and Testing. Generator sets shall be inspected and tested in accordance with 6.4.4.1.1.3. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition. 8.1* General.	K 918	requirements. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review confirmed tests annually during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 25th.	

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K 918	Continued From page 52 8.1.1 The routine maintenance and operational testing program shall be based on all of the following: (1) Manufacturer's recommendations (2) Instruction manuals (3) Minimum requirements of this chapter (4) The authority having jurisdiction 8.3 Maintenance and Operational Testing. 8.3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. Table A8.3.1(a) Findings: On 07/10/24, during a observation an record review with the Maintenance Director (MD), the generator was observed. 1. At 9:37 a.m., there was incomplete weekly visual inspection test records for the generator. There appeared to be 38 of 52 weeks of visual inspection test records. The MD stated the former MD did not complete the weekly visual inspections but would start completing the weekly inspections moving forward. 2. At 9:45 a.m., there was no maintenance testing records for the four-hour load test for diesel engine generators. The MD stated the paperwork could not be located, but if they were found he would send them to the email provided during the exit conference. The paperwork was not provided by the end of the day.	K 918		

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K 918	Continued From page 53 3. At 3:35 p.m., there was no inspection records for the conductance testing for the battery for the generator. The MD stated the facility was unaware of the requirement and would complete the requirement moving forward. The MD the finding at the exit conference.	K 918		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.	K 921		7/26/24

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K 921	Continued From page 54 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain and test their patient care related electrical equipment (PCREE). This was evidenced by incomplete documentation of testing of PCREE and the lack of testing their ground fault circuit interrupters (GFCI). This affected seven of seven smoke compartments. This could cause staff to be unaware of malfunctioning equipment that could possibly cause a fire, which could harm residents, visitors and staff. NFPA 99, Health Care Facilities Code 2012 Edition 3.3.137 Patient-Care Related Electrical Equipment. Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. 3.3.139 Patient Care Vicinity. A space, within a location intended for the examination and treatment of patients, extending 1.8 m (6 ft) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extending vertically to 2.3 m (7 ft 6 in.) above the floor. (MED) 10.3.1* Physical Integrity. The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. 10.4.2.1 Non-patient care related electrical equipment, including facility or patient owned appliances that are used in the patient care vicinity and will, in normal use, contact patients, shall be visually inspected by the patient's care	K 921	What corrective action(s) will be accomplished for the deficiencies identified? Maintenance Director is now aware and understands requirements for both PCREE testing as well as testing for GFCI. Included with this POC is a log that shows tracking for both at appropriate intervals. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? There will be a log signed monthly or annually (as defined by regulations) by Director of Maintenance to ensure PCREE and GFCI testing done appropriately. How the facility plans to monitor its performance to make sure that solutions are sustained? Administrator or designee to review the log quarterly during scheduled QA meetings. Any negative findings to be reported to the QA committee to ensure facility compliance. Date when corrective action will be completed: July 26th.	

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K 921	Continued From page 55 staff or other personnel. 10.5.2.1.1 The facility shall establish polices and protocols for type of test and intervals of testing for patient care-related electrical equipment. 10.5.2.1.2 All patient care-related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or medication that might have compromised electrical safety. 10.5.6.1.1 A permanent file of instruction and maintenance manuals shall be maintained and be accessible. 10.5.6.1.2 The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. 10.5.6.2.1 A record shall be maintained of the tests required by this chapter and associated repairs or documentation's. 10.5.6.2.2 At a minimum, the record shall contain all of the following: (1) Date (2) Unique identification of the equipment tested (3) Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 Findings: On 07/10/24, during a tour of the facility with the Maintenance Director (MD), the patient care related electrical equipment was observed and the maintenance record reviewed. 1. At 11:40 a.m., the facility failed to provide complete documents of for the electrical receptacle tension and polarity testing of receptacles at patient bed locations. The MD stated that he was not unaware of the PCREE	K 921		

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K 921	Continued From page 56 maintenance requirement. Moving forward maintenance staff will complete the testing requirement. 2. At 11:40 a.m., the facility failed to provide complete documents of the GFCI testing. The MD acknowledged the finding at the exit conference.	K 921		