Accepted 12-18-19 13871

PRINTED: 11/25/2019
FORM APPROVED
OMB NO. 0938-0391

'PARTMENT OF HEALTH AND HUMAN SERVICES
_ TERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. BUILDING _____ B. WING _____	11/12/2019

'E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 90201

(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: Surveyor ID Number: 13871, REHS, Certified Fire Inspector 1, Life Safety Code The facility was not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities Licensed: 136 Census: 131	E 000	**Please accept this Plan of Correction as our Credible Allegation Package. This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence no later than 12/05/19.** **Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 483.73.** RP (Initials)	
E 039 SS=C	S/S= C EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]	E 039	**E 039 – EP Annual Drill/Testing Requirements** **CORRECTIVE ACTION** The facility's Emergency Operations Plan binder is complete. The facility completed a disaster Table-Top exercise review on 09/13/19 using the scenario that a large earthquake affected the region. On 12/03/19 and 12/04/19, the Administrator reviewed the California Association of Health Facilities (CAHF) 'disaster prep' website (www.cahfdisasterprep.com) planning for completion of the Full-Scale disaster drill by January 31, 2020.	01/31/20

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Pellicer | TITLE: Administrator | (X8) DATE: 12/5/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 039	Continued From page 1 (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. 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 a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, 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 RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] 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 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response	E 039	**IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of all visitors and residents within the facility is at risk due to this deficiency. The training overview and mock drills associated with disaster preparedness will ensure the facility can adequately react when there is an actual emergency. No residents were directly affected by this finding. The Administrator is actively in the process of completing the Full-Scale drill in January 2020. **SYSTEMIC CHANGES** The facility will continue utilizing Delta Fire, Inc for the monthly and quarterly fire & disaster drills as per regulation. The facility will continue to maintain website access to www.reddinet.net in coordination with annual table-top and full-scale drill notifications, as per regulation. **MONITORING EFFECTIVENESS** At the monthly safety committee meeting and quarterly Quality Assurance (QA) committee, the Administrator and maintenance supervisor will discuss fire and disaster drill trainings completed as well as scheduled annual table-top and full-scale drills, ensuring the facility will remain in compliance with regulatory requirements.	

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E 039	Continued From page 2 to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and maintain an emergency preparedness program that must comply with all applicable Federal, State, and local emergency preparedness requirements that must include, but not limited to the elements of a Emergency Plan that must be reviewed, evaluated, and updated at least annually. Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, 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. This deficient practice had the potential of staff delaying or not responding in accordance with a developed and practiced emergency preparedness program and plan with clear duties and responsibilities in the event of a fire, disaster, and need for emergency evacuation, relocation or shelter in place. The staff's level of training and familiarity with the facility's plan affects the safety of all the clients and occupants of the facility.	E 039		

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E 039	Continued From page 3 Findings: On November 12, 2019, at 7 a.m., during a record review of the emergency preparedness program, the evaluator noted the plan did not include: a full scale exercise, a second full-scale exercise, a tabletop exercise, and an analysis to the exercises. On November 12, 2019 at 7:15 a.m., the administrator stated the facility did not conduct a full scale exercise that included analysis response to the exercises. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	E 039		

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during the Life Safety Code Survey. Highest Severity and Scope = F Representing the Department of Public Health: 13871 Total licensed beds: 136 Total resident census: 131	K 000	Please accept this Plan of Correction as our Credible Allegation Package. This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence no later than 12/05/19. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907. RP (Initials)	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 223	K223 – It is the policy of this facility to ensure doors in an exit passageway, smoke barrier or hazardous area enclosure are self-closing or automatic closing in accordance with Section 7.2.1.8.2. CORRECTIVE ACTION On 11/13/19, the Maintenance Supervisor (MS) and designee adjusted the closure mechanism on the maintenance room entry door so it will fully self-close. IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION	11/13/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Pellon | TITLE: ADMINISTRATOR | (X6) DATE: 12/5/19

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K 223	Continued From page 1 failed to ensure the doors' self-closing devices to the maintenance room, were capable of completely closing the doors. In the event of fire and /or smoke emergency, doors that do not automatically self-close and thus establish conditions conducive to the rapid spread of fire, smoke and heat to the rest of the facility. Findings: On November 11, 2019, during the life safety tour observation between 9 a.m. and 10:30 a.m., the evaluator tested the self-closing device of the entry door for the maintenance room. The self-closing device did not completely close the door and an opening of 1.5 feet was observed. At 10:30 a.m., during an interview, the maintenance supervisor, stated she would repair the self-closing device so it would close completely. This affected one of three smoke compartments. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	K 223	The safety of all visitors and residents within the facility was at risk due to this deficiency. The immediate repair/adjustment of the self-closing device by the MS ensured fire or smoke in the maintenance room will be contained only in this one compartment. No other self-closing door devices were found to need adjusting; no residents were directly affected by this deficiency. **SYSTEMIC CHANGES** During daily rounds, the MS or designees will ensure all doors with self-closing device are functioning properly. If any inoperative devices are found, repairs will be immediate and reported to the Administrator. **MONITORING EFFECTIVENESS** At the monthly safety committee meeting and quarterly Quality Assurance (QA) committee, the MS will report that all facility door self-closing devices will function properly in the event of a fire or emergency.	
K 293 SS=D	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	K 293	**K293 – It is the policy of this facility that exits are marked by approved, readily visible signs in accordance with NFPA LSC 101-7.10.1.5.1 Readily visible exits will ensure the exit way is apparent to the occupant during an emergency exit.** **CORRECTIVE ACTION** On 11/21/19, the maintenance staff installed new exit signage in the kitchen ensuring the	11/21/19

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K 293	Continued From page 2 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure access to exits were marked by approved, readily visible signs in all cases where the exit or way to reach exit were not readily apparent to the occupants in accordance to NFPA LSC 101-7.10.1.5.1. Readily visible exits will ensure the exit way is apparent to the occupant during an emergency exit. NFPA 101-7.10.1.5.1- Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Findings: On November 12, 2019, at 10:09 a.m., during an observation, the kitchen was observed with multiple passages with one of the passageways which lead to a storage area and not an exit. The facility was observed with no exit signs (illuminated) to ensure the way to reach the exit was readily apparent. The maintenance supervisor was informed an approved exit (illumination capabilities) would be required. At 10:11 a.m., during an interview, the maintenance supervisor acknowledged the need for an exit sign in the kitchen area and stated she would provide them. This affected one of three smoke compartments. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the	K 293	way to reach the exit is readily apparent to room occupants. **IDENTIFYING OTHERS AT RISK & CORRECTIVE ACTION** The safety of occupants in the kitchen area was at risk due to this deficiency because the exit paths were not readily apparent. During the 11/11/19 surveyor inspection and subsequent MS floor rounds, all other exits were found clearly marked and illuminated in accordance with regulations. **SYSTEMIC CHANGES** The MS will ensure that all exits are marked or illuminated during daily rounds. If any exit signage is blocked or not illuminated properly, repairs will be immediate and reported to the Administrator at the daily department head stand-up meeting. **MONITORING EFFECTIVENESS** At the safety committee meeting and quarterly QA meeting, the MS will report that all points of exit in the facility are properly marked and visible in accordance with NFPA regulations.	

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K 293	Continued From page 3 maintenance supervisor were informed of the deficiency.	K 293	**K321 – It is the policy of this facility to ensure hazardous areas are enclosed with a fire barrier and/or automatic extinguishing system.** **CORRECTIVE ACTION** On 12/3/19, the maintenance staff moved the (1) wooden shed and (1) aluminum shed to a new permanent location in the facility parking lot, eliminating any potential fire hazard. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility was at risk due to this deficiency. On 11/12/19, during floor rounds the MS found no similar storage shed hazard deficiencies. No other residents were directly affected by this finding. **SYSTEMIC CHANGES** During their daily rounds, the MS or designees will visually inspect all general occupancy areas of the building, ensuring compliant fire hazard safety precautions. **MONITORING EFFECTIVENESS** The MS or designees will remove and report findings of potential fire hazards to the Administrator during the daily department head stand-up meeting. Findings may also be discussed at the monthly safety committee meeting and quarterly QA Committee for analysis and suggestions.	12/3/19
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: NFPA 101 8.7 Special Hazards Protection. 8.7.1 General	K 321		

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K 321	Continued From page 4 8.7.1.1 * Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.3. (2) Protecting the area with automatic extinguishing systems in accordance with Section 9.7 (3) Applying both 8.7.1 (1) and (2) where the hazard is severe or where otherwise specified by Chapters 11 through 43. Based on observation and interview, the facility failed to ensure hazardous areas were enclosed with a fire barrier and/or automatic extinguishing system. Hazard areas that are not protected with a fire barrier or an automatic extinguishing system increases the likelihood of a fire emergency. Findings: On November 12, 2019, during the life safety tour at 9 am to 10 am, the evaluator noted a wood storage shed that measured 6' length x 4.5' width x 6' 10" height and another aluminum/light metal shed that measured 7.6' L x 6 'W x 6'10" H. The storage sheds were not under a fire sprinkler system and both were directly in contact with the exterior kitchen wall of the facility. The sheds were also in the designated smoking area. The chairs and table used in the smoking area was approximately 3-6 feet away from the sheds. The maintenance supervisor opened the sheds and revealed the wood shed stored decorations and activities supplies. The second shed contained	K 321		

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K 321	Continued From page 5 multiple bottles of cleaning chemicals. The maintenance supervisor was informed the evaluator deemed the sheds hazardous due to the direct contact to the facility wall and the close proximity of the table that the smokers used in the designated smoking area. At 10 a.m., the maintenance supervisor stated they would remove the sheds and relocate all the supplies to the large steel metal storage containers in the parking lot. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	K 321	**K324 – It is the policy of this facility that cooking facilities and equipment are protected in accordance with NFPA 96 – 10.2.3.** **CORRECTIVE ACTION** On 11/26/19 and 12/2/19, the facility maintenance consultant was contacted regarding the installation of the ANSI/UL 300 (ANSUL) fire suppression system. On 12/5/19, third-party vendor GNA-Fire Protection contact person Steve Cope completed kitchen area walkthrough with the Administrator and MS as initial planning for the ANSUL system project. Mr. Cope's estimate for project completion is approximately June 2020. This estimate may change as the project commences.	12/5/19
K 324 SS=F	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	K 324	**IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility may be at risk if the facility remains noncompliant. The initial planning phase has commenced to bring the facility into compliance. No residents or visitors were affected by this finding. **SYSTEMIC CHANGES** After the ANSUL suppression system is installed, maintenance and kitchen staff will receive fire safety in-service from GNA-Fire Protection or similarly skilled trainers,	

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K 324	Continued From page 6 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 This REQUIREMENT is not met as evidenced by: NFPA 96 10.1.1 Fire-extinguishing equipment for the protection of grease removal devices, hood exhaust plenums, and exhaust duct systems shall be provided. 10.1.2* Cooking equipment that produces grease laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. 10.2. Types of equipment. 10.2.1 Fire-extinguishing equipment shall include both automatic fire-extinguishing systems as primary protection and portable fire extinguishers as secondary backup. 10.2.2* A placard shall be conspicuously placed near each extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. 10.2.2.1 The language and wording for the placard shall be approved by the authority having jurisdiction. 10.2.3* Automatic fire extinguishing systems shall comply with ANSI/UL 300 or other equivalent standards and shall be installed in accordance	K 324	ensuring proper maintenance and use of the ANSUL system during fire emergencies. **MONITORING EFFECTIVENESS** The Administrator and MS will continue installation proceedings with GNA-Fire Protection and the Office of Statewide Health Planning and Development (OSHPD) until project completion. The ANSUL system installation progress will be discussed at the monthly Safety Committee meeting with additional discussion of progress at the quarterly QA committee meeting.	

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K 324	Continued From page 7 with the requirements of the listing. Based on observation and interview, the facility failed to provide cooking equipment in accordance with NFPA 96, by failing to provide an approved fire (ANSI/UL 300) extinguishing system in the kitchen. The fire suppression system (Ansul) that uses dry chemical, foam, and gaseous extinguishing agents inside grease hoods prevents the possibility of grease fires, decreasing the potential for a fire hazard. Findings; On November 12, 2019, at 10 a.m., during the life safety code tour observation, the evaluated noted a flat grill cooking equipment under a ventilation hood system in the kitchen. There was no automatic fire extinguishing equipment installed within the hood ventilation system. During an interview, at 10:05 a.m., the dietary supervisor/consultant stated the staff cook with the flat grill for various food items (meats/dairy). Thus the production of grease laden vapors. At 10:10 a.m., during an interview, the maintenance supervisor stated they did not know they had to install an Ansul fire extinguishing system. This affected one of three smoke compartments. On November 12, 2019, during the life safety tour and exit conference, the administrator and the maintenance supervisor were informed of this deficiency.	K 324		
K 325	Alcohol Based Hand Rub Dispenser (ABHR)	K 325		

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K 325 SS=E	Continued From page 8 CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure all Alcohol Based Hand Rub (ABHR) dispensers are not installed over, or adjacent to, any ignition sources. Areas where ABHR dispensers are installed near ignition sources may increase the risk of fire emergencies. Findings:	K 325	**K325 – It is the policy of this facility that all alcohol-based hand rub dispensers (ABHR) are protected in accordance with 8.7.3.1.** **CORRECTIVE ACTION** On 11/12/19 the MS relocated the noncompliant ABHRs in Room-144 and Room-146, away from the electrical outlets, eliminating the fire hazard risk. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility was at risk due to this deficiency. On 11/12/19, during facility rounds the MS found no other noncompliant ABHRs in the building. **SYSTEMIC CHANGES** During their daily rounds the MS or designees will visually inspect all general occupancy areas of the building, ensuring compliant fire hazard safety precautions. **MONITORING EFFECTIVENESS** The MS or designees will remove and report any potential fire hazards to the Administrator during the daily department head stand-up meeting and may report findings at the monthly safety committee meetings. This deficiency will be discussed during the quarterly QA Committee for trends and suggestions.	11/12/19

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K 325	Continued From page 9 On November 12 , 2019, between 9:00 a.m. and 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, there were numerous 12 ounce wall-mounted ABHR dispensers throughout the facility and the following were observed: 1. At 9:30 a.m., it was observed that a wall-mounted ABHR dispenser was approximately 36 inches directly above an electrical outlet, inside resident room 144. 2. At 9:33 a.m., it was observed that a wall-mounted ABHR dispenser was 36 inches directly above an electrical outlet, inside resident room 146. During this LSC tour, an interview was conducted with the maintenance supervisor regarding the wall-mounted ABHR dispenser, above the ignition source (the electrical outlets). At the end of the interview, the maintenance supervisor stated that she would relocate this ABHR dispenser away from the ignition source, immediately. This deficiency affected one of three smoke compartments. On November 12, 2019, during the life safety tour and exit conference, the administrator and the maintenance supervisor were informed of this deficiency.	K 325		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355	**K355 – All facility portable fire extinguishers are installed, inspected and maintained in accordance with NFPA 10 and that the top of fire extinguishers is not more than 5 ft. above the floor.**	11/13/19

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 10 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: NFPA 10 2010, 2013- 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Based on observation and interview, the facility failed to ensure fire extinguishers were installed so that the top of the fire extinguisher is not more than 5 ft. above the floor. Fire extinguishers installed at an appropriative height allows easy access for an immediate response to subdue a localized fire. Findings: On November 12, 2019, during the life safety tour between 9 a.m. and 10 a.m., the top of the fire extinguishers were stored at 5 feet 3 inches above the floor in the rehabilitation and maintenance rooms. This maintenance supervisor was informed of the height requirement. At 9:55 a.m., the during an interview, the maintenance supervisor stated she was unaware of the height requirement and would lower the height of the fire extinguishers. This affected 2 of 3 smoke compartments. On November 12, 2019, during the life safety tour	K 355	**CORRECTIVE ACTION** On 11/13/19 the MS and designees lowered the heights of all noncompliant fire extinguishers ensuring they are not more than 5 ft above the floor. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility was at risk due to this deficiency. On 11/13/19, during facility rounds the MS or maintenance staff found no other noncompliant fire extinguishers in the building. **SYSTEMIC CHANGES** During their daily rounds, the MS or designees will visually inspect all general occupancy areas of the building to ensure fire safety equipment is maintained in accordance with regulations. **MONITORING EFFECTIVENESS** The MS or designees will repair/remedy noncompliant fire protection equipment immediately after discovery. Any findings will be reported to the Administrator and may be reported at the monthly safety committee meetings. This deficiency will be discussed during the quarterly QA Committee for trends and suggestions.	

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K 355	Continued From page 11 and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	K 355	**K363 – It is the policy of this facility to ensure that resident doors are free from impediments and allowed full closure in the event of a fire or other emergency.**	11/27/19
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363	**CORRECTIVE ACTION** 1) On 11/12/19, the MS adjusted the fall prevention mat in Room-148 ensuring the entry door can fully close without obstruction. 2) On 11/12/19, the MS relocated the resident wheelchair in Room-106 ensuring the entry door can fully close without obstruction. On 11/27/19, the subacute supervisor conducted in-service to nursing staff on the topic resident room safety and proper placement of fall floor mats to allow free, full closure of entry doors. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility was at risk due to this deficiency because the obstruction would have prevented rapid closures of doors during a fire emergency. The MS checked all other resident room doors and entryway doors on 11/12/19 to ensure that all door closures were unobstructed; no additional obstructions were found. **SYSTEMIC CHANGES**	

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K 363	Continued From page 12 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the doors to two resident sleeping rooms were free from impediments and allowed the full closure of the doors. In the event of a fire emergency, rapid closure of doors without any impediment is an essential component in the containment of smoke and/or fire. Findings: On November 12, 2019, during the life safety tour from 9 a.m., to 10:30 a.m., the evaluator with the presence of the maintenance supevisor, noted a fall prevention mat on the left side of resident 148A's bed was preventing the door from closing. The wheelchair in resident room 106A was placed in the entry area and thus preventing the door from closing. The maintenance supervisior was informed of the significance of the closed doors and to consult with nursing to develop the continual use of the floor mat in room 148A and yet meet the life safety code requirement of rapid and full closure of the door during a fire emergency. At 10:10 a.m., during an interview, the maintenance supervisor acknowledged and stated the wheelchair and floor mat need to be relocated to ensure proper closure of the doors. This deficiency affected two of three smoke	K 363	During their daily rounds, the MS or designees will visually inspect all entryway doors and general pathways in the building to ensure no obstructions are present. **MONITORING EFFECTIVENESS** During their daily floor rounds, the MS and designees will remove or remedy all obstruction hazards and update the Administrator during the daily department head stand-up meeting. Any trends may be discussed at the monthly safety committee meeting as well as during the quarterly QA Committee meeting.	

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K 363	Continued From page 13 compartments. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	K 363	**K741 – 1) It is the policy of this facility to provide ashtrays of non-combustible material and safe design in all areas where smoking is permitted. 2) The facility must post 'No Smoking' signs in areas where oxygen is stored or in use.**	11/21/19
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by:	K 741	**CORRECTIVE ACTION** 1) On 11/21/19, the maintenance staff installed new wall-mounted ashtrays made of non-combustible material and safe design in the designated smoking area. 2) On 11/12/19, the maintenance staff posted new 'No Smoking' signage on the non-compliant crash carts. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility was at risk due to these findings. Upon inspection of the building by the Administrator and maintenance staff on 11/22/19, no residents were found directly affected by this deficiency. **SYSTEMIC CHANGES** During their daily rounds, the Administrator, MS or designees will inspect all general occupancy areas of the building, ensuring compliant fire hazard safety equipment is functioning properly and safety/caution signage is visible.	

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K 741	Continued From page 14 Based on observation and interview, (1) The facility failed to provide ashtrays of non-combustible material and safe design in all areas where smoking is permitted and metal containers with self-closing devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Failure to properly use smoking equipment present at the designated smoking areas could lead to a fire/smoke emergency. Approved ashtray containers are designed to prevent embers from igniting fires. (2) The facility also failed to post "No Smoking" signs in areas where oxygen is stored or in use. Areas where oxygen tanks and oxygen equipment are stored or in use without the proper signs could lead to accident hazards and/or fire emergencies. Findings: 1. On November 7, 2019, at 9 a.m., the evaluator and the maintenance supervisor conducted an initial tour of the facility. During this initial observation tour, the following were observed: a. At 9 a.m., there was a "crash" cart (which was not in use), with a 25 cubic feet (cu ft) oxygen tank, stored at the east of the main nursing station. Further observation showed that "No Smoking" signs were not posted on or near the "crash" cart. b. At 9:01 a.m., there was a "crash" cart (which was not in use), with a 25 cu ft oxygen tank, stored near the wall by west entry of the main nursing station. Further observation showed that "No Smoking" signs were not posted on or near the "crash" cart.	K 741	**MONITORING EFFECTIVENESS** During their daily floor rounds, the MS or designees will inspect designated smoking areas ensuring safety equipment is functioning properly and compliant 'No Smoking' signs are visible. Any findings of repair will be reported to the Administrator during daily department head stand-up meetings. This deficiency will be reviewed at the monthly Safety Committee meeting and during the quarterly QA Committee for analysis and suggestions.	

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K 741	Continued From page 15 This deficient practice affected one of three smoke compartments. 2. On November 7, 2019, at 11 a.m., during an observation at the center patio designated smoking area for residents, the evaluator noted there were no ashtrays of non-combustible material and safe design and metal containers with self-closing devices. At 11:35 a.m., during an interview, the administrator acknowledged the fact they did not have the safe design ashtrays in the facility, but would provide them soon as possible. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	K 741	**K918 – Electrical Systems – It is the policy of this facility to test the emergency generator once every 36-months for 4-continuous hours under load.** **CORRECTIVE ACTION** The facility's emergency generator load test, for 4-continuous hours, was completed on 11/26/19 by Delta Fire Equipment, Inc. (See attached report)	11/26/19
K 918 SS=D	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	K 918	**IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety and welfare of everyone in the building was at risk due to this deficiency because periodic testing of the generator ensures it will work properly during an actual emergency. No residents were found affected by this deficiency. **SYSTEMIC CHANGES** The MS will continue to maintain log records of any emergency generator maintenance and periodic testing in accordance with regulations. **MONITORING EFFECTIVENESS**	

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K 918	Continued From page 16 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 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 interview and record review, the facility failed to exercise the generator under full load once every 36 months for 4 continuous hours. In the event of any interruption of normal power, the emergency generator system needed to immediately provide the required illumination and power for the safety and welfare of the occupants inside the facility. The testing of the generator increases the awareness of it's capacity and the need for maintenance or repairs to ensure it will work properly during an actual emergency. Findings: On November 12, 2019 at 7:15 a.m., during a record review, there was no documentation for a full load 4 hour generator test that needed to be completed every 36 months. This test demonstrates the generator is able to operate	K 918	The MS will update department heads during the daily stand-up meeting, any planned periodic emergency generator testing. This deficiency will be reviewed at the monthly safety committee meeting and during the quarterly QA Committee for analysis and suggestions.	

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K 918	Continued From page 17 long enough during a power outage to ensure the safety of life. At 7:20 a.m., during an interview, the maintenance supervisor stated they did not complete a 4 hour full load generator test within the last 3 years because she was not aware of the requirement to do so. This affected 1 of 3 smoke compartments. On November 12, 2019, during the life safety code tour and exit conference, the administrator and maintenance supervisor were informed of the deficiency. This deficiency potentially affected one of three smoke compartments.	K 918	**K923 – Gas Equipment – Oxygen tanks – It is the policy of this facility to properly store oxygen tanks in accordance with NFPA 99/11-3 regulation.** **CORRECTIVE ACTION** On 11/07/19, the maintenance staff removed all oxygen h-tanks from the subacute resident rooms. On 11/12/19, oxygen e-tanks were secured to the wall in the subacute resident rooms in compliance with NFPA safety regulation. On 11/07/19, the registered nurse (RN) supervisor provided an in-service to subacute staff on the topic of proper oxygen tank handling/storage as well to housekeeping staff regarding proper oxygen tube safety precautions.	11/12/19
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are	K 923	**IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety and welfare of everyone in the building was at risk due to this deficiency. No residents were found directly affected by this deficiency. **SYSTEMIC CHANGES** During their frequent floor rounds, the	

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	056220	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2019**

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K 923	Continued From page 18 separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: NFPA 99 11-3 Cylinder and Container Storage Requirements 11.3.1* Storage for non-flammable gases equal to or greater than 3000 ft3 at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 5.1.3.3.2 Designed Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements.	K 923	Subacute supervisor nurse, MS or designees will inspect all subacute resident rooms ensuring secured oxygen e-tanks and compliant oxygen tubing maintenance. **MONITORING EFFECTIVENESS** Any findings of repair or equipment malfunction will be reported to the Administrator during daily department head stand-up meetings. This deficiency will be reviewed at the monthly safety committee meeting and during the quarterly QA Committee for analysis and suggestions.	

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K 923	Continued From page 19 (2) They shall be secured with lockable doors or gates or otherwise secured. (4) If indoors, they shall be constructed and use interior finishes of non-combustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of minimum 1- hour fire resistance rating. (7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. NFPA 55 7.1.9.2 Valve-Protective Caps. Where compressed gas containers, cylinders, and tanks are designed to accept valve protective caps, the user shall keep such caps on the compressed gas containers, cylinders, and tanks at all times, except when empty, being processed, or connected for use. Based on observation and interview, the facility failed to ensure oxygen cylinder tanks greater than 3,000 cubic feet were stored with lockable doors/gates and secured with the appropriate equipment (chains/fasteners) to secure all cylinders from falling, and valve protective caps were on the cylinders at all times, except when empty, being processed, or connected for use. Findings: On November 7, during the life safety tour with the maintenance supervisor, the evaluator noted a total of 24 H tanks (2660 cubic feet of oxygen) stored in the 10 resident subacute rooms. There were 3 H tanks in resident rooms 141, 142, 144, 146, and 2 H tanks in rooms 143, 145, 147, 149,	K 923		

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K 923	Continued From page 20 148, and 150. The total amount of oxygen in the three bed resident rooms was 7980 cubic feet of oxygen (three tanks) and 5320 cubic feet of oxygen (two tanks) for two bed rooms in the the sub acute rooms. It was also noted all the H tanks in the subacute area were not properly secured and did not have the valve protective cap in use. The evaluator noted the tanks were easily moveable and thus had a high risk for tipping over during seismic activity or when accidentally displaced. In addition, the evaluator observed the H tanks in all the subacute rooms could easily tip over due to the unstable/ineffective plastic bases. The maintenance supervisor was informed the H tanks could be stored outside with the appropriate safety measures. She was informed with some of the safety measures, which included the tanks to be 20 feet away from the designated smoking area, proper temperatures, valve protective caps, racks/shelves to secure, walls and mechanical or natural ventilation. The facility would need to investigate and collect all safety requirements for outside storage to ensure safe storage of oxygen tanks. On November 7, 2019 at 12:05 p.m., during an interview, in the presence of the maintenance supervisor (MS), evaluator, and the charge nurse (RN) of the subacute area, the respiratory therapist (RT) stated the H tanks were used as a back up for when the resident needed more oxygen (15 L). She further stated, the staff would be able to manage the need for an increase oxygen need of 15 L per resident exclusively with the use of the E tanks ((293 cubic feet of oxygen). She was also informed the E tanks may be used as a back up in the resident rooms, but also needed to be effectively secured while stored/available for use in the rooms. The charge	K 923		

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K 923	Continued From page 21 nurse, RT, and MS acknowledged and verbally informed the evaluator the facility would remove all H tanks from the facility and choose to exclusively use E tanks as the back for oxygen in the sub acute rooms. At 12:10 p.m., during another interview, the maintenance supervisor again informed the evaluator the facility will remove all H tanks from the facility and use E tanks as the back up oxygen in the sub acute rooms. This deficiency affected one of three smoke compartments. On November 12, 2019, during the life safety tour and the exit conference, the administrator and the maintenance supervisor were informed of the deficiency.	K 923		