PRINTED: 10/25/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 62 055001 8. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1620 WEST FERN AVENUE REDLANDS HEALTHCARE CENTER REDLANDS, CA 92373 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX TAG PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE DEFICIENCY) K 000 | INITIAL COMMENTS Redlands healthcare center submits K 000 this Plan of Correction as part of the Surveyor: 21101 requirements under State and Federal law. The Plan of Correction is submitted in accordance with K3 BUILDING: 01 specific regulatory requirements. It K6 PLAN APPROVAL: 1978 shall not be construed as admission K7 SURVEY UNDER: 2012 Existing of any alleged deficiency cited or STRUCTURE TYPE: ONE STORY, any liability. CONSTRUCTION TYPE V(111), FULLY The provider submits this Plan of SPRINKLERED. Correction with the intention that it is inadmissible by any third party in The following reflects the findings of the California any civil criminal action or Department of Public Health, during an annual Life Safety Code recertification survey. The proceedings against the provider of findings are in accordance with 42 CFR (Code of its employees, agents, officers, Federal Regulations) 483,70 (a) National Fire directors or sharcholders. Protection Association (NFPA) 101, Life Safety Any changes to provider policy or Code 2012 Edition, and NFPA 99 Health Care procedures should be considered to Facilities Code 2012 Edition. be subsequent remedial measures as Representing the California Department of Public that condept is employed in Rule Health: 21101 407 of the federal rules of evidence and California evidence code The facility is not in substantial compliance with section 1151 and should be 42 CFR 483.70 (a) for Long Term Care Facilities. inadmissible in any proceeding on that basis Census = 76 NFPA 101 Soiled Linen and Trash Containers K 754 CT K 754 풄 SS≃D K 754 Soiled Linen and Trash Containers Spiled linen or trash collection receptacles shall Barrels for each shower rooms were not exceed 32 gallons in capacity. The average

(X6) DATE tommes to Any deficiency statement ending with an approach (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection 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 compellory is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total

exceeded within any 54 square feet area. Mobile soiled linen or trash collection receptacles with

container capacity of 32 gallons shall not be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event (D:3UPL21

Facility ID: CA240000160

If continuation sheet Page 1 of 5

Removed by Maintenance Staff on

11/9/2017 and will no longer place

in shower room.

Continue to page 2

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

PRINTED: 10/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MUI A. BUILE | | LE CONSTRUCTIO 02 | N | (X3) DAT | . 0938-039 E SURVEY PLETED |
|--|--|---|--|---|----------------------|--|--|---|--------------------------------|----------------------------------|
| | | 055001 | | _ | B, WING | | . | L | 101 | 19/2017 |
| NAME OF PROVIDER OR SUPPLIER REDLANDS HEALTHCARE CENTER | | | | | 1 | TREET ADDRESS 620 WEST FERN REDLANDS, CA | | 10/19/2017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT | աւժ | | ID PREFI TAG | х | PROVI | DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY) | n re | (X5) COMPLETION DATE |
| caplociscon which controls who controls who can be controls who can be controls with controls with controls cape required cape r | ated in a room per not attended, ntainers used so be excluded from the each containers used so be excluded from the each containers attended. Approval Stand 7.5.7, 19.7.5.7 as STANDARD is reyor: 21101 and to ensure soiled in a room per a when not attended in a room per a time and pallons stored in a per a fire a per 19 Existing 7.5.7 Soiled Line 2.5.7.1 Soiled Line 2.5.7.1 Soiled Line 2.5.7.1 Soiled Line 2.5.7.1 Soiled Line 2.5.7 Soiled L | han 32 gallons shall be rotected as a hazardo slely for recycling are put the above requirement of the above requirement of the above requirement of the above than or equivalent of the above that are evidence on and interview, the state of than 32 gallons were | permits to by the second of th | nitted 96 ng ity acies by ling ns, toke | K 7 | 754 | Re-In-se and main DSD on barrels we room. So placed o Rounds Director to ensure Random Director Any disc QAA Co Maintena recomme | CATION PROGRA | by that tower by by gnee y tt. | CALIFORNIA DEPARTMEN |

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X4) ID PREFIX

TAG

PREFIX

TAG

K 918

(2/S) COMPLETION

DATE

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

PRINTED: 10/25/2017 FORM APPROVED <u>OMB NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 02 COMPLETED 055001 B. WING 10/19/2017 STREET ADDRESS CITY, STATE, ZIP CODE 1620 WEST FERN AVENUE

NAME OF PROVIDER OR SUPPLIER

REDLANDS HEALTHCARE CENTER

REDLANDS, CA 92373

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

K 754 | Continued From page 2 Continued from Page 2 K 754 (4) Container size and density shall not be limited in hazardous areas.

Findings: During a tour of the facility with the Director of Maintenance on 10/19/17, the mobile soiled linen

and trash containers were observed.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

At 2:15 p.m., two of three shower rooms had soiled linen containers that exceeded 32 gallons left unattened in the shower rooms. During an interview, the Director of Maintenance stated the containers were left in the shower rooms until the laundry staff removes them.

K 918 NFPA 101 Electrical Systems - Essential Electric 88=D

> 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

K 918

On 10/19/2017 Director of Maintenance called Generator Services Company, On 10/20/2017 General Services Company came to take the sample of the fuel to be sent to Laboratory Services and inspection was done in compliance by Generator Services Company.

Director of Maintenance will call Generator Services Company to check and service and inspect the fuel and generator yearly.

Report to be provided and filed in Maintendace log.

Continue to page 4

Facility ID: CA2/10000150

If continuation cheet Page R 3 F

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: \$UPL21 .

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

PRINTED: 10/25/2017 FORMAPPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER; | | (X2) MULTIPLE CONSTRUCTIO | | | N | | (X3) DAT | . U938-U39 E SURVEY PLIETED |
|---|--|---|--------------|---------------------------|--------|----------------------|----------------|---------------------------------------|--------------|-----------------------------------|
| | | 055001 | | B. WING | | , . | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | 033001 | - | D. VIIIAG | | TREET ADDRESS | CITY STATE 7 | PCODE | 10/ | <u> 19/2017</u> |
| REDLANDS HEALTHCARE CENTER | | | | 1620 WEST FERM | | | 1 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | | (c) | _ | | DER'S PLAN OF | CORRECTIO | <u> </u> | 1361 |
| PRÉFIX TAG | (EACH DEFICIENC) REGULATORY OR L | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | PREFI | | (EACH CO CROSS-RE | PRECTIVE ACT | GOMPLETION DATE | | |
| K 918 | Continued From pa | ane 3 | | , K8 | 40 | | | | | 1 |
| | accordance with Ni | FPA 111. Main and feede inspected annually, and | | ı ı | ı to | K 918 | | | | |
| | program for periodi | cally exercising the | - | İ | | Adminis | trator will cl | heck | | |
| | | ablished according to | £ | | | | ance log on | | hasis | |
| | | rements. Written records esting are maintained and | | <u> </u> | | | | | Que i, | |
| | readily available. E | ES electrical panels and | | | | | repancies w | | | |
| | | and readily identifiable. | , | ! | | QAA Co | mmittee by | Director of | \mathbf{f} | İ |
| | Minimizing the posi emergency power: | sibility of damage of the | 1 | | | | ance is respo | onsible for | r the | } |
| | consideration for n | source is a design | | | | impleme | ntation. | | | |
| | | NFPA 99), NFPA 110, NF | PA | | | · | | | | |
| | This STANDARD i Surveyor, 21101 | s not met as evidenced b | • | , | | | | | · | |
| | Based on documer | nt review and interview, th | ė | | | • | | | | |
| | tacility failed to mai | ntain the emergency gene | erator | | | | | | | 1 |
| | fuel quality test. Th | o documentation for an arthis had the potential for th | nual i | İ | | | | | | |
| | emergency general | tor failing to function and | | | | |] | | | |
| | provide emergency | ' power in the event of not | mal | | | 1 E | | | | ļ |
| | | ent in three of three smok | 9 | | | | | | | |
| | compartments. | | | | | | | _ | | ! ! |
| | NITTO AAD THE A | | | | | • | | CERTIFICA | 2017 NOV | Ž |
| | NFPA 110: Standar Power Systems, 20 | d for Emergency and Star | hdby | | | | | = | ~-3 22° | 커크 |
| | 8.3 Maintenance at | nd Operational Testing. | | ı | | • | | <u>-</u> ;_ | 9 | |
| | 8.3.8 A fuel quality | test shall be performed a | at I | | | | | >음 | | B # |
| ļ | least annually using standards. | tests approved by ASTM | · . | | Ì | | | N N N N N N N N N N N N N N N N N N N | 5 PM | IC H |
| - | Findings: | · | | | | | | FROGRAM | ΐ | ARTI |
| | Director of Mainter | eview and interview with the | | a [‡] | | • | | RAM | 34 | |
| ٳؙ | emergency general | or maintenance records v | rere | | ļ | | | | | |
| | quality test was req | | | , | i I | | | | ı | |
| M CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: | 3UPL21 | | Fac | illy ID; CA24000018 | | (f earlious | | t Page 4 of |

If continuation sheet Page 4 of 5

11/07/2017 08:33

9093834452

CDPH

PAGE 12

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | | | | PRINTED: 10/25/2017 FORM APPROVED . OMB NO, 0938-0391 | | | |
|---|--|--|-----------|-------------|--------------------------------|-----|---------------------|---|---|----------|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/AND PLAN OF CORRECTION IDENTIFICATION NUMB | | | | | | 1 | · | (X3) DAT | E SURVEY PLETED | | | |
| | | 055001 | | | B' MING | | | | | 10/ | 19/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | | ! | | | | STREET ADDRESS, | | ZIP CODE | <u> </u> | | |
| | DS HEALTHCARE CE | | | | 1620 WEST FERI REDLANDS, CA | | | 92373 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI | | 1 | PREFIX TAG | × | i <i>(</i> EACH CO | ER'S PLAN OF RRECTIVE AC ERENGED TO DEFICIEN | THE APPROI | D RE | (X5) COMPLETION DATE | |
| K 918 | On 4/19/17, at 10:1 provide documenta test for the emerger interview, the Direct was not familiar with | ge 4 1 e.m., the facility faile tion for the annual fuel ncy generator. During tor of Maintenance sta h the fuel quality test a endor that services the | qu ted | ality he | Κ9 | | | • | | | | |
| ОПМ СМ8-25 | 57(02-89) Previous V⊵rsions (| Disolete Even | t D; | 3UP\21 | | Fac | Hity ID: CA24000015 | | CERTIFICATION PROGRAM | | CALIFORNIA DEPARTMENT OF PUBLIC HEALTH Some | |
| | - | | | | | | | | | • | | |