STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. BUILDING _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4853 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 43399, REHS, HFE I Surveyor ID Number 43244, REHS, HFE I The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Licensed : 198 beds Census: 178 residents No deficiencies were cited during this survey.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Eccleston — TITLE: Administrator — (X6) DATE: 03/04/2022

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.

Approved by 43244 on 03/09/22

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

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19 Existing Health Care Occupancies and other applicable codes. The Following reflects the findings of the Department of Public Health Services during the Life Safety Code Survey. Representing the Department of Public Health Services: Surveyor ID Number: 43244, REHS, HFE 1 43399, REHS, HFE 1 Licensed beds: 198 Resident Census: 178 Highest Severity and Scope = E	K 000	**Disclaimer:** The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as our written credible allegation of compliance.	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and hazardous free environment by ensuring the following:	K 211	**K- 211 Means of Egress:** **Immediate Corrective action:** 1. Upon identification, on 2/10/22, the Maintenance Supervisor replaced the exit sign in the middle patio. 2. Upon identification, on 2/11/22, the Maintenance Supervisor removed the medical equipment and placed it on one side of the hallway. 3. Immediately, on 2/10/22, the Maintenance Supervisor removed the equipment medical cart and patient lift by the exit near room 35.	2/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Eckler
TITLE: Administrator
(X6) DATE: 3/4/22

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

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K 211	Continued From page 1 A. The hallways remain clear of equipment stored on both sides of the hallway. In the event of a fire emergency, an emergency exit route is to be free from equipment and allow occupants to safely evacuate the facility. All equipment should be stored on one side of the hallway to ensure the exit route is readily accessible. B. All doors, passages, stairways are neither an exit nor a way of exit access and located or arranged so it was not likely mistaken for an exit shall be identified by a sign that reads "NO EXIT. "Failure to post the required signage may result in confusion when attempting to exit the building during an emergency, thus increasing the risk for loss of life." Findings: On February 9, 2022, between 9:00 a.m. and 2:45 p.m., the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. The following observations were made: 1. During the tour at 9:38 a.m., it was observed the doors to the middle "patio" did not have a "NO EXIT" sign. During a concurrent interview the maintenance supervisor stated that he did not realize there was no sign and would correct it immediately. 2. At 10:15 a.m., medical equipment (electrical patient lift) was stored on both sides of the hallways when not in use. In a concurrent interview, the maintenance supervisor stated that he will remove the medical equipment from both sides of the hallway.	K 211	Identification of others at risk: 1. The Maintenance Supervisor immediately conducted Environmental rounds to ensure all areas have appropriate exit signs and that all medical equipment is on one side of the facility. 3 out of 3 areas had appropriate exit signs. All medical equipment was removed from exit doorways, and 4/4 hallways had equipment stored properly on one side. No other areas were identified. Measures to prevent recurrence: 1. An In-service was provided by the Director of Staff Development and Administrator to the Maintenance, Safety Committee Members, RN Supervisors and Housekeeping staff on 3/1/22, regarding the policy on Means of Egress being continously maintained and free of all obstructions in case of an emergency, and also ensuring proper exit signs are placed accordingly, and specifically that equipment is and not blocking the exit doorways. 2. The Safety Committee implemented an Environmental Safety QAPI which will focus on conducting means of egress, equipment and safety rounds. The Committee will review findings on a monthly basis.	2/11/22 3/1/22

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K 211	Continued From page 2 3. At 10:24 a.m., it was observed that one of the facility's exits near room 35 was blocked by equipment (medical cart and electrical patient lift). In a concurrent interview the maintenance supervisor stated this would be corrected at once. The deficient practice affected one of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 211	Monitoring performance and integration into the Quality Assurance System: The Maintenance Director and Safety Committee will present a summary findings by completing inservices, spot check observation, QAPI Committee, and Safety rounds, and subsequent follow up at the monthly Quality Assessment and Assurance Committee Meeting for review and action as indicated.	3/4/22
K 342 SS=E	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of seven manual fire alarm pull stations release the electro-magnetically held cross-corridor doors and activate an audible alarm. Fire alarm pull stations that do not release the electro-magnetically held cross corridor doors	K 342	K- 342- Fire Alarm System Initiation Immediate Corrective Action: 1. Immediately, on 2/11/22, the Maintenance Supervisor contacted our Fire Alarm Vendor to repair pull station #8. 2. Upon notification, on 2/11/22, the Maintenance Supervisor removed the electrical patient lift equipment that was blocking the pull station. Identification of other residents: a. Upon notification, on 2/11/22, the Maintenance Director conducted observation and spot checks on all pull stations to ensure they were all functioning properly, and 6 out of 6 pull stations were working, no other pull stations were identified as not working.	2/11/22 2/11/22

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K 342	Continued From page 3 would fail to close upon the activation of the fire alarm system. This would allow smoke/or fire to pass from one smoke compartment to other areas of the facility. Fire alarm systems should be unobstructed and easily accessible. When a fire alarm pull box is obstructed, the facility will have difficulty accessing this particular pull box if an emergency should arise. These notification devices would alert the occupants of a fire emergency and to evacuate the building. Findings: a. On February 9, 2022, between 9:00 a.m. and 2:45 p.m., the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. The following observation was made: 1. At 11:30 a.m., pull station number eight failed to sound the fire alarm system and release the electro-magnetically held cross- corridor doors. During a concurrent interview, the maintenance supervisor stated that the pull station was previously working and he did not know why it was not activating. He stated that he would call the company to come and fix it. 2. At 10:24 a.m., a pull station was observed to be blocked by equipment (electrical patient lift). During a concurrent interview the maintenance supervisor stated that this would be corrected at once and the staff will be later in-serviced. The deficient practice affected one of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and	K 342	b. On 2/11/22, the Maintenance Supervisor developed a Fire Alarm Pull Station CQI Checklist tool to ensure all the pull stations are working properly. <u>Measures to prevent recurrence</u>: a. An In-service was given by the Director of Staff Developer on 3/2/22 to all Maintenance and Safety Committee personnel regarding the policy on Fire Alarm Pull Stations are functioning properly. b. The Safety Committee implemented an Environmental Fire Alarm QAPI on 3/3/22 to ensure all pull stations are properly functioning, and that equipment is not blocking the fire alarm system. This will be reviewed and analyzed on a monthly basis. <u>Monitoring performance and integration into the Quality Assurance System</u>: The Maintenance Supervisor and Safety Committee members will be responsible to monitor the Fire Alarm Pull Stations by spot check random observation, QAPI Committee, and routine inservices. Findings will be reported by the Maintenance Supervisor and Safety Committee members to the monthly QA Committee for review and follow up as needed.	3/3/22 3/4/22

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K 342	Continued From page 4 during the exit conference, with the administrator and the maintenance supervisor. b. 2. At 10:24 a.m., a pull station was observed to be blocked by equipment (electrical patient lift). During a concurrent interview the maintenance supervisor stated that this would be corrected at once and the staff will be later in-serviced. The deficient practice affected one of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 342		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351	K351 Sprinkler System-Installation Immediate Corrective Action: a.) Upon notification, on 2/11/2022, the Maintenance Director removed the large trash bag in the activity closet that was stored 3 inches from the sprinkler defector. b.) Upon notification, on 2/11/22, the Maintenance Director removed the two large boxes from Nursing station 4 that was 16 inches from the sprinkler defector. Identification of Others at Risk: The Director of Maintenance implemented a CQI Sprinkler Deflector CQI Tracking log to identify if the sprinkler deflectors in the facility all have the proper 18 inch clearance to ensure that there were no obstructions in storage areas throughout the facility.	2/11/22 2/11/22

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K 351	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure and maintain an 18-inch clearance below the sprinkler deflectors at storage areas throughout the facility. Unobstructed areas below the sprinkler deflectors will ensure an effective response of the fire sprinklers to provide water discharge in a horizontal plane and will function as designed, in case of fire emergencies. Findings: On February 9, 2022 between 9:00 a.m. and 2:45 p.m., the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. The following observations were made: 1.At 10:10 a.m., one large plastic black trash bag was stored three inches from the sprinkler deflector in the activity storage closet. During a concurrent interview, the maintenance supervisor stated that he was unaware of the item and removed the trash bag from its position. 2.At 10:11 a.m., two medium sized boxes stored sixteen inches from the sprinkler deflector at nurses' station 4. During a concurrent interview, the maintenance supervisor stated that he was unaware of the items and would have them removed. The deficient practice affected two of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and during the exit conference, with the administrator	K 351	Measures to Prevent Reoccurrence: a.) An Inservice regarding the policy and regulation on Sprinkler Systems, proper installation, was given by the Administrator on 3/2/22 to all Maintenance, Housekeeping, and Safety Committee Members. b.) The Safety Committee will conduct monthly Safety Walkthrough Checklists to ensure all Sprinkler deflectors have an 18 inch clearance. Monitoring Process: The Director of Maintenance and Safety Committee Members will be responsible to monitor the Sprinkler System policy by routine Inservices, rounds, observation and CQI Sprinkler Safety Checklists to ensure compliance on a monthly basis. Findings will be reported to the quarterly Quality Assurance Committee for compliance.	3/2/22 3/4/22

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K 351	Continued From page 6 and the maintenance supervisor.	K 351		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of corridor walls/common areas by having penetrations, thereby compromising the fire rated surfaces. In the event of a fire, the separation of the corridor/common area would not be achieved because these penetrations would allow smoke and/or fire to travel from one area to another. Findings:	K 362	K 362 Corridors-Construction of Walls Immediate Corrective Action: 1. Upon identification, on 2/11/22, the Maintenance Supervisor sealed the one-half penetration that was observed on the ceiling of the kitchen storage room. Identification of others at risk: 1. The Maintenance Supervisor immediately conducted environmental rounds on all walls, common areas, and ceilings to ensure all penetrations were properly sealed. 19 out of 19 ceilings, common areas, and walls were observed to be properly sealed, and no other areas were identified. Measures to prevent recurrence: 1. An In-service was provided by the Director of Staff Development and Administrator to the Maintenance, Safety Committee Members, on 3/3/22 regarding ensuring corridors are separated from use areas by walls constructed with at least a 1/2 hour fire resistance rating, and that the facility must maintain A, B or C flame spread rating finish of the corridor walls, ceiling, common areas by not having any penetrations which compromise the fire rated surfaces.	2/11/22 2/10/22 3/3/22

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K 362	Continued From page 7 On February 9, 2022, between 9:00 a.m. and 2:45 p.m., the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. The following observations were made: At 10:32 a.m., a one-half inch penetration was observed on the ceiling of the kitchen storage room. During a concurrent interview the maintenance supervisor stated that the penetration was not sealed because the company who installed the wiring did not seal it after the work was done, this would be corrected immediately. The deficient practice affected one of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor	K 362	2. The Safety Committee will be responsible to ensure compliance by conducting safety walkthrough rounds, spot-check observation, and routine Inservices to ensure there are no penetrations in the facility. <u>Monitoring performance and integration into the Quality Assurance System</u>: The Maintenance Director and Safety Committee Members will present a summary of findings by completing routine inservices, spot check observation, and safety rounds, and subsequent follow up at the monthly Quality Assessment and Assurance Committee Meeting for review and action as indicated.	3/4/22
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	K 741	<u>K- 741 Smoking Regulations</u> <u>Immediate Corrective Action:</u> 1. Upon identification, on 2/11/22, the Maintenance Supervisor immediately placed signs indicating the oxygen tanks as either "full" or "empty". 2. Upon notification, on 2/11/22, the Maintenance Supervisor and Respiratory Lead Therapist organized the oxygen closet near the Director of Nursing office, separating and labeling the oxygen tanks as either "full" or "empty".	2/11/22

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K 741	Continued From page 8 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: Based on observation and interview, the facility failed to post "No Smoking" signs in areas where oxygen is used or stored. Areas where oxygen tanks and oxygen equipment are used or stored without the proper signs could lead to accident hazards and/or fire emergencies. Findings: On February 9, 2022 between 9:00 a.m. and 2:45 p.m., the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. The following observations were made: 1. At 9:54 a.m., upon entering the oxygen closet near room 124, it was noted that eighteen full and empty oxygen tanks were stored in the same location without any indication of which tanks were "full" or "empty." During a concurrent interview with the maintenance supervisor, he stated he would have the respiratory therapist	K 741	3. Upon notification, on 2/11/22, the Maintenance Supervisor placed a "No Smoking" sign on the front door and inside of the activities closet where the helium tank was stored. 4. Upon notification, on 2/12/22, the Maintenance Supervisor and Respiratory Lead Therapist immediately placed a sign indicating "empty" or "full" on the oxygen tanks in the central supply storage area. Identification of others at risk: 1. The Maintenance Supervisor and Respiratory Lead Therapist immediately conducted environmental rounds on all oxygen storage areas, including all nursing station and activities closets to ensure the oxygen tanks were properly labeled and organized, with signs indicating whether the oxygen tanks are "full" or "empty". 4 out of 4 Oxygen closets were observed to have the proper labeling indicating "full" or "empty", and were organized accordingly. Measures to prevent recurrence: 1. An In-service was provided by the Director of Staff Development and Administrator to the Maintenance, Charge Nurses, RN Supervisors,	2/12/22 3/3/22

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K 741	Continued From page 9 that was in-charge of organizing the closet come and correct the problem. 2. At 10:05 a.m., upon entering the oxygen storage closet near the Director of Nurses' office, it was noted that full and empty oxygen tanks were stored in the same location without any indication of which tanks were "full" or "empty." During a concurrent interview with the maintenance supervisor, stated he would have the respiratory therapist that was in-charge of organizing the closet come and correct the problem. 3. At 10:00 a.m., a helium tank was being stored in the activity's storage closet. Upon exiting the closet, it was noted that a "No Smoking" sign was not posted on or near the room door. During a concurrent interview, the maintenance supervisor stated he would have a sign posted on the door of the closet. 4. At 10:12 a.m., upon entering the central supply closet, it was noted that full and empty oxygen tanks were stored in the same location without any indication of which tanks were "full" or "empty." During a concurrent interview with the maintenance supervisor, stated he would have the respiratory therapist that was in-charge of organizing the closet come and correct the problem. The deficient practice affected four of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and	K 741	Activities, and Safety Committee Members on 3/3/22 regarding ensuring Oxygen tanks are labeled and organized properly. 2. The Safety Committee will be responsible on a monthly basis to ensure compliance by conducting safety walkthrough rounds, spot-check observation, and routine Inservices to ensure there the oxygen tanks are properly labeled are organized. 3. The Maintenance Supervisor and Lead Respiratory Therapist implemented a QAPI regarding ensuring the oxygen tanks are labeled and organized correctly, findings will be reviewed on a monthly basis.. <u>Monitoring performance and integration into the Quality Assurance System</u>: The Maintenance Director and Safety Committee Members will present a summary of findings by completing routine Inservices, spot check observation, and a QAPI Committee at the monthly Quality Assessment and Assurance Committee Meeting for review and action as indicated.	3/4/22 3/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/10/2022

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K 741	Continued From page 10 during the exit conference, with the administrator and the maintenance supervisor.	K 741		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to plug all electrical power strips directly into electrical outlets by plugging one power strip into another (daisy chaining). Daisy chaining power strips could create the possibility of an electrical overload and/or possible fire.	K 920	K- 920 Electrical Equipment -Power Cords and Extensions Immediate Corrective Action: 1. Upon identification, on 2/10/22, the Maintenance Supervisor removed the daily chain from the Director of Social Service's office. 2. Upon identification, on 2/10/22, the Maintenance Supervisor removed the daisy chain by the computers in the Director of Staff Development's office. Identification of others at risk: 1. The Maintenance Supervisor immediately conducted Environmental rounds in all offices and nursing stations to ensure there were no daisy chains in any of the power strips. 6 out of 6 offices were observed to not have any daisy chains and no other issues were identified. Measures to prevent recurrence: 1. An In-service was provided on 3/1/22 by the Director of Staff Development and Administrator to the Maintenance, Safety Committee Members, on 3/2/22 regarding the policy ensuring that there were no daisy chains with any power strips in the facility.	2/10/22 2/11/22 3/2/22

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K 920	Continued From page 11 Findings: On February 9, 2022, between 9:00 a.m. and 2:45 p.m., the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. The following observation was made: 1. At 10:02 a.m., a daisy chain was observed next to the computers in the office of the Director of Social Services. 2. At 10:57 a.m., a daisy chain was observed by the computers in the staff development room. The deficient practice affected two of six smoke compartments. On February 10, 2022, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 920	2. The Safety Committee implemented an Electrical Equipment Power Strip QAPI to ensure compliance by conducting electrical equipment and safety rounds. This will be conducted on a monthly basis for compliance. <u>Monitoring performance and integration into the Quality Assurance System</u>: The Maintenance Director and Safety Committee will present a summary findings by completing inservices, spot check observation, QAPI Committee, and Safety rounds, and subsequent follow up at the monthly Quality Assessment and Assurance Committee Meeting for review and action as indicated.	3/4/22 3/4/22