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

PRINTED: 04/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 02 B. WING	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 37135 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: 37135 Census: 95	E 000	"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 the conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 Et seq."	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA	E 041	E 041 1. The maintenance supervisor or designee updated the facility policy and procedure to show the fuel supply is supplied by natural gas from the city to keep the emergency power system operational for the minimum required time of 96 hours. 2. The maintenance supervisor or designee completed a check of the propane fuel tank and labeled the correct fuel supply on the propane fuel tank. No other areas were identified for correction. 3. The maintenance supervisor or designee shall monitor the propane fuel tank monthly for six months for proper labeling of gallons of propane fuel in the tank. 4. The maintenance supervisor or designee shall review for any trends or changes	

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

LABO[redacted] TITLE (X6) DATE 5-9-2018

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.

5/10/18 — Approved by Cynthia W

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E 041	Continued From page 1 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a	E 041	identified with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/18.	

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E 041	Continued From page 2 document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, Issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, Issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review, observation, and interview, the facility failed to maintain the emergency preparedness plan to include policy and procedure for the emergency power system. This was evidenced by no policy and procedure that addressed how the fuel supply will be obtained to keep the emergency power system operational for the minimum required time. This affected seven of seven smoke compartments	E 041		

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E 041	Continued From page 3 and could results in the generator being non-operational during an emergency. Findings: During document review, a tour of the facility, and interview with the Director of Maintenance on 4/17/18, the emergency power system was observed and the emergency preparedness plan policy and procedures for the system were requested. 1. At 11:15 a.m., a page from the facility emergency preparedness plan titled, "Alternate Sources of Energy" was provided and reviewed. The document noted the following: "The generator is located in the back of the building. It is a ONAN fueled by natural gas/propane with a tank that holds 3-4 hours of fuel." The policy and procedure did not indicate how much fuel was store and how/where they will get the fuel supply to maintain the emergency power system running for a minimum of 96 hours. Upon interview, the Director of Maintenance confirmed the finding and stated that they have an additional 50-55 gallons of fuel onsite, he was not sure how many hours of run time it would provide. At 12:35 p.m., the propane tank being used as additional fuel for the generator was observed. The tank did not indicate how many gallons of fuel it holds. Upon interview, the Director of Maintenance confirmed the finding and stated that it holds about 50-55 gallons of fuel.	E 041		
K 000	INITIAL COMMENTS	K 000		

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K 000	Continued From page 4 Surveyor: 37135 K3 BUILDING: 01 K6 PLAN APPROVAL: 1965 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 37135 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 95	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories	K 161	K 161 1. The maintenance supervisor or designee shall repair the ceiling area near the north wall by 5/15/18. 2. The maintenance supervisor or designee completed a check of the facility. No other penetrations were noted. 3. The maintenance supervisor or designee shall monitor for penetrations in	

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K 161	Continued From page 5 non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by an unsealed penetration in the ceiling. This affected one of seven smoke compartments and could result in the spread of fire and smoke in the event of a fire.	K 161	the facility by completing a facility-wide check each month for 6 months. 4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018.	

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K 161	Continued From page 6 Findings: During a tour of the facility and interview with the Maintenance Director on 4/17/18, the ceiling was observed. 1. At 11:45 a.m., the ceiling of the Back Dinning Room was observed. The ceiling was observed to have water damage and was leaking. The ceiling area near the north wall had an approximate 1 foot by 1/2 inch penetration that was caused by the water damage. There were four buckets placed below the area to catch the water that was dripping. Upon interview, the Maintenance Director confirmed the finding and stated that the damage started in November 2017 and was caused by heavy rain. The Maintenance Director also stated that they had contacted two vendors for bids to repair.	K 161		
K 211 SS=D	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: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the door openings. This was evidenced by the absence of an annual inspection and test for door assemblies. This affected seven of seven smoke compartments	K 211	K 211 1. An annual fire door assemblies testing and inspection was conducted by an outside licensed vendor by 6/13/17. 2. Facility fire door assembly deficiencies shall be corrected by 9/30/18. 3. The maintenance supervisor or designee shall ensure that a fire door assemblies testing and inspection will be conducted annually. 4. The maintenance supervisor or designee shall review and monitor for changes or trends identified with the quality assurance	

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K 211	Continued From page 7 and could result in the malfunction of the egress doors during an emergency situation. NFPA 101, Life Safety Code, 2012 Edition 19.1.1.4.1.1 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) 8.3.3 Fire Doors and Windows. 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. 5.2.3 Functional Testing. 5.2.3.1 Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 5.2.3.2 Before testing, a visual inspection shall be performed to identify any damaged or missing parts that can create a hazard during testing or affect operation or resetting. 5.2.4 Swinging Doors with Builders Hardware or Fire Door Hardware.	K 211	committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018.	

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K 211	Continued From page 8 5.2.4.1 Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. 5.2.4.2 As a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity: Findings: During document review and interview with the Director of Maintenance and Administrator on 4/17/18, the annual inspection and testing for doors were requested.	K 211		

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K 211	Continued From page 9 1. At 11:08 a.m., no annual door assemblies inspection and/or testing had been completed. Upon interview, the Director of Maintenance confirmed the finding. During the survey exit conference, the Administrator stated that they were going to contact the vendor for the annual report on the door assemblies. The facility was given until 10:00 a.m., on 4/18/18 to provide the report for the annual door assemblies inspection and/or testing to the California Department of Public Health (CDPH). At 10:00 a.m., on 4/18/18, CDPH did not receive a report for the annual door assemblies inspection and/or testing from the facility.	K 211		
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 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the exit signs. This was evidenced by 26 of 26 battery powered exit signs that were not tested as required. This affected seven of seven smoke compartments and could	K 293	K 293 1. An outside vendor completed a facility exit sign inspection by 5/1/18. All exit signs are operational. 2. The maintenance supervisor or designee shall complete a 30 second battery powered exit sign test monthly and a 90 minute exit sign test annually. 3. The maintenance supervisor or designee shall monitor monthly for six months for compliance. 4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be	

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K 293	Continued From page 10 result in the malfunction of the battery operated exit signs during an emergency. NFPA 101 Life Safety Code, 2012 edition 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. 7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1; 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered.	K 293	reviewed for any changes with the quality assurance committee quarterly for 6 months. 5. Plan of correction completed by 5/15/2018.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING 02 B. WING	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 11 (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1172 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1172-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.	K 293		

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K 293	Continued From page 12 (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1172 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. Findings: During document review and interview with the Director of Maintenance on 4/17/18, the exit sign records were requested. 1. At 10:20 a.m., records provided indicated that the facility had 26 battery powered exit signs that were tested on a monthly basis. The records did not indicate the amount of time the exit signs were tested for. There were no records provided that indicated that 26 of 26 battery powered exit signs were tested for 30 seconds on a monthly basis and for 90 minutes on an annual basis. Upon interview, the Director of Maintenance confirmed the finding and stated that they test the exit signs for about 3 to 4 seconds monthly. The Director of Maintenance also stated that they thought that they only had to test the battery powered emergency lights for 30 seconds monthly and for 90 minutes annually, not the battery powered exit signs. This finding was also found during last year's Life Safety Code annual recertification dated 4/25/17.	K 293		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345	K 345 1. An annual fire alarm system test and inspection including load voltage test of	

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K 345	Continued From page 13 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review, observation, and interview, the facility failed to maintain the fire alarm system. This was evidenced by the an incomplete annual fire alarm report and the absence of one of two semi-annual load voltage test for two of two sealed lead-acid fire alarm control panel (FACP) back-up batteries. This affected seven of seven smoke compartments and could result in system impairment during an emergency situation. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if	K 345	two sealed lead-acid fire alarm control panel back-up batteries and testing audible alarms throughout the facility was completed on 8/31/17. The inspection shows that the batteries passed inspection. On 11/28/17, an outside vendor replaced the back-up batteries with the service request form stating the system is "normal." No findings were identified. 2. The maintenance supervisor or designee shall ensure that a comprehensive annual fire alarm system test and inspection shall be completed annually and semi-annual load voltage test for both sealed lead-acid fire alarm control panel back-up batteries. 3. The maintenance supervisor or designee shall monitor for compliance monthly for six months for compliance. 4. The maintenance supervisor or designee shall review and monitor findings quarterly. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for six months for compliance. 5. Plan of correction completed by 5/15/2018.	

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K 345	Continued From page 14 required by the authority having jurisdiction. 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5 Testing Frequencies 6. Batteries-fire alarm systems (d) Sealed lead-acid type (1) Charger test (Replace battery within 5 years after manufacture or more frequently as needed)-annually (2) Discharge test (30 minutes)-annually (3) Load voltage test-semi-annually Table 14.4.5 Test Fequencies 20. Alarm notification appliances-Annually (a) Audible devices-Annually (b) Audible textual notification appliances-Annually (c) Visible devices-Annually Findings: During document review, a tour of the facility, and interview with the Director of Maintenance on 4/17/18, the fire alarm system records were requested. 1. At 10:30 a.m., the annual fire alarm system report was requested. A document titled, "Alarm & Detection Equipment Test Report" was provided. The report was dated 8/31/17. The report did not indicate that the audible alarms throughout the facility were tested. Upon interview, the Director of Maintenance confirmed the finding and stated that the audible alarms were tested, but they were not sure why they	K 345		

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K 345	Continued From page 15 were not noted on the report. This finding was also found during last year's Life Safety Code annual recertification dated 4/25/17. 2. At 10:43 a.m., the annual fire alarm system report dated 8/31/17 indicated that two of two sealed lead-acid back-up batteries for the FACP were tested for load voltage. There was no other documentation provided that indicated the two back-up batteries had a load voltage test completed 6 months prior or after to 8/31/17. Upon interview, the Director of Maintenance confirmed th finding and stated they were unaware of this requirement.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	K 353 1. The maintenance supervisor or designee visually inspected the alarm system riser check valves and pressure gauges for all sprinklers by 5/15/18. 2. The maintenance supervisor or designee completed a check of the facility sprinkler heads. No findings were identified. 3. The maintenance supervisor or designee shall monitor by completing a check of all sprinkler heads and inspecting the alarm system riser check valves and pressure gauges monthly for 6 months. 4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be	

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K 353	Continued From page 16 by: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the automatic sprinkler system and its components. This was evidenced by the absence of 7 of 12 monthly inspections. This affected seven of seven smoke compartments and could result in the malfunction of the automatic sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by the Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 4.3 Records 4.3.1* Records shall be made inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 5.2.4 Gauges 5.2.4.1* Gauges on a wet pipe sprinkler shall be inspected monthly to ensure that they are in good	K 353	reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018.	

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K 353	Continued From page 17 condition and the normal water supply pressure is being maintained. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification 13.4.1.1* Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained. (2) The valve is free of physical damage. (3) All valves are in the appropriate open or closed position. (4) The retarding chamber or alarm drains are not leaking. 13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. Findings: During document review and interview with the Director of Maintenance on 4/17/18, the automatic sprinkler system records were requested. 1. At 10:35 a.m., records provided indicated that	K 353		

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K 353	Continued From page 18 monthly visual inspections for the alarm and system riser check valves and pressure gauge for the following months were not completed: May, June, September, October, and December of 2017 and January and February of 2018. Upon interview, the Director of Maintenance confirmed the finding and stated they were not aware of this requirement. This finding was also found during last year's Life Safety Code annual recertification dated 4/25/17.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by an ABC type portable extinguisher that was obstructed from access. This affected one of seven smoke compartments and could result in the inability to obtain the extinguisher in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of	K 355	K 355 1. The maintenance supervisor or designee removed the ladder placed up against the extinguisher immediately. 2. The maintenance supervisor or designee completed a check of all fire extinguishers in the building to determine if any objects were obstructing access to the fire extinguishers. No findings were identified. 3. The maintenance supervisor or designee shall monitor by completing a check of all fire extinguishers monthly for 6 months. 4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for	

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K 355	Continued From page 19 another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Extinguishers, 2010 Edition. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. Findings: During a tour of the facility and interview with the Director of Maintenance on 4/17/18, the portable fire extinguishers were observed. 1. At 10:00 a.m., the ABC type fire extinguisher located in the Mechanical Room was observed. There was a ladder placed up against the extinguisher obstructing it from access. Upon interview, the Director of Maintenance confirmed the finding.	K 355	compliance. 5. Plan of correction completed by 5/15/2018.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363	K 363 1. The maintenance supervisor or designee removed the wheelchair immediately from the corridor door for rooms 9 and 40; repaired the door latch on the door located between resident room 32 and resident room 33 and now latches; the door knob was replaced on the corridor clean linen closet door located between resident room 3 and resident room 4. 2. The maintenance supervisor or designee completed a check of the facility corridor	

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K 363	Continued From page 20 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by two corridor doors that were obstructed from closing, one corridor door that did not latch and another that had a broken door knob. This affected three of seven smoke compartments and could result in the spread of fire and/or smoke in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.6.3* Corridor Doors.	K 363	doors and obstructions to resident room doors. No other doors were identified for correction. 3. The maintenance supervisor or designee shall monitor by completing a check of corridor doors in the facility monthly for 6 months. 4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018. 2018 MAY 10 AM 7:41 LICENSING & CERTIFICATION PROGRAM CALIFORNIA DEPARTMENT OF PUBLIC HEALTH	

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K 363	Continued From page 21 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13.4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes 19.3.6.3.10* Doors shall not be held open be devices other then those that release when the door is pushed or pulled. Findings: During a tour of the facility and interview with the Director of Maintenance on 4/17/18, the corridor doors were observed. 1. At 11:56 a.m., the corridor door to Resident Room 40 was obstructed from closing by a wheelchair that was stationed in front of the door. 2. At 12:00 p.m., the corridor door to the Storage Closet located between Resident Room 32 and Resident Room 33 did not latch when tested by the Director of Maintenance. The door was equipped with a self-closing device. 3. At 12:20 p.m., the corridor door to Resident Room 9 was obstructed from closing by a wheelchair that was stationed in front of the door. 4. At 12:25 p.m., the corridor door to the Clean Linen Closet located between Resident Room 3 and Resident Room 4 was tested by the Director of Maintenance. When the door was opened, the knob came off the door.	K 363		

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K 363	Continued From page 22 These findings were confirmed by the Director of Maintenance.	K 363		
K 524 SS=D	HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the direct-vent gas fireplaces. This was evidenced by one of two direct-vent gas fireplace that was not equipped with a sealed safety glass enclosure and a hard wired carbon monoxide (CO) detector. This affected one of seven smoke compartments, and could result in the spread of smoke and/or fire to other locations of the facility in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.5.2.3 The requirements of 19.5.2.2 shall not apply where otherwise permitted by the following: (2) Direct-vent gas fireplaces, as defined in NFPA 54, National Fuel Gas Code, shall be permitted inside of smoke compartments containing patient sleeping areas, provided that all of the following criteria are met: (a) All such devices shall be installed, maintained,	K 524	K 524 1. The maintenance supervisor or designee capped off the gas pipe and sealed the fire place with a metal panel on 4/19/2018. 2. The maintenance supervisor or designee checked the facility with no other fireplaces identified. 3. The maintenance supervisor or designee shall monitor by completing a check quarterly for proper seal of fireplace for 6 months. 4. The maintenance supervisor or designee shall review and monitor findings quarterly for six months. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018.	

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	555673	A. BUILDING 02 B. WING	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

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K 524	Continued From page 23 and used in accordance with 9.2.2. (b) No such device shall be located inside of a patient sleeping room. (c) The smoke compartment in which the direct-vent gas fireplace is located shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 9.7.1.1(1) with listed quick response or listed residential sprinklers. (d)*The direct-vent fireplace shall include a sealed glass front with a wire mesh panel or screen. (e)*The controls for the direct-vent gas fireplace shall be locked or located in a restricted location. (f) Electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is located. 9.2.2 Ventilating or Heat-Producing Equipment. Ventilating or heat-producing equipment shall be in accordance with NFPA 91, Standard for Exhaust Systems for Air Conveying of Vapors,Gases, Mists, and Noncombustible Particulate Solids; NFPA 211, Standard for Chimneys, Fireplaces, Vents, and Solid Fuel-Burning Appliances; NFPA 31, Standard for the Installation of Oil-Burning Equipment; NFPA 54, National Fuel Gas Code; or NFPA 70, National Electrical Code, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. 9.8 Carbon Monoxide (CO) Detection and Warning Equipment. Where required by another section of this Code, carbon monoxide (CO) detection and warning equipment shall be provided in accordance with NFPA 720, Standard	K 524		

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K 524	Continued From page 24 for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment. NFPA 54, National Fuel Gas Code, 2012 Edition 3.3.43.1 Gas Fireplace. 3.3.43.1.1 Direct Vent Gas Fireplace. A system consisting of (1) an appliance for indoor installation that allows the view of flames and provides the simulation of a solid fuel fireplace, (2) combustion air connections between the appliance and the vent air intake terminal, (3) flue-gas connections between the appliance and the vent-air intake terminal, and (4) a vent air intake terminal for installation outdoors, constructed such that all air for combustion is obtained from the outdoor atmosphere and all flue gases are discharged to the outdoor atmosphere. NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment, 2012 Edition 9.5 Power Supplies. 9.5.1 General. 9.5.1.1 All power supplies shall have sufficient capacity to operate the alarm signal(s) for at least 12 continuous hours. Findings: During a tour of the facility and interview with Director of Maintenance and Administrator on 4/17/18, the direct-vent gas fireplaces were observed. 1. At 11:50 a.m., the Back Dining Room was observed with a fireplace that was equipped with a direct-vent gas and had two logs inside. The	K 524		

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K 524	Continued From page 25 fireplace was not in use at the time. The fireplace had two metal mesh screens installed in the front, but no safety glass enclosure. There was no a hard wired CO detector located in the room. The fireplace was located inside a smoke compartment containing the following patient sleeping rooms: Room 22, 23, 24, 25, 26, 27, 28, 29, 46, 47, and 48. Upon interview, the Director of Maintenance confirmed the finding. During the survey exit conference, the Administrator confirmed the finding and stated that they had the same issue with the fireplace located in the Front Dinning Room during last year's Life Safety Code annual recertification survey.	K 524		
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 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918	K 918 1. The maintenance supervisor or designee completed a test of the electrolyte specific gravity test or battery conductance test on 4/23/2018. 2. The maintenance supervisor or designee shall complete monthly testing and recording of the electrolyte specific gravity test or battery conductance test. 3. The maintenance supervisor or designee shall monitor electrolyte specific gravity testing or battery conductance testing monthly for 6 months. 4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be	

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

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K 918	Continued From page 26 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the emergency power system. This was evidenced by the absence of 12 of 12 monthly electrolyte specific gravity tests for the 30 kilowatt (KW) natural gas generator battery. This affected seven of seven smoke compartments and could result in the failure of the generator in the event of a power outage. NFPA 99, Health Care Facilities Code, 2012 Edition. 6.4.4.1.1.3 Maintenance shall be preformed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance	K 918	reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018.	

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K 918	Continued From page 27 testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. Findings: During document review and and interview with the Director of Maintenance on 4/17/18, the records for the 30KW natural gas generator were requested. 1. At 10:10 a.m., there were no records provided that indicated the lead-acid battery on the generator was tested for electrolyte specific gravity on a monthly basis. Upon interview, the Director of Maintenance confirmed the finding and stated they were not testing the battery, but if the battery were ever low they would be alerted by the generator annunciator panel.	K 918		
K 923 SS=C	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 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	K 923	K 923 1. The maintenance supervisor or designee placed a precautionary sign outside the oxygen storage room immediately. 2. The maintenance supervisor or designee completed a check of the other oxygen storage room for a precautionary sign and was in place. No other findings were identified. 3. The maintenance supervisor or designee shall monitor by completing a check of each oxygen storage room for precautionary signs placed outside of each oxygen storage room door monthly for 6 months.	

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K 923	Continued From page 28 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: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the oxygen cylinder storage. This was evidenced by one of two Oxygen Cylinder Storage Closets did not have a precautionary sign. This affected one of seven smoke compartments and could result in a hazardous situation. NFPA 99, Health Care Facilities Code, 2012 Edition: 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following	K 923	4. The maintenance supervisor or designee shall review and monitor findings monthly for six months. Trends identified shall be reviewed for any changes with the quality assurance committee quarterly for a duration of 6 months for compliance. 5. Plan of correction completed by 5/15/2018.	

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K 923	Continued From page 29 wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING Findings: During a tour of the facility and interview with the Director of Maintenance on 4/17/18, the oxygen storage rooms were observed. 1. At 12:28 p.m., the Oxygen Storage Room located next to Resident Room 2 was observed. There was no precautionary sign posted outside the room. Upon interview, the Director of Maintenance confirmed the finding and grabbed a precautionary sign from the inside of the Oxygen Storage Room and place it outside the room where it was visible.	K 923		