STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A110	A. BUILDING 02 B. WING _____	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HOME INC.	13435 PEACH AVENUE LIVINGSTON, CA 95334

(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: 43379 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: 43379 Census = 32 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000	RECEIVED By LSC at 2:15 pm, Mar 15, 2024	
K 000	INITIAL COMMENTS Surveyor: 43379 K3 BUILDING: 01 K6 PLAN APPROVAL: 4/1/1974 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 33 Resident Census: 32 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 -	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/15/24

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.

3/18/2024: POC accepted per Beverly Ong-Sladek, SSM-1

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K 000	Continued From page 1 Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 43379 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000	*This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.*	
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Surveyor: 43379	K 325	**K325 Alcohol Based Hand Rub dispenser (ABHR)** **1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 3/5/24 the maintenance director removed the ABHR in room 7 and relocated it to a compliant area. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This had the potential to affect all residents in the building. On 3/12/24 an audit was done of all ABHRs and all were in compliance for placement (attached).	

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K 325	Continued From page 2 Based on observation and interview, the facility failed to maintain the Alcohol-Based Hand Rub (ABHR) dispensers. This was evidenced by ABHR that was installed directly above an ignition source. This affected one of two smoke compartments and two of 32 residents and could result in an electrical fire. Findings: During a tour of the facility and interview with Maintenance Staff on 3/4/24, the ABHR dispenser was observed. At 12:05 p.m., Resident Room seven was observed with an ABHR dispenser was approximately four inches above the light switch. Upon interview, the Maintenance Staff stated that it was an oversight to install the ABHR dispenser above an ignition source.	K 325	**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ABHR placement education (attached) was provided to the maintenance director on 3/12/24. A PIP was started to ensure proper ABHR placement (attached). **4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;** The ABHR placement audit (attached) will be performed monthly by the maintenance director for 3 months as directed by the PIP. The PIP will be reviewed monthly and evaluated at the quarterly QAPI/QA to ensure effectiveness.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		

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K 341	Continued From page 3 This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by the circuit disconnecting means for the fire alarm system that was not identified with red marking. This affected 32 of 32 residents and two of two smoke compartments, could result in staff inability to identify the circuit breaker in the event of an emergency. NFPA 101, Life Safety Code, 2012 Edition 19.3.4 Detection, Alarm, and Communications Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6 Fire Detection, Alarm, and Communications Systems. 9.6.1* General. 9.6.1.1 The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. 9.6.1.2 Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it	K 341	**K341 Fire Alarm System - Installation** **1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 3/5/24 the maintenance director applied red tape marking to identify the fire alarm circuit disconnect. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This had the potential to affect all residents in the building. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Emergency panel marking education (attached) was provided to the maintenance director on 3/12/24. A PIP was started to ensure proper E panel identification (attached).	

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K 341	Continued From page 4 is an approved existing installation, which shall be permitted to be continued in use. NFPA 72: National Fire Alarm and Signaling Code, 2010 edition 10.5.5.2 Circuit Identification and Accessibility. 10.5.5.2.1 The location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. 10.5.5.2.2 For fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." 10.5.5.2.3 For fire alarm systems the circuit disconnecting means shall have a red marking. 10.5.5.2.4 The circuit disconnecting means shall be accessible only to authorized personnel. Findings: During a tour of the facility and interview with Maintenance Staff on 3/4/24, the fire alarm systems circuit disconnecting means was observed. At 11:42 a.m., electrical panel E located in the generator room was observed without red identification for the fire alarm circuit disconnecting means. Upon interview, the Maintenance Staff stated that he was not aware of the code requirement.	K 341	**4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;** An E panel identification audit will be performed monthly by the maintenance director for 3 months as directed by the PIP. The PIP will be reviewed monthly and evaluated at the quarterly QAPI/QA to ensure effectiveness.	
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	K 355		

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K 355	Continued From page 5 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by missing monthly visual inspections. This affected the maintenance shop area that was located in the exterior of the facility, and could result in a malfunction of the fire extinguisher. 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 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Findings:	K 355	**K355 Portable Fire Extinguishers** **1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 3/5/24 the maintenance director performed and recorded the monthly visual inspection on the fire extinguisher located in the exterior of the facility. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This had the potential to affect the maintenance shop which is not a resident area. On 3/12/24 an audit was done of all fire extinguishers in the facility and all were in compliance for monthly visual inspection (attached). **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Fire extinguisher inspection education (attached) was provided to the maintenance director on 3/12/24. A PIP was started to ensure proper fire extinguisher inspection (attached).	

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K 355	Continued From page 6 During a tour of the facility and interview with the Maintenance Staff on 3/4/24, the fire extinguishers were observed. At 11:47 a.m., the ABC fire extinguisher located in the Maintenance Shop area was observed without any indication that it was visually inspected for the months of September, October, November, and December of 2023, and January and February of 2024. Upon interview, the Maintenance Staff stated that it was an oversight on his behalf.	K 355	**4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;** The fire extinguisher inspection audit will be performed monthly by the maintenance director and recorded in the PIP for 3 months as directed by the PIP. The PIP will be reviewed monthly and evaluated at the quarterly QAPI/ QA to ensure effectiveness.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	**K363 Corridor – Doors** **1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 3/5/24 the maintenance director adjusted the closure on the DON office door and it closes and latches.	

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K 363	Continued From page 7 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: 43379 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by corridor doors that failed to latch when tested. This could result in the passage of smoke in the event of a fire, and affected one of two smoke compartments and 12 of 32 residents. Findings: During a tour of the facility and interview with Maintenance Staff on 3/4/24, the corridor doors were observed and tested. At 12:19 p.m., the corridor door with a self-closing device to the Director of Nurse office failed to latch when allowed to self close. The door was tested three times and failed to latch on all three occasions. Upon interview, the Maintenance Staff stated that the self-closing device needed to be adjusted to allow sufficient closing force to close and latch the corridor door.	K 363	**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This had the potential to affect all residents in the building in the event of a fire. On 3/12/24 an audit was done of all corridor doors and all were in compliance for latching (attached). **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Corridor door latching education (attached) was provided to the maintenance director on 3/12/24. A PIP was started to ensure compliant corridor door latching (attached). *continued*	

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			4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; The corridor door latching audit (attached) will be performed monthly by the maintenance director for 3 months as directed by the PIP. The PIP will be reviewed monthly and evaluated at the quarterly QAPI/QA to ensure effectiveness.	