STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555841	A. BUILDING **02** B. WING _____	**01/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS MANOR	**238 VIRGINIA AVENUE** **CAMPBELL, CA 95008**

(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: 46858 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: 46858 CENSUS: 23 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000		
E 026 SS=E	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 026		2/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2024

3/11/2024: POC accepted per Brian Fenton, SSM-1

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E 026	Continued From page 1 (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Surveyor: 46858 Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by missing policy and procedures for the facility roles under an 1135 waiver. This could result in the delay in protecting the health and safety of 23 of 23 residents. Findings: During document review and interview with staff on 1/16/24, the EPP was reviewed. At 1:30 p.m., the facility failed to provide a policy and procedure describing the facility's role in providing care and treatment at an alternate care site under an 1135 waiver at the time of the survey. During a concurrent interview, Staff 2 stated that he was not sure what an 1135 waiver was.	E 026	This facility has a policy and procedure in place for the facility's role under the 1135 waiver which includes the provisions of care of facility residents to protect their health and safety. The policy is located in the facility's Emergency Disaster Preparedness and Response Manual. A copy of the policy has been reviewed by the NHA Consultant with the facility Managers on 01/20/24. All residents have the potential to be affected. The policy and procedure for the Facility's role under the 1135 waiver which includes provisions of care to protect the health and safety of the facility residents shall be maintained in the facility's Emergency Disaster Preparedness and Response binder. The policy and procedure shall be reviewed and updated as necessary once every year by the facility Quality Assessment and Process Improvement Committee. An in-service training was provided to the	

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E 026	Continued From page 2	E 026	facility managers by the NHA Consultant on 1/20/24 regarding but not limited to: 1. Location of the policy and procedure of the Facility's role under the 1135 waiver and 2. Review of the policy & procedure for the facility's role under the 1135 waiver. An in-service training shall be provided to facility staff regarding the in-service topics above by the Staff Development Director by 2/16/24. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	
E 041 SS=E	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (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), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] 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), §485.542(e)(1),	E 041		2/2/24

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E 041	Continued From page 3 §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 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), §485.542(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),§485.542(e)(2) 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), REHs at §485.542(g), and 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	E 041		

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E 041	Continued From page 4 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 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..	E 041		

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E 041	Continued From page 5 This REQUIREMENT is not met as evidenced by: Surveyor: 46858 Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan. This was evidenced by missing a contract between the facility and a fuel-providing vendor. This could result in the loss of back-up power in the event of an emergency. This affected the health and safety of 23 of 23 residents. Findings: During document review and interview with staff on 1/16/24, the emergency fuel plan was requested. At 1:35 p.m., the facility failed to provide a written vendor agreement for the delivery of fuel for the 80-kilowatt diesel generator in the event of an emergency. During a concurrent interview, Staff 2 stated that the facility has a vendor that occasionally delivers diesel to the generator but confirmed to not have a written contract with the vendor.	E 041	The facility has signed an agreement with a licensed vendor on 2/2/24 to resupply diesel fuel to the facility emergency power generator in the event of any disaster emergency. All residents have the potential to be affected. The Administrator, Maintenance Service Staff, or designee shall be responsible in notifying immediately and making request to contracted vendor to resupply diesel fuel to the facility emergency power generator in the event of any disaster emergencies. Records of emergency power generator fuel resupply service shall be kept in the Fire Safety Inspection Report Binder located in the Administrator's office. The Staff Development Director shall provide in-service training to facility staff regarding but not limited to: 1. Facility Emergency Power Generator fuel resupply procedures in the event of disaster emergency. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement. The facility submitted contracts to be reviewed on 3/5/24.	

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K 000	Continued From page 6	K 000		
K 000	INITIAL COMMENTS	K 000		
	Surveyor: 46858 K3 BUILDING: 01 K6 PLAN APPROVAL: 2007 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. Resident Certified Beds: 45 Resident Census: 23 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: 46858 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.			
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		1/29/24

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K 345	Continued From page 7 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: 46858 Based on document review and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by missing semi-annual FAS inspection and Fire Alarm Control Panel (FACP) battery testing. This affected 23 of 23 residents and two of two smoke compartments. 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 Fire Detection, Alarm, and Communications 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 is an approved existing installation, which shall be permitted to be continued in use. NFPA 72- National Fire Alarm and Signaling Code- 2010 Edition 14.3.1 * Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1 Testing Frequencies	K 345	The facility fire alarm system shall be tested and maintained in accordance to facility policy, State and Federal regulations. The semi-annual Fire Alarm System (FAS) Inspection and Fire Alarm Control Panel (FACP) battery testing was completed on 1/29/24 by Kelex Security. All residents have the potential to be affected. The Maintenance Service Staff shall be responsible for monitoring when service testing is due and scheduling for the semi-annual FAS and FACP battery testing according to facility policy, State and Federal regulations. Records of the semi-annual FAS and FACP battery testing shall be kept in the Fire Safety Inspection Report Binder located in the Administrator's office. The Administrator or designee shall monitor by reviewing the Fire Safety Inspection Report binder every month to ensure compliance. The Maintenance Service Staff was provided in-service training by the Assistant Administrator on 1/29/24 regarding the following but not limited to: testing frequency for 1. Semi-Annual testing of the FAS and FACP battery load voltage testing according to facility policy, State and Federal regulations. The Administrator or designee shall report trends in compliance with the established	

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K 345	Continued From page 8 9.Initiating devices (a) Air sampling; Semiannually (b) Duct detectors; Semiannually (c) Electromechanical releasing devices; Semiannually (d) Fire extinguishing system(s) or suppression system(s) switches; Semiannually (e) Manual fire alarm boxes; Semiannually (f) Heat detectors; Semiannually (g) Radiant energy fire detectors: Semiannually (h) Smoke detectors (excluding one- and two-family dwellings); Semiannually (i) Supervisory signal devices; Semiannually (j) Waterflow devices; Semiannually 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 1. Control equipment systems connected to supervising station (a) Functions-Initial/Reacceptance, Annually (b) Fuses-Initial/Reacceptance, Annually (c) Interfaced equipment-Initial/Reacceptance, Annually (d) Lamps and LEDs-Initial/Reacceptance, Annually (e) Primary (main) power supply-Initial/Reacceptance, Annually (f) Transponders-Initial/Reacceptance, Annually 6. Batteries-fire alarm systems (d) Sealed lead-acid type (1) Charger test (Replace battery as needed.) - Initial/Reacceptance; Annually (2) Discharge test (30 minutes) - Initial/Reacceptance; Annually (3) Load voltage test - Initial/Reacceptance;	K 345	systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	

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K 345	Continued From page 9 Semiannually Findings: During document review and interview with staff on 1/16/24, the FAS inspection and testing records were requested and reviewed. 1. At 1:07 p.m., the facility failed to conduct the semi-annual FAS inspection. The date of the last semi-annual FAS inspection was unknown. During a concurrent interview, Staff 2 stated that he was unsure if the semi-annual FAS inspection was conducted, and that the facility would contact their vendors to confirm. The facility was given until 9 a.m. on 1/17/24 to submit the according inspection records. As of 1/17/24 the requested documentation was not received. 2. At 1:08 p.m., the facility failed to conduct one of two semi-annual load voltage tests for the FACP. The date of the last load voltage testing record was during their annual test and inspection on 9/5/23. During a concurrent interview, Staff 2 stated that the facility would contact their vendors to ask for battery testing records. The facility was given until 9 a.m. on 1/17/24 to submit the according inspection records. As of 1/17/24 the requested documentation was not received.	K 345		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced	K 347		1/29/24

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K 347	Continued From page 10 by: Surveyor: 46858 Based on document review and interview, the facility failed to maintain the smoke detectors. This was evidenced by the failure to conduct smoke detector sensitivity testing. This could result in a failure to activate the Fire Alarm System in the event of a fire. This affected 23 of 23 residents and two of two smoke compartments. 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* General. 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. 9.6.2.10.1.1 Where required by another section of this Code, single-station and multiple-station smoke alarms shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code, unless otherwise provided in 9.6.2.10.1.2, 9.6.2.10.1.3, or 9.6.2.10.1.4. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with14.4.5.3.3.	K 347	This Facility shall maintain the smoke detectors by completing the required Smoke Detector Sensitivity Testing once every other year. The smoke detector sensitivity testing was completed on 1/29/24. All residents have the potential to be affected. The Maintenance Service Staff shall be responsible for maintaining the facility smoke detectors by scheduling with Licensed Contracted vendor to complete the Smoke Detector Sensitivity Testing once every other year. The completed Smoke Detector Sensitivity Testing reports shall be kept and maintained in the Fire Safety Inspection Report binder located in the Administrator's office. The Administrator or designee shall monitor by reviewing the Fire Safety Inspection Report binder once every month to ensure compliance. The Maintenance Service Staff was provided in-service training by the Assistant Administrator and DSD on 1/29/24 regarding the following but not limited to: 1. Smoke Detector Sensitivity Testing every other year, according to facility policy, State, Federal regulations. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	

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K 347	Continued From page 11 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. 14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained. Findings: During document review and interview with staff on 1/16/24, the smoke detector testing records were requested. At 1:12 p.m., the facility failed to conduct smoke detector sensitivity testing. The date of the last smoke detector sensitivity testing was unknown. During a concurrent interview, Staff 2 stated that he was unsure if the sensitivity testing had been conducted. The facility was given until 9 a.m. on 1/17/24 to submit the according sensitivity testing records. The sensitivity record that was submitted was dated 9/22/21. As of 1/17/24 the requested records were not recieved.	K 347		
K 353 SS=E	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,	K 353		2/15/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 12 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 by: Surveyor: 46858 Based on observation, document review, and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by the failure to maintain sprinkler components and by the failure to conduct inspections on the gauges and valves. This could result in a malfunction to the automatic sprinkler system in the event of a fire. This affected 23 of 23 residents and two of two smoke compartments. 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 this Code shall be inspected, tested, and maintained	K 353	This Facility shall maintain the automatic sprinkler systems according to facility policy, State and Federal regulations. A visual inspection of the sprinkler system gauges and valve shall be completed by the Maintenance Service Staff before or by 2/15/24. The fire sprinkler above resident in Room 14B was inspected and cleaned by the Maintenance Service Staff. All residents have the potential to be affected. The Maintenance Service Staff shall be responsible for maintaining the automatic sprinkler systems by conducting routine inspections of the automatic sprinklers. The inspection of the automatic sprinklers shall include the following: 1. Visually inspection of all sprinkler risers, valves opened and locked, connections and gauges, 2. Inspection of all pressure gauges on sprinkler system to ensure that they are in good condition and that normal air and water pressures are being	

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K 353	Continued From page 13 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 5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Gauges (dry, preaction, and deluge systems) - Weekly/monthly 5.2.4.2, 5.2.4.3, 5.2.4.4 Control valves Table 13.1 Waterflow alarm devices - Quarterly 5.2.5 Valve supervisory alarm devices - Quarterly 5.2.5 Supervisory signal devices (except valve supervisory switches) - Quarterly 5.2.5 Gauges (wet pipe systems) - Monthly 5.2.4.1 Hydraulic nameplate - Quarterly 5.2.6 Buildings - Annually (prior to freezing weather) 4.1.1.1 Hanger/seismic bracing - Annually 5.2.3 Pipe and fittings - Annually 5.2.2 Sprinklers - Annually 5.2.1 Spare sprinklers - Annually 5.2.1.4 Information sign - Annually 5.2.6.1 Fire department connections Table 13.1 Valves (all types) Table 13.1 Obstruction, internal inspection of piping -5 years 14.2 5.2.1.1.1 * Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).	K 353	maintained, 3. Verify that all valves are opened, chained and locked, 4. Verify that both valves are chained and locked, 5. Inventory the spare sprinkler heads in the spare sprinkler head box to ensure that there are enough spares of each type in on hand, 6. Verify availability of fixed wrench of the proper size(s) in spare sprinkler head box to change heads in an emergency, 7. Visually inspect tamper switches, 8. For dry systems, the dry pipe valve shall be externally inspected to verify the valve is free of physical damage, all trim valves are in the appropriate open of closed position, and there is no leakage from the intermediate chamber, 9. Drain low points and also drain compressor tank if so equipped. 10. Make sure no obstructions or debris are within 18 inches of sprinkler heads, 11. Visually inspect the PIV, its open and locked, 12. Check that sprinkler heads are clean and functional, 13. Check to ensure escutcheon ring is present and clean, 14. Take pressure readings on the main sprinkler riser (system), and 15. Check for corrosive sprinkler heads and plates. These inspections shall be conducted once every month by the Maintenance Service Staff. Any deficient findings during the inspections shall be corrected and addressed accordingly. The results of the monthly inspections shall be documented and kept in the Maintenance Log Binder located in the Nurses' Station. Maintenance Service Staff shall be provided in-service training regarding the inspection procedures discussed above	

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K 353	Continued From page 14 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer 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.	K 353	before or by 2/15/24. The Administrator or designee shall be responsible in providing the in-service training. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	

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K 353	Continued From page 15 Findings: During a tour of the facility, document review and interview with staff on 1/16/24, the sprinkler system components were observed, and inspection records were reviewed. 1. At 11:54 a.m., the sprinkler above resident Bed B in Room 14 was observed with cobwebs along the frame and deflector. During a concurrent interview, Staff 2 stated that the facility did not have a maintenance routine for the sprinklers. 2. At 1:19 p.m., the facility failed to conduct 7 of 12 monthly visual inspection for the sprinkler system gauges and valves. The facility failed to conduct gauge and valve inspections during the months of February, March, May, June, August, November, and December of 2023. During a concurrent interview, Staff 2 stated that he was unaware a visual inspection was required for the gauges and valves.	K 353		
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	K 363		2/2/24

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K 363	Continued From page 16 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: 46858 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a non-latching corridor door. This can increase the passage of smoke through smoke compartments. This affected 12 of 23 residents and one of two smoke compartments. Findings: During a tour of the facility and interview with staff on 1/16/24, the corridor doors were observed.	K 363	The corridor door to the oxygen room by Room 13 and equipped with a self-closing device was inspected and fixed on 1/16/24 by the maintenance service staff. All residents have the potential to be affected. All fire doors equipped with a self-closing device shall be maintained and kept in good repair by the Maintenance Service staff at all times. The Maintenance Staff shall conduct rounds daily and inspect corridor doors equipped with a self-closing mechanism to ensure door latches	

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K 363	Continued From page 17 At 11:51 a.m., the corridor door to the Oxygen Room by Room 13 was observed with a self-closing mechanism. The corridor door failed to latch when tested. The door was tested for closure three times. During a concurrent interview, Staff 1 stated that the door had failed to latch since the heater was on.	K 363	completely when it closes. The maintenance staff shall also review the maintenance request binder daily, for the timely follow-up and repair of any issues identified with the corridor fire doors. The results of the inspections shall be documented and kept in the Maintenance Log Binder located in the Nurses' Station. The Administrator, or designee shall monitor by conducting random inspection of the corridor doors once every week for the next three (3) months to ensure compliance. Staff Development Director provided in-service training facility staff regarding the following but not limited to: 1. Immediate reporting of maintenance issues observed with the corridor fire doors by logging the request in the Maintenance Request Binder located in the nursing station according to facility policy for timely repairs. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	
K 918 SS=E	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	K 918		2/2/24

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K 918	Continued From page 18 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in 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: 46858 Based on document review and interview, the facility failed to maintain the emergency power supply system. This was evidenced by the failure to conduct the required inspections for the emergency generator. This could result in the ineffective operation of the generator in the event	K 918	The facility shall maintain its emergency power generator, by routinely conducting weekly visual inspections. The Maintenance Service Staff shall be responsible in completing these tasks. All residents have the potential to be affected.	

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K 918	Continued From page 19 of an emergency. This affected 23 of 23 residents and two of two smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3 Emergency Generators and Standby Power Systems. Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition 8.1* General. 8.1.1 The routine maintenance and operational testing program shall be based on all of the following: (1) Manufacturer ' s recommendations (2) Instruction manuals (3) Minimum requirements of this chapter (4) The authority having jurisdiction 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. Findings:	K 918	The Maintenance Service Staff shall conduct weekly visual inspections of the emergency power generator according to facility policy, State and Federal regulation. Any findings shall be addressed accordingly in a timely manner. The results of the weekly visual inspections shall be documented and kept in the Maintenance Log Binder located in the Nurses' Station. The Administrator and designee shall monitor by reviewing the maintenance log binder once every week for the next three (3) months to ensure compliance. Maintenance Service Staff shall be provided in-service training regarding but not limited to: 1. Weekly visual inspection of the emergency power generator by or before 2/15/24 according to facility policy, State and Federal regulations. The Administrator or designee shall be responsible in providing the in-service training. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	

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K 918	Continued From page 20 During document review and interview with staff on 1/16/24, the generator inspection and testing records were reviewed. At 1:21 p.m., the facility failed to provide 12 of 52 weekly visual inspection of the 80-kilowatt diesel generator. During a concurrent interview, Staff 1 stated that the facility had been replacing their Automatic Transfer Switch at the beginning of 2023, so they had failed to conduct the generator weekly inspection.	K 918		
K 920 SS=D	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	K 920		1/16/24

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K 920	Continued From page 21 This REQUIREMENT is not met as evidenced by: Surveyor: 46858 Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by the use of extension cords and daisy-chained power strips. This could result in an electrical fire. This affected 12 of 23 residents and one of two smoke compartments. Findings: During a tour of the facility and interview with staff on 1/16/24, the electrical equipment was observed. 1. At 11:33 a.m., an extension cord was observed connected to the northwest wall of the Business Office. The extension cord was observed powering a miniature refrigerator on a desk. During a concurrent interview, Staff 2 stated that he was unaware the extension cord was being used. 2. At 11:49 a.m., an extension cord was observed connected to the south wall of Room 13. The extension cord was powering a television. During a concurrent interview, Staff 1 stated that he was unaware the extension cord was being used. 3. At 12:07 p.m., two power strips were observed daisy-chained along the west wall of the Activities Office. During a concurrent interview, Staff 2 stated that there should be enough outlets in the office for staff to use.	K 920	The extension cords located in the business office, Room 13 and the two power strip daisy-chained in the activity office was removed by the Maintenance Service Staff on 1/16/24. All residents have the potential to be affected. The Maintenance staff shall be responsible in ensuring extension cords are not used in the facility. Only power power strip with proper UL certification (medical grade), can be used, and shall be used properly at all times in the facility premises. Maintenance Service staff shall monitor by conducting daily facility rounds. The Administrator or designee shall monitor by conducting rounds once every week to ensure compliance. Staff was provided in-service training on 1/16/24 by the Staff Development Director regarding but not limited to: 1. Proper use of power strip and 2. Policy on use of extensions cords according to facility policy State and Federal regulations. The Administrator or designee shall report trends in compliance with the established systems to the QAPI Committee meetings every month for the next three (3), months for review. The Committee shall review identified trends, make recommendations and resolve identified issues for continuous quality assurance and improvement.	