STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING 01 B. WING _____	08/06/2015

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ELNESS CONVALESCENT HOSPITAL	812 WEST MAIN STREET TURLOCK, CA 95380

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1/1/67 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), 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 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 28602 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 92	K 000	Elness Convalescent Hospital - SNF makes its best effort to operate in substantial compliance with both Federal and State Law. Nothing in this Plan of Correction is an admission otherwise. The facility has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. The facility is submitting this plan of correction as required by law as its written credible allegation of compliance for the alleged deficiencies.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM SEP 28 2015 LIFE SAFETY CODE UNIT SAN BERNARDINO	

LA [redacted] TITLE (X6) DATE

9-28-15

Any [illegible] 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.

POC accepted 9/28/15 per Jared Okimoto

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K 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that corridor doors closed and latch. This was evidenced by two self-closing doors that failed to close and six that were impeded from closing. This affected five of six smoke compartments and could result in the spread of smoke or fire, in the event of a fire. NFPA 101 Life Safety Code 2000 Edition 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	K 018 **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. There were no residents affected by the deficient practice **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:** A. There are not resident's affected by the deficient practice. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The latch to the kitchen was fixed the same day 8/5/15 by Maintenance Supervisor (MS). B. The staff was educated by the DSD regarding the over-head tables and they were moved so they do not impede the closing of any doors in case of an emergency on the same day of 8/5/15. C. The nursing staff are responsible for moving the over-bed tables so they will not obstruct any doors from closing in an emergency	

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K 018	Continued From page 2 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 7.2.1.8.1 A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Findings: During a facility tour with staff from 8/5/15 to 8/6/15, the corridor doors were tested and observed. 1. At 3:59 p.m., the self-closing corridor door to the soiled linen room, between Rooms 3 and 4, failed to close and latch. The door was tested three times. 2. At 4:02 p.m., the corridor door to Room 4 was impeded from closing by a privacy curtain. 3. At 4:17 p.m., the corridor door to Room 9 was impeded from closing by an over the bed table positioned in the swing path of the door. 4. At 4:18 p.m., the corridor door to Room 10 was impeded from closing by an over the bed table positioned in the swing path of the door.	K 018	daily before and after care of each resident. D. The MS fixed the latch on the corridor door between Room 3 and 4 on 8/76/15. E. The Maintenance Supervisor (MS) will check all doors during monthly maintenance rounds and repair as needed. F. The DON instructed nursing staff to make sure all privacy curtains are pulled all the way back so they do not impede the doors. The DON fixed the curtain to Room 4 and checked to make sure the door closes on 8/6/15. The MS also checked the privacy curtain the same day and made sure it was pulled back all the way and that the door to Room 4 closed without anything impeding it on 8/5/15 and again checked the door on the morning of 8/6/15. G. The Director of Staff (DSD) and the DON moved the wheelchairs out of the doorways in the Day Room the same day on 8/5/15. The DON and DSD also verbally educated the staff on the same day 8/5/15 to make sure that nothing is in the way of the doors closing on 8/5/15. H. DSD will in service all staff on proper storage/positioning of over bed tables, keeping all doorways clear from anything obstructing the door from closing and making sure privacy curtains are not impeding the doors of the rooms from closing every time they leave the room from patient care. I. Staff were in serviced on 8/21/15 by the DSD regarding fire safety and equipment being positioned in	

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K 018	Continued From page 3 5. At 4:40 p.m., one of two self closing corridor doors to the kitchen failed to fully close and latch. The door was tested four times. 6. At 4:58 p.m., one of two self-closing corridor doors to the Day Room was impeded from closing by a wheelchair positioned directly in front of the open door. The doors were held open by magnetic holds. 8/6/15 7. At 7:30 a.m., the corridor door to Room 28 was impeded from closing by an over the bed table positioned in the swing path of the door. 8. At 7:41 a.m., the corridor door to Room 16 was impeded from closing by an over the bed table positioned in the swing path of the door.	K 018	front doors that will impede the doors from closing in case of an emergency. (See attached exhibit #1) **How the facility plans to monitor its performance to make sure that solutions are sustained.** A. The Administrator will monitor corrective actions through on-going compliance and results written reports by the MS. The administrator will review maintenance logs frequently to assure the doors are checked and logs are maintained. B. The DON, DSD, Shift Supervisors, Charge Nurses will monitor and make rounds on the floor for ongoing compliance of the corrective measures. The PI Committee will monitor the process until compliance is achieved.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their exit access doors. This was evidenced by one of six exit access doors that failed to open. This affected one of six smoke compartments and could result in a delayed evacuation, in the event of a fire emergency. Findings:	K 038	**K 038** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. There were no residents found to have been affected by the deficient practice. **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:**	

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K 038	Continued From page 4 During fire alarm testing with maintenance staff from 8/5/15 to 8/6/15, the exit doors were observed. 8/6/15 1. At 9:34 a.m., the southeast smoke barrier door by Room 17 failed to open when the push bar was tested. The door was used as exit access. The door was tested four times. The door opened on the fifth attempt. The door could not be opened to achieve 32 inches in clear width.	K 038	A. There were no residents found to have been affected by the deficient practice **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The MS adjusted the exit door by Room 17 on 8/7/15.	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review, the facility failed to conduct fire drills a minimum of once per staff shift per quarter. This was evidenced by the facility's failure to conduct one of four quarterly PM shift fire drills. This affected six of six smoke compartments and could result in a delayed staff response to a fire emergency. Findings:	K 050	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The MS will monitor corrective actions through on-going compliance and results of audits completed by the Matson Fire Alarm Company. The MS will report the results of monitoring to the Performance Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved. **K 050** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. No residents were found to have been affected by the deficient practice.	

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K 050	Continued From page 5 During record review with maintenance staff from 8/5/15 to 8/6/15, the fire drill records were requested and reviewed. 8/6/15 1. At 8:25 a.m., there were no records that indicated the facility had completed a PM shift fire drill during the second quarter of 2015.	K 050	**What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. G & S Fire Protection, INC has completed the fire drill for the PM Shift on 8/11/2015 @ 6pm. (See exhibit #2). B. The DSD will monitor and keep a track log on all fire and disaster drills. The DSD will make sure the drills are done quarterly for each shift at various times of the day.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire alarm system. This was evidenced by the failure to maintain a manual fire alarm pull station. This affected one of six smoke compartments and could result in a delayed notification of a fire alarm system activation. NFPA 101, Life Safety Code, 2000 edition 4.6.12.1 Whenever or wherever any device,	K 052	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The DSD will monitor corrective actions through on-going compliance. The DSD will report the results of the monitoring to the Performance Improvement (PI) Committee for review and recommendations.	

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K 052	Continued From page 6 equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 9.6.1.7 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 Electric Code, and NFPA 72, National Fire Alarm Code. NFPA 72, National Fire Alarm Code, 1999 edition 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system. Findings: During the facility tour with maintenance staff from 8/5/15 and 8/6/15, the fire alarm system components were observed throughout the building. 8/5/15 1. At 4:29 p.m., the manual pull alarm in the corridor, located across the dish washing room in the kitchen, had a vendor tape over the pull alarm. At 4:30 p.m., during an interview, Maintenance Staff 1 stated that the vendor was working on the pull alarm as a ground fault was found last week	K 052	**K 052** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. No residents were found to have been affected by the deficient practice. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The vendor tape was removed from the Manuel Pull Alarm in the corridor located by the dish washer on 8/12/2015. (See exhibit #3) B. On 8/12/15 Matson Alarm was at facility and tested the pull stations and they were functioning normally. All signals were verified and were ok. (See Matson service ticket). C. CD Power will come out on 9/16/15 to do an annual service and load bank on the generator. (See # B) C. The MS and/or his department will inspect all Manuel Pull Alarms monthly during maintenance monthly rounds. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The MS will monitor corrective actions through on-going compliance and results of the inspections monthly. The MS will report	

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K 052	Continued From page 7 during the annul testing. Maintenance Staff 1 reported that the pull alarm was not functioning and the vendor was trying to locate the ground fault.	K 052	the results of monitoring to the Performance Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic sprinkler system. This was evidenced by sprinklers that did not have 18 inches of clearance. This affected one of six smoke compartments and could result in a delayed response of the automatic sprinkler system, in the event of a fire emergency. NFPA 101, 2000 Edition 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code. Exception No. 2: NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes,	K 062	**K062** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. No residents were found to have been affected by t the deficient practice. **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:** A. No residents will be affected by the deficient practice. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. Housekeeping Supervisor (HS) removed all linens on 8/5/15 to make 18 inches of clearance in the linen room between Rooms 12 and 14. B. The Housekeeping Supervisor (HS) removed all blankets on 8/5/15 from the closet in room 14 and the sprinkler deflector has 18 inches clearance. C. Housekeeping supervisor in-serviced her staff on 8/20/15 to	

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K 062	Continued From page 8 shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code. 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. NFPA 13 Installation of Sprinkler Systems 1999 edition 5-5.6 Clearance to Storage. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Findings: During a facility tour with maintenance staff from 8/5/15 to 8/6/15, the automatic sprinkler system was observed. 8/5/15 1. At 4:27 p.m., there was linen stored within approximately 15 inches of the sprinkler deflector in the storage linen room located between Rooms 12 and 14. The sprinkler did not have a minimum of 18 inches of clearance. 2. At 4:28 p.m., there were blankets stored within approximately 5 inches of the sprinkler deflector in the closet in Room 14. The sprinkler did not	K 062	assure when linen is placed in the linen closets that there is 18 inches of clearance for the fire sprinkler reflector. (See Attached #4) D. DSD in-serviced nursing staff on 8/21/15 regarding the storage of linen, or any other objects impeding the fire sprinkler deflector and to make sure there is at least 18 inches of clearance (See Attached #1) **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Housekeeping Supervisor, DSD, and DON will monitor corrective actions through on-going compliance. The DSD will report the results of monitoring to the Performance Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM SEP 14 2015 LIFE SAFETY CODE UNIT SAN BERNARDINO	

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K 062	Continued From page 9 have a minimum of 18 inches of clearance.	K 062	K 076	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their medical gas storage locations. This was evidenced by empty and full oxygen gas cylinders that were stored in the same rack in the same room and not clearly segregated. This affected two of six smoke compartments and could result in a delay in providing residents with full oxygen cylinders in an emergency. NFPA 101, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, 1999 Edition	K 076	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. No residents were found to have been affected by the deficient practice. **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:** A. No residents will be affected by the deficient practice. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The Director of Nurses (DON) and the shift supervisor placed full E-Tanks in the proper holders and the empty tanks were placed on the proper side of the room and labeled on 8/6/15. B. The DSD in-serviced nursing staff on 8/21/15 for proper placement of the oxygen tanks. There are signs posted on the walls for staff to be aware which side is the empty tanks kept and where the full tanks are kept. (See Attached # 1) **How the facility plans to monitor its performance to make sure that solutions are sustained.** The DSD and/or DON will monitor corrective actions through on-going compliance. The DSD and/or DON will report the results of monitoring to the Performance	

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K 076	Continued From page 10 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 4 4-3.5.2.2 Storage of Cylinders and Containers. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. Chapter 16 Nursing Home Requirements 16-3.8 Gas Equipment Requirements. 16-3.8.1 Patient. Equipment shall conform to requirements for patient equipment in Chapter 8. Chapter 8 Gas Equipment 8-3-1.11.1 Storage Requirements 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft.3 (85 m3). (h) Cylinder or container restraint shall meet 4-3.5.2.1 (b) 27 Findings: During a tour of the facility with maintenance staff from 8/5/15 to 8/6/15, the medical gas storage locations were observed. 8/5/15 1. At 4:08 p.m., the full oxygen storage room, between Rooms 4 and 5, had three of five E	K 076	Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM SEP 14 2015 LIFE SAFETY CODE UNIT SAN BERNARDINO	

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	055475	A. BUILDING 01 B. WING	08/06/2015

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K 076	Continued From page 11 sized cylinders stored in one rack and not labeled. During an interview, healthcare staff stated that two of the three cylinders were full, but the third one was empty. During an interview, healthcare staff stated a cylinder without a label was full but the gauge was indicating it was empty. Healthcare staff indicated that other staff from other stations also store the oxygen cylinders in the storage room, but that only full oxygen cylinders should be stored in the room. 8/6/15 2. At 7:55 a.m., the empty oxygen storage room had mixed storage in the racks. There were two full E sized oxygen tanks in the empty storage room. At 7:56 a.m., during an interview, healthcare staff confirmed the mixed storage and the two full oxygen tanks. Healthcare staff reported there should only be empty oxygen tanks in the storage room.	K 076		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	**K 144** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. No residents were found to have been affected by the deficient practice. **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:** A. No residents will be affected by the deficient practice.	

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K 144	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their emergency generator. This was evidenced by no generator equipment enclosure and by the failure to correct deficiencies noted with the emergency generator. This affected six of six smoke compartments and could result in an increased risk of engine failure and complete loss of emergency power, in the event of a power failure. NFPA 101, Life Safety Code, 2000 Edition 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 edition. 5-2.3* The rooms, shelters, or separate buildings housing Level 1 or Level 2 EPSS equipment shall be located to minimize the possibility of damage from flooding, including flooding resulting from fire fighting, sewer water backup, and similar disasters or occurrences. 5-2.4* Consideration shall be given to the location	K 144	**What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The fire retardant enclosure for the generator as noted in accordance to life safety codes was orders obtained on 9/11/2015 by (MS). The MS replaced the enclosure. B. The (MS) took the muffler for the diesel generator was ordered from America Muffler and was ordered on 9/4/2015. America Muffler will come out and replace the muffler when it arrives. (See Attached # A) **How the facility plans to monitor its performance to make sure that solutions are sustained.** The MS will monitor corrective actions through on-going compliance. The MS will report the results of monitoring to the Performance Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM SEP 14 2015 LIFE SAFETY CODE UNIT SAN BERNARDINO	

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K 144	Continued From page 13 of the Level 1 and Level 2 EPSS equipment to minimize the possibility of damage resulting from interruptions of the emergency power source caused by the following: (a)* Natural conditions such as storms, floods, earthquakes, tornadoes, hurricanes, lightning, ice storms, wind, and fire (b) Conditions such as vandalism, sabotage, and other similar occurrences (c) Material and equipment failures. 5-2.5 The EPS equipment shall be installed in a location that will permit ready accessibility and adequate [minimum of 30 in. (76 cm)] working space around the unit for inspection, repair, maintenance, cleaning, or replacement. 6-1.1 The routine maintenance and operation testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer 6-3.6 Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.	K 144		

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K 144	Continued From page 14 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. Findings: During a facility tour and record review with maintenance staff from 8/5/15 to 8/6/15, the generator was observed and maintenance records were reviewed. 8/5/15 1. At 8:30 a.m., the diesel fueled emergency generator was observed in the exterior of the facility. The generator did not have an enclosure covering the engine, nor was the emergency generator in a room or area to prevent damage from the weather elements. 2. At 8:44 a.m., records from the vendor indicated that a service was performed on 8/12/14. The record reported, "started load test and found exhaust getting very hot and against the plywood roof, also soot and carbon build up has plugged stack & muffler, recommend replacing exhaust and roof before retesting." At 8:45 a.m., during an interview, Maintenance Staff 1 was asked if the emergency generator had been retested and if repairs were made. Maintenance Staff 1 stated that he did not know,	K 144		

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K 144	Continued From page 15 as he had only been at this position for approximately one month. He stated that they had a power outage approximately two weeks ago and that the emergency generator ran for approximately three hours without a problem. There were no records indicating the emergency generator was repaired as recommended by the vendor.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their electrical equipment and wiring connections. This was evidenced by electrical receptacle outlets with broken ground ports and by the use of surge protectors as a substitute for fixed wiring. This affected one of six smoke compartments and could result in an increased risk of an electrical fire. NFPA 101, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 19.5.1 Utilities. Utilities shall comply with the provisions of Section 9.1. Exception: Existing installations shall be permitted to be continued in service, provided that the systems do not present a serious hazard to life.	K 147		

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K 147	Continued From page 16 NFPA 70, National Electrical Code, 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (c) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 240-4, Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent. A. Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified. 400-8 Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.	K 147	**K 147** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. Room 6, all had receptacle replaced and are now in working condition with no broken ground ports. B. Room 8 has had the 6 plug surge protector removed and the radio clock was plugged into a wall receptacle. **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:** A. The MS will test the receptacles annually and will replace any as needed. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The MS checked all house receptacles and replaced any that are broken by 8/19/15. B. Monthly the maintenance crew will inspect all receptacles and replace them as required. All inspections and any subsequent replacements will be noted on the maintenance log (see log attachment)	

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K 147	Continued From page 17 (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. NFPA 99, 1999 Edition 3-3.2.1.2, All patient care areas. d(2) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use in the patients care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Findings: During a facility tour with the maintenance staff from 8/5/15 to 8/6/15, the electrical equipment and wiring connections were observed. 8/5/15 1. At 4:10 p.m., there were 2 two-plug receptacle wall outlets in Room 6 with broken ground ports. The receptacles were located on the southeast wall. 2. At 4:16 p.m., there was a six plug surge protector connecting an oxygen concentrator and a radio clock in Room 8 near Bed B.	K 147	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The MS will monitor corrective actions through on-going compliance and results of the inspections performed by himself and his crew. The MS will report the results of monitoring to the Performance Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of	K 211	**K 211** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A. No residents were found to have been affected by the deficient practice.	

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K 211	Continued From page 18 rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their Alcohol Based Hand Rub (ABHR) dispensers. This was evidenced by one ABHR dispenser mounted above and adjacent to an ignition source. This affected one of six smoke compartments and could result in an ABHR ignited fire emergency. Findings: During the facility tour with maintenance staff from 8/5/15 to 8/6/15, the ABHR dispensers were observed. 1. At 4:50 p.m., the corridor, outside Room 34, had an ABHR dispenser mounted four inches adjacent to and above a light switch. The hand rub was 70 percent ethyl alcohol by volume.	K 211	**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:** A. No residents were found to have been affected by the deficient practice. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** A. The MS removed the ABHR dispenser mounted outside Room 34 mounted four inches above the light switch on 8/5/15. B. The MS made rounds throughout the facility on 8/5/15 and did not find any other ABHR dispensers that needed to be removed or adjusted to ensure compliance with fire safety codes. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The MS will monitor corrective actions through on-going compliance and results of the inspections performed by himself and his crew. The MS will report the results of monitoring to the Performance Improvement (PI) Committee for review and recommendations The PI Committee will monitor the process until compliance is achieved.	