STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055078	A. BUILDING **02** B. WING _____	**12/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HILLS NURSING & REHABILITATION	**7760 PARKWAY DRIVE** **LA MESA, CA 91942**

(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: 40325 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: 40325 The facility is not in substantial compliance with 42 CFR §483.70 for Long Term Care Facilities. Census = 53	E 000		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [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 annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following:	E 015		1/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/09/2019

Approved - Joel Yalung, SSMI, 01/11/2019

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E 015	Continued From page 1 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on record review and interview, the facility failed to maintain their Emergency Plan. This was evidenced by no written policies and procedures for subsistence needs in their Emergency Plan. During a shelter-in-place emergency, this could result in a delay in receiving essential goods and	E 015	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. Submission of this Plan of correction is not an admission that the deficiency was cited correctly. This Plan of Correction is submitted to meet all requirements established by the state and	

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E 015	Continued From page 2 services, and could harm visitors, staff, and 53 of 53 residents. Findings: On 12/20/18, during a record review of the Emergency Plan with the Administrator, the Subsistence Needs portion was reviewed. At 2:25 p.m., no record of a vendor contact list was found. In the Emergency Plan binder, the page for the vendor contact list had spaces for the vendors but nothing was filled in. The Administrator acknowledged the finding.	E 015	federal guidelines E015 The following corrective measures were immediately put into place. The complete vendor contact list was provided on pages 7-11 of the Emergency Operations Plan Binder upon survey. The Administrator immediately removed all blank reference/placeholder pages and inserted delineated tabs into the EOP Binders for expedient use. To ensure no other deficient practices were found the following actions were put into place. The reference/placeholder pages were removed and the binder tabs were updated clearly outlining contents within the binder. To ensure the same practice does not occur again the following steps have been put into place. The binder will be reviewed/updated by the Administrator on a monthly basis to ensure all content is current and up to date. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place The Administrator/designee will review the Emergency Operations monthly to ensure all information is current and up to date for 3 months and then quarterly thereafter. If there are any discrepancies, they will be fixed in a timely manner. Trends will be forwarded to the QA&A committee for review and	

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E 015	Continued From page 3	E 015	recommendation. Compliance date 1/17/19	
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		1/17/19

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E 039	Continued From page 4 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on record review and interview, the facility failed to maintain their Emergency Plan. This was evidenced by no record that the facility participated in a State- or Community-based drill in the previous 12 months. This could cause delay or confusion during an emergency, and affected visitors, staff, and 53 of 53 residents. Findings: On 12/20/18, during a record review with the Administrator, the Emergency Plan was reviewed. At 2:40 p.m., no record was found that	E 039	The following corrective measures were immediately put into place The facility participated in the 2018 Statewide Medical and Health Exercise on November 15th, 2018. This information was provided upon exit. The facility did not participate in the countywide tabletop exercise. To ensure the same practice does not occur again the following steps have been put into place. The facility contacted Public Health Preparedness and Response (PHPR) Branch of San Diego Health & Human	

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E 039	Continued From page 5 the facility participated in a State- or Community-based drill. The Administrator acknowledged the finding and stated that the facility did not participate in one.	E 039	Services Agency and the Disaster Task Force Area Coordinator to ensure we are on the contact list for future county and statewide exercises. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The facility is in contact with emergency disaster coordinators for San Diego county and is now included on the safety outlook systems mailing list. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date 1/17/19	
K 000	INITIAL COMMENTS Surveyor: 40325 K3 BUILDING: 01 K6 PLAN APPROVAL: 1980 K7 SURVEY UNDER: 2012 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 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: 40325	K 000		

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K 000	Continued From page 6 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain their self-closing doors. This was evidenced by doors which failed to self-close and latch when tested. During a fire, this could allow smoke and flames to pass through the open door and harm residents, visitors, and staff. This affected two of three smoke compartments. Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor (MS), the self-closing doors were observed.	K 223	K223 The following corrective measures were immediately put into place The self-closing doors to the utility closet and the door to the linen closet was fixed on 12/24/18. To ensure no other deficient practices were found the following actions were put into place. The Maintenance Supervisor immediately conducted an inspection to ensure all self-closing doors in the facility closed and latched properly. There were no other findings. To ensure the same practice does not	1/17/19

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K 223	Continued From page 7 1. At 9:35 a.m., the door to the Utility Closet, located by Room 11, failed to latch securely when closed. 2. At 9:43 a.m., the door to the Clean Utility Closet failed to latch securely when closed. 3. At 9:44 a.m., the door to the Linen Closet, located by Room 23, failed to latch securely when closed.	K 223	occur again the following steps have been put into place. The Maintenance Supervisor will conduct a weekly check for proper door closure to the weekly checklist for 3 months to ensure compliance is maintained. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a weekly door check for 3 months to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date 1/17/19	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation, the facility failed to maintain the exit signs. This was evidenced by exit signs that failed to have an illuminating light source, and by a sign with a broken face plate.	K 293	K293 The following corrective measures were immediately put into place The Maintenance Supervisor immediately replaced the exit sign above the	1/17/19

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K 293	Continued From page 8 This could potentially delay evacuation in the event of a power outage and an emergency evacuation. This affected two of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.5.1* General. Every sign required by 7.10.1.2, 7.10.1.5, or 7.10.8.1, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. Findings: During a tour of the facility with the Maintenance Supervisor (MS) on 12/20/18, the exit signs were observed. 1. At 10:10 a.m., the exit sign installed above the cross-corridor doors by Room 10 did not have an illuminating light source. 2. At 10:12 a.m., the exit sign installed in the corridor by Room 15 did not have an illuminating light source. 3. At 10:13 a.m., the exit sign installed above the cross-corridor doors by Room 12 did not have an	K 293	cross-corridor door by Room 10, Room 15, Room 12 and the entrance from the Courtyard with illuminated signage. To ensure no other deficient practices were found the following actions were put into place. An inspection was conducted by Maintenance Supervisor and no other exit sign was found to be deficient. To ensure the same practice does not occur again the following steps have been put into place. Maintenance Supervisor will include all exit signage to his weekly check to ensure all signs are properly illuminated and functioning per manufacturer□s guidelines. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a weekly exit signage check for 90 days to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date 1/17/19	

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K 293	Continued From page 9 illuminating light source. 4. At 10:21, the exit sign located at the entrance from the Courtyard to the TV room was cracked and had a hole in the plastic plate. The MS stated that the signs would glow, but that they had no illumination device. The first three deficiencies were identified during the previous Life Safety Survey of 10/11/17. The Administrator and MS acknowledged the findings during the exit interview.	K 293		
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain their fire-rated interior ceiling construction. This was evidenced by a penetrations in walls and ceilings. During a fire, this could allow smoke and flames to pass through the penetrations and harm residents, visitors, and staff. This affected two of three smoke compartments.	K 331	K331 The following corrective measures were immediately put into place The Maintenance Supervisor immediately filled the cable hole in the cable room, as well as the holes in the weight room. This was complete 12/24.18. To ensure no other deficient practices were found the following actions were put	1/17/19

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K 331	Continued From page 10 Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor (MS), the interior wall and ceiling finishes were observed. 1. At 9:00 a.m., in the Telephone Cable Room, the ceiling had a penetration measuring approximately two inches in diameter. A bundle of approximately 20 to 30 electrical wires passes through the unsealed penetration. 2. At 9:30 a.m., in the Weight Room, the southwest wall had four penetrations measuring approximately one half-inch, and three penetrations measuring approximately one quarter inch. The MS stated the penetrations were left from a shelving unit that was once attached there but removed.	K 331	into place. Maintenance Supervisor inspected the facility and found no other issues. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor will add inspection for unsealed penetrations to his daily checklist to ensure deficient practice is fixed and sustained. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a daily check for 90 days to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date 1/17/19	
K 343 SS=D	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire.	K 343		1/17/19

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K 343	Continued From page 11 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain their fire alarm system. This was evidenced by a fire alarm bell which failed to sound during testing. This could delay notification and evacuation of staff, and could cause harm. This affected one of three smoke compartments. Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor (MS), the fire alarm system was tested. At 10:43 a.m., the fire alarm bell located by the Laundry Room failed to sound. During the test, Laundry Staff I was asked if she could hear the fire alarm. She said she could not hear it. The MS stated he would call the vendor to repair the fire alarm bell.	K 343	The following corrective measures were immediately put into place The Maintenance Supervisor immediately contacted the fire inspection company and requested they come out to fix the fire alarm in the laundry room. This was completed on 12/18/19. To ensure no other deficient practices were found the following actions were put into place The Maintenance Supervisor checked all other fire alarm bells and no others were found to be deficient. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor will add fire alarm check to his monthly checklist to ensure compliance is achieved and sustained. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a monthly check for 3 months to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date: 1/17/19	
K 352 SS=E	Sprinkler System - Supervisory Signals CFR(s): NFPA 101	K 352		1/17/19

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PARKWAY HILLS NURSING & REHABILITATION	**7760 PARKWAY DRIVE** **LA MESA, CA 91942**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 352	Continued From page 12 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to ensure their sprinkler control valves were electronically supervised. This was evidenced by an Outside Screw & Yoke (OS&Y) valve and Post-Indicator Valve (PIV) which failed to activate a supervisory signal to the fire alarm system. This could result in a delay of notification of sprinkler system impairment and a delay in extinguishing a fire. This affected three of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements. 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. 19.3.5.3 Where required by 19.1.6, buildings containing hospitals or limited care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise	K 352	K352 The following corrective measures were immediately put into place The Maintenance Supervisor immediately contacted the fire inspection company and requested they come out to service the PIV and ensure the trouble code was functioning properly. This inspection was completed on 12/18/19. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor will the PIV and Trouble Code check to his monthly checklist to ensure compliance is achieved and sustained. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a monthly check for 3 months to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up.	

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	055078	A. BUILDING **02** B. WING _____	**12/20/2018**

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PARKWAY HILLS NURSING & REHABILITATION	**7760 PARKWAY DRIVE** **LA MESA, CA 91942**

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K 352	Continued From page 13 permitted by 19.3.5.5. 19.3.5.7 Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet all of the following criteria: (1) It shall be in accordance with Section 9.7. (2) It shall be installed in accordance with 9.7.1.1(1), unless it is an approved existing system. (3) It shall be electrically connected to the fire alarm system. (4) It shall be fully supervised. 9.7.2.1 Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. 9.7.2.2 Alarm Signal Transmission. Where supervision of automatic sprinkler systems is provided in accordance with another provision of this Code, waterflow alarms shall be transmitted to an approved, proprietary alarm-receiving facility, a remote station, a central station, or the fire department. Such connection shall be in accordance with 9.6.1.3. NFPA 72, National Fire Alarm Signaling Code,	K 352	Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date: 1/17/19	

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K 352	Continued From page 14 2010 Edition. 17.16.1 Control Valve Supervisory Signal-Initiating Device. 17.16.1.1 Two separate and distinct signals shall be initiated: one indicating movement of the valve from its normal position (off-normal), and the other indicating restoration of the valve to its normal position. 17.16.1.2 The off-normal signal shall be initiated during the first two revolutions of the handwheel or during one-fifth of the travel distance of the valve control apparatus from its normal position. 17.16.1.3 The off-normal signal shall not be restored at any valve position except normal. 17.16.1.4 An initiating device for supervising the position of a control valve shall not interfere with the operation of the valve, obstruct the view of its indicator, or prevent access for valve maintenance. Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor (MS), the operation of the PIV was observed. At 10:50 a.m., the MS closed the OS&Y valve. The closure of the valve failed to activate the supervisory light on the fire alarm panel. The MS tried a second and third time, with the same result. The activity report generated by the vendor failed to log a PIV trouble code. The MS stated he would contact the vendor to repair the system.	K 352		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		1/17/19

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K 353	Continued From page 15 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on record review and interview, the facility failed to maintain their wet-pipe sprinkler system. This was evidenced by no records of quarterly sprinkler tests and inspections for two of four quarters. During a fire, this could cause delay in the operation of the sprinkler system, and could harm residents, visitors, and staff. This affected three of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 353	K353 The following corrective measures were immediately put into place. The Administrator immediately contacted the fire inspection company and requested the documentation showing the facility was in compliance with all quarterly sprinkler system inspection and testing. To ensure no other deficient practices were found the following actions were put into place. The Administrator will require the fire inspection company to send over all inspection documentation within a timely manner, so the facility has them readily available.	

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K 353	Continued From page 16 Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition Table 13.1.1.2 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Inspection Control Valves Sealed Weekly 13.3.2.1 Locked Monthly 13.3.2.1.1 Tamper switches Monthly 13.3.2.1.1 Alarm Valves Exterior Monthly 13.4.1.1 Interior 5 years 13.4.1.2 Strainers, filters, orifices 5 years 13.4.1.2 Check Valves Interior 5 years 13.4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Daily/weekly 13.4.3.1 Exterior Monthly 13.4.3.1.6 Interior Annually/5 years 13.4.3.1.7 Strainers, filters, orifices 5 years 13.4.3.1.8 Dry Pipe Valves/ Quick-Opening Devices Gauges Weekly/monthly 13.4.4.1.2.4, 13.4.4.1.2.5 Enclosure (during cold weather) Daily/weekly 13.4.4.1.1 Exterior Monthly 13.4.4.1.4 Interior Annually 13.4.4.1.5 Strainers, filters, orifices 5 years 13.4.4.1.6 Pressure Reducing and Relief Valves Sprinkler systems Quarterly 13.5.1.1	K 353	To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor/designee will conduct a monthly check for 90 days to ensure the facility has all fire inspection testing documents. This will be done until compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date: 1/17/19	

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K 353	Continued From page 17 Hose connections Annually 13.5.2.1 Hose racks Annually 13.5.3.1 Fire Pumps Casing relief valves Weekly 13.5.7.1, 13.5.7.1.1 Pressure relief valves Weekly 13.5.7.2, 13.5.7.2.1 Backflow Prevention Assemblies Reduced pressure Weekly/monthly 13.6.1 Reduced pressure detectors Weekly/monthly 13.6.1 Fire Department Connections Quarterly 13.7.1 Testing Main Drains Annually/quarterly 13.2.5, 13.2.5.1, 13.3.3.4 Waterflow Alarms Quarterly/semiannually 13.2.6 Control Valves Position Annually 13.3.3.1 Operation Annually 13.3.3.1 Supervisory Semiannually 13.3.3.5 Preaction/Deluge Valves Priming water Quarterly 13.4.3.2.1 Low air pressure alarms Quarterly/annually 13.4.3.2.13, 13.4.3.2.14 Full flow Annually 13.4.3.2.2 Dry Pipe Valves/ Quick-Opening Devices Priming water Quarterly 13.4.4.2.1 Low air pressure alarm Quarterly 13.4.4.2.6 Quick-opening devices Quarterly 13.4.4.2.4 Trip test Annually 13.4.4.2.2 Full flow trip test 3 years 13.4.4.2.2.2 Pressure Reducing and Relief Valves Sprinkler systems 5 years 13.5.1.2 Circulation relief Annually 13.5.7.1.2 Pressure relief valves Annually 13.5.7.2.2 Hose connections 5 years 13.5.2.2 Hose racks 5 years 13.5.3.2 Backflow Prevention Assemblies Annually 13.6.2	K 353		

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K 353	Continued From page 18 Maintenance Control Valves Annually 13.3.4 Preaction/Deluge Valves Annually 13.4.3.3.2 Dry Pipe Valves/ Quick-Opening Devices Annually 13.4.4.3 13.2.3 * All system valves shall be protected from physical damage and shall be accessible. 13.3.1 * Each control valve shall be identified and have a sign indicating the system or portion of the system it controls. Findings: On 12/20/18, at 11:23 a.m., during a record review with the Maintenance Supervisor (MS), the records of quarterly sprinkler system inspection and testing failed to show documentation for the first and second quarters of 2018. The MS acknowledged the finding and stated the inspection and testing was done but he did not have the documents available.	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	K 363		1/17/19

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K 363	Continued From page 19 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 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: 40325 Based on observation and interview, the facility failed to maintain their fire-rated doors. This was evidenced by a door which could not close because of an obstruction, and by a door which required more than five pounds of pressure to close and latch. This could allow smoke and flames to pass through the open door and harm residents, visitors, and staff. This affected two of	K 363	K363 The following corrective measures were immediately put into place The obstruction in the ice machine room was immediately removed. The door frame and hinge for room 2 was replaced on 12/28/18. To ensure no other deficient practices were found the following actions were put	

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K 363	Continued From page 20 three smoke compartments. NFPA 101, Life Safety Code, 2012 edition 18.3.6.3.7 Powered doors that comply with the requirements of 7.2.1.9 shall not be required to meet the latching requirements of 18.3.6.3.5, provided that both of the following criteria are met: (1) The door is equipped with a means for keeping the door closed that is acceptable to the authority having jurisdiction. (2) The device used is capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of a swinging door and applied in any direction to a sliding or folding door, whether or not power is applied. Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor (MS), the fire-rated doors were observed. 1. At 8:56 a.m., the door to the Ice Machine Room could not close because the water machine was installed in the doorway, just inside the room. When the door was closed to its maximum point it was still more than two feet from the doorjamb. 2. At 1:48 p.m., the door to Resident Room Two required more than five pounds of pressure to latch. The MS stated he needed to replace the door frame and part of the door.	K 363	into place An inspection was immediately conducted after these findings to ensure all doors in the facility properly closed. There were no other findings. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor will include a door check for faulty functions to the weekly checklist. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct weekly door checks for 90 days to ensure compliance is sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date 1/17/19	
K 700	Operating Features - Other	K 700		1/17/19

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K 700 SS=D	Continued From page 21 CFR(s): NFPA 101 Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567. This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on interview, the facility failed to ensure that staff had knowledge of the proper fire protection procedures, as evidenced by kitchen staff that could not determine the correct fire extinguisher to use for an electrical fire. This could result in the rapid spread of fire and injury to staff since the extinguishing agents in many Class K extinguishers are electrically conductive. This affected one of three smoke compartments. NFPA 101 Life Safety Code, 2012 Edition 19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures devices. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 5.1 General Requirements. The selection of fire extinguishers for a given situation shall be determined by the applicable requirements of Sections 5.2 through 5.6 and the following factors: (1) Type of fire most likely to occur (2) Size of fire most likely to occur (3) Hazards in the area where the fire is most likely to occur	K 700	K700 The following corrective measures were immediately put into place The Dietary Supervisor immediately in-serviced dietary staff on proper use of extinguishers in the kitchen. The Dietary Supervisor also posted signage above each extinguisher for specific use. To ensure the same practice does not occur again the following steps have been put into place. The Dietary Supervisor will hold a monthly in-service for all dietary staff on kitchen safety. The Dietary Supervisor will also in-service all new dietary staff on kitchen safety upon hire. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Dietary Supervisor will conduct a random weekly check for 90 days to ensure dietary staff knowledge on extinguisher use. This will be done until compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up.	

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K 700	Continued From page 22 (4) Energized electrical equipment in the vicinity of the fire (5) Ambient temperature conditions (6) Other factors (See Section H.2.) 5.2 Classifications of Fires. Fires shall be classified in accordance with the guidelines specified in 5.2.1 through 5.2.5. 5.2.1 Class A Fires. Class A fires are fires in ordinary combustible materials, such as wood, cloth, paper, rubber, and many plastics. 5.2.2 Class B Fires. Class B fires are fires in flammable liquids, combustible liquids, petroleum greases, tars, oils, oil-based paints, solvents, lacquers, alcohols, and flammable gases. 5.2.3 Class C Fires. Class C fires are fires that involve energized electrical equipment. 5.2.4 Class D Fires. Class D fires are fires in combustible metals, such as magnesium, titanium, zirconium, sodium, lithium, and potassium. 5.2.5 Class K Fires. Class K fires are fires in cooking appliances that involve combustible cooking media (vegetable or animal oils and fats). Findings: On 12/20/18, during a facility tour with the Environmental Services Director, the surveyor interviewed staff to determine their knowledge and usage of life safety equipment. At 9:08 a.m., Kitchen Staff I was asked which extinguisher he would use in an electrical fire. He stated he would use the silver one, referring to the K-type extinguisher used for grease fire.	K 700	Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date: 1/17/19	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101	K 753		1/17/19

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K 753	Continued From page 23 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation, the facility failed to maintain the flame spread rating of their fire-rated doors. This was evidenced by the use of a combustible decoration on a resident room door. This decreased the fire and flame spread rating of the door, and could increase the possibility of fire and the spread of smoke and flames. This could harm residents, visitors, and staff. This affected one of three smoke compartments. Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor, the use of combustible decorations was observed. At 9:35 a.m., the door to Resident Room ten was covered approximately 75 percent in a plastic decoration.	K 753	K753 The following corrective measures were immediately put into place The Maintenance Supervisor immediately removed the decorations covering the door for Room 10. To ensure no other deficient practices were found the following actions were put into place The Maintenance Supervisor conducted an inspection and found no other decorations causing the facility to be deficient. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor will check daily to ensure that no decorations are covering more than 75% of any resident	

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PARKWAY HILLS NURSING & REHABILITATION	**7760 PARKWAY DRIVE** **LA MESA, CA 91942**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 753	Continued From page 24	K 753	doors. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a daily check for 90 days to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date: 1/17/19	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		1/17/19

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K 918	Continued From page 25 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: 40325 Based on record review and interview, the facility failed to maintain their generator. This was evidenced by no record of generator weekly visual inspections. During a power outage, this could cause delay or malfunction of the generator and could harm residents, visitors, and staff. This affected three of three 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. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. 9.1.3 Emergency Generators and Standby Power Systems.	K 918	K918 The following corrective measures were immediately put into place The Maintenance Supervisor immediately conducted a full generator test and there were no issues found. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor added the full generator test to his weekly checklist. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor/designee will conduct a weekly generator check for 90 days to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation.	

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K 918	Continued From page 26 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 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.3.7.2 Defective batteries shall be replaced immediately upon discovery of defects. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. 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: On 12/20/18, during a record review with the Maintenance Supervisor (MS), the generator weekly visual inspection records were requested. At 11:05 a.m., the MS stated he did not keep weekly visual inspection records for the generator. He stated he was new and was going off the previous maintenance director's logs.	K 918	Compliance date 1/17/19	
K 920	Electrical Equipment - Power Cords and Extens	K 920		1/17/19

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K 920 SS=D	Continued From page 27 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation, the facility failed to maintain electrical safety. This was evidenced by the use of UL-listed power strips tensioned by the power cords of electrical devices. This could cause sparking, electrical overload, smoke and fire, and could harm residents, visitors, and staff. This affected one of three smoke compartments. NFPA 99, Health Care Facilities Code, 2012	K 920	K920 The following corrective measures were immediately put into place All power strips in patient care rooms and offices were immediately removed or secured to the wall. To ensure no other deficient practices were found the following actions were put into place. An inspection was conducted in all	

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K 920	Continued From page 28 Edition 10.2.3.5 Cord Strain Relief. 10.2.3.5.1 Cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. 10.2.3.5.2 A strain relief molded onto the cord shall be bonded to the jacket and shall be of compatible material. 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cart-mounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2)* The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)* The electrical and mechanical integrity of the assembly is regularly verified and documented. (5)* Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe.	K 920	resident areas and offices and there were no other power strips found suspended. To ensure the same practice does not occur again the following steps have been put into place. The Administrator in serviced all department heads on proper UL power strips use, power strip installment and NFPA code regarding the deficient practice. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. All department heads will conduct daily room rounds to check for proper power strip use and installment for 90 days. The Maintenance Supervisor/designee will be notified if any power strips are found to be out of compliance. Any noncompliance will be reported to the Administrator for further follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date 1/17/19	

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K 920	Continued From page 29 NFPA 70, National Electrical Code, 2011 Edition: 400.10 Pull at Joints and Terminals. Flexible cords and cables shall be connected to devices and to fittings so that tension is not transmitted to joints or terminals. Findings: On 12/20/18, during a facility tour with the Maintenance Supervisor, the power strips and electrical devices were observed. 1. At 8:30 a.m., in the Admissions Office, a UL-listed power strip was dangling mid-air, supported by the electrical cords of a computer, monitor, and printer. One of the electrical cords was partially out of the power strip outlet. The power strip was connected to the duplex receptacle wall outlet. 2. At 9:14 a.m., in the MDS and Social Services Office, a UL-listed power strip was dangling mid-air, supported by four power cords of an electrical network. The power strip was connected to the duplex receptacle wall outlet.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923		1/17/19

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K 923	Continued From page 30 gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain their gas equipment. This was evidenced by an oxygen storage room which could not be secured from authorized access. This could allow unauthorized persons to access the oxygen cylinders, and harm residents, visitors, and staff. This affected one of three	K 923	K923 The following corrective measures were immediately put into place. The Maintenance Supervisor installed a lock on the Oxygen Storage Room on 12/21/18. To ensure no other deficient practices were found the following actions were put	

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K 923	Continued From page 31 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition 11.3 Cylinder and Container Storage Requirements. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. Findings: On 12/20/18, during a facility tour with the Environmental Services Director (ESD), the gas storage rooms were observed. At 9:42 a.m., the door to the Oxygen Cylinder Storage room had no locking mechanism.	K 923	into place. The Maintenance Supervisor checked all other storage rooms and no other room was found to be out of compliance. To ensure the same practice does not occur again the following steps have been put into place. The Maintenance Supervisor will check daily to ensure the locking mechanism is functioning properly on the Oxygen Storage Room. To ensure that the plan of correction is achieved and maintained the following system of monitoring has been put into place. The Maintenance Supervisor will conduct a daily check for 90 days to ensure compliance is achieved and sustained. Any noncompliance will be reported to the Administrator for follow up. Trends will be forwarded to the QA&A committee for review and recommendation. Compliance date: 1/17/19	