STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056436	A. BUILDING **02** B. WING _____	**05/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICAL CENTER CONVALESCENT HOSPITAL	**467 E GILBERT ST** **SAN BERNARDINO, CA 92404**

(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: 40597 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: 40597 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 95	E 000		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(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 every 2 years [annually for LTC facilities]. 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:	E 015		6/15/23

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

Electronically Signed | 05/31/2023

06/02/2023: POC acceptable per Brian Fenton, SSM-1

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E 015	Continued From page 1 (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (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: 40597 Based on document review and interview, the facility failed to maintain the emergency preparedness program. This was evidenced by	E 015	F000 This plan of correction serve as Medical Center Convalescent Hospital credible allegation of compliance to correct	

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E 015	Continued From page 2 the failure to provide the required provisions for subsistence needs. This could result in not having the necessary planning and preparation in place during an emergency, and this affected 95 of 95 residents. Findings: During document review and interview with the Administrator and Maintenance Supervisor on 5/16/23, the emergency preparedness program policies and procedures were reviewed, and staff was interviewed. At 9:24 a.m., the facility failed to provide provisions of subsistence needs whether they evacuate or shelter in place. The emergency plan did not include an alternate source of energy to maintain temperatures to protect the resident health and safety, safe and sanitary storage, emergency lighting, fire detection, extinguishing, and sewage and waste disposal. At 10:30 a.m., upon interview, the Maintenance Supervisor stated that the generator can provide emergency power to the call lights, fire alarm system, and red outlets. The generator does not provide power to the Heating, Ventilation, and Air Conditioning system. At 3:20 p.m., the Administrator confirmed that the emergency operations plan was missing two pages including the section for alternative source of energy.	E 015	identified deficiencies. Preparation and execution of this plan of correction does not constitute admission or agreement the truth of the facts alleged of conclusion set forth on the statement of deficiencies. This plan of correction is prepared and executed solely as required by the provision of Health and Safety Code Section 1280 and 42CFR 404.1907. EO15 SUBSISTENSE NEED FOR STATT AND PATIENTS How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Facility will ensure during emergency staff and resident's provision for Subsistence needs is available. Facility current generator is KATO LIGHT 30 KW, Powered by Propane. Propane Capacity 250 gallons (burn rate of 3.2 gallons /hour) good for 3.25 days. If disaster will last more than three (3) days, our propane provider (Camp Propane at 1893 Brown Ave, Jurupa, CA. 92509) will deliver propane on or before the 3rd day during disaster. Generator is Capable of Powering 1 Freezer, one (1) ref. and 4 Industrial portable AC/Heating units. Sun-belt Rental Company (318 W Tullock Street, Rialto, CA. 92376) will provide Emergency industrial portable AC/HEATING units and Industrial generator to tie up with facility AC/Heating	

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E 015	Continued From page 3	E 015	units as needed. The two missing pages of EOP were found and added to current Facility EOP How the facility will identify other residents having the potential to be affected by the deficient practice. All residents are affected Systemic changes the facility will make to ensure that the deficient practice does not recur. The facility will ensure during emergency staff and resident's provision for subsistence needs is available. Facility current generator is KATO LIGHT 3O KW Powered by propane. Propane capacity 250 gallons (burn rate 3.2 gallon per hour) good for 3.25 days. I disaster will last for more than 3 days our propane provider (Camp Propane at 1893 Brown Avenue, Jurupa CA. 92509) will deliver propane on or before the third day as Facility alternate fuel source. Facility's generator is capable to powering 1 freezer, 1 ref. and 4 industrial portable AC/Heating Units. Sun-Belt Rental Company (318 W. Tullock Street Rialto, CA. 92376) will provide emergency Portable AC/Heating units and i8ndustrial generator to connect facility AC/Heating units as needed. Missing pages of EOP found and added to the existing EOP. Facility Administrator or designee will review EOP annually to ensure no missing pages and subsistence needs included in the manual. Any identified problems will be corrected	

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E 015	Continued From page 4	E 015	immediately. How the facility plans to monitor its performance to make sure the solution is achieved and sustained. Facility administrator or designee will be responsible for implementation and monitoring of this plan of correction. Report of Non-compliance shall be presented and discuss in the QAPI Committee meeting. The QAPI committee will review and monitor if correction is effective and sustained. QAPI Committee will recommend additional corrective actions as needed.	
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the	E 035		6/15/23

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E 035	Continued From page 5 emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on document review and interview, the facility failed to maintain the emergency preparedness communication plan. This was evidenced by the failure to provide a method for sharing the emergency plan with residents and their family members or representatives. This could result in a delay of notification to family members when the emergency plan is activated, and this affected 95 of 95 residents. Findings: During document review and interview with the Administrator on 5/16/23, the emergency preparedness communication plan was reviewed, and staff was interviewed. At 9:14 a.m., the method for sharing the emergency plan was not specific to the facility. The document that was titled, "Sharing Information on the EOP" indicated that the facility needed to enter a description of the format of this information-sharing and provide a sample in the appendices. No additional information was readily available in the appendix section of the emergency plan. At 3:40 p.m., the Administrator stated that the emergency procedures are shared during admissions and also during interdisciplinary team meetings (IDT).	E 035	EO35 SHARING PLAN WITH THE PATIENT How corrective action will be accomplished for those residents found to have been affected by the deficient Practice. Facility created a brochure that entails staff things to do during an emergency situation and type of staff training received to be shared to the family members, representatives and resident during admission and interdisciplinary team meeting. How the facility identify other residents having the potential to be affected by the same deficient practice. All residents are affected. Systemic changes the facility will make to ensure that the deficient practice do not recur. Facility Administrator will review EOP Manual once a year to ensure that sharing emergency plan is included. Facility created an emergency plan brochure to be shared to Family Members, Responsible party and residents during admission process and Inter-disciplinary meeting. How the facility plan to monitor its performance to make sure the solution	

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E 035	Continued From page 6	E 035	are achieved and sustained, Administrator or designee is responsible for the implementation and monitoring of the plan of correction. Report of non-compliance shall be presented and discussed in the QAPI Committee meeting. The QAPI Committee shall review the correction if it is effective and sustained. QAPI Committee will recommend additional corrective action as needed.	
K 000	INITIAL COMMENTS Surveyor: 40597 K3 BUILDING: 2 K6 PLAN APPROVAL: 4/11/1974 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY WITH ADMINISTRATION OFFICES ON SECOND FLOOR, 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: 40597 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		

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K 000	Continued From page 7 Census = 95	K 000		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on document review and interview, the facility failed to maintain fire drills. This was evidenced by the failure to activate the fire alarm system during fire drills that were conducted between the hours of 6:00 a.m. to 9:00 p.m. This could result in staff not being familiar with their respective roles and responsibilities during an emergency, and this affected 95 of 95 residents in two of two smoke compartments. Findings: During document review and interview with the Administrator, Director of Staff Development, and Maintenance Supervisor on 5/16/23, the fire drills were reviewed, and staff was interviewed.	K 712	F000 This plan of correction serve as Medical Center Convalescent Hospital credible allegation of compliance to correct identified deficiencies. Preparation and execution of this plan of correction does not constitute admission or agreement the truth of the facts alleged of conclusion set forth on the statement of deficiencies. This plan of correction is prepared and executed solely as required by the provision of Health and Safety Code Section 1280 and 42CFR 404.1907. K712 FIRE DRILLS How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	6/15/23

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K 712	Continued From page 8 1. At 9:43 a.m., the facility failed to activate the fire alarm system between the hours of 6 a.m. to 9 p.m. The fire drill reports during the p.m. shifts indicated that the task was simulated because there was nobody available to reset the fire alarm control panel. The first quarter drill was conducted on 2/11/23 at 7:01 p.m. The second quarter drill was conducted on 5/22/22 at 8:46 p.m. The third quarter drill was conducted on 8/17/22 at 6:29 p.m. The fourth quarter drill was conducted on 11/14/22 at 7:13 p.m. At 2:43 p.m., the Maintenance Supervisor stated that he contacted the monitoring station to verify if there were any fire alarm signals received during the p.m. shifts. At 3:20 p.m., there were no additional information provided.	K 712	In-service conducted to Maintenance supervisor by Administrator on 5-16-23, to ensure to activate the fire alarm system during fire drills or disaster drills between the times of 9 AM to 9 PM. During the absence of Maintenance supervisor, Janitor or Nursing supervisor will activate and re-set the fire alarm system. Maintenance supervisor conducted in-service to Janitors and Nursing supervisors on 5-18-23, how to call monitoring service to put the fire alarm system to test mode and how to return to active mode. Maintenance supervisor demonstrate the proper way to activate fire alarm system and re-set to active mode. Participants was able to do return demonstration accordingly. Fire and Disaster drill provider was notified by Director of Staff Development and Maintenance supervisor on 5-16-23 to activate the fire alarm system during fire drills and disaster drills. How the facility identify other residents having the potential to be affected by the same deficient practice. All residents are affected. Systemic Changes the facility will make to ensure that the deficient practice does not recur. Maintenance Supervisor, Director of staff Development and Nursing supervisor shall monitor the Life Safety Provider to ensure fire alarm system is activated during fire drill, and disaster drill. Any	

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K 712	Continued From page 9	K 712	identified problems will be corrected immediately. In-service conducted to Maintenance supervisor on 5-16-23 by Administrator to ensure fire alarm system activated during fire and disaster drills. Maintenance Supervisor conducted in-service to Janitors, and nursing supervisors on 5-18-23 who to call to put the alarm system on test mode how to return to active mode. Maintenance supervisor demonstrate the proper way to activate fire alarm system and re-set to active mode. Participants was able to do return demonstration accordingly. Fire and disaster drill instructor was notified by Director of Staff Development and maintenance Supervisor on 5-16-23 to activate the fire alarm system during fire drills and disaster drills. How the facility plans to monitor its performance to make sure the solutions are achieved and sustained. Administrator or designee is responsible for implementation and monitoring the correction. Report of non-compliance shall be presented and discussed in the QAPI Committee meeting. The QAPI Committee will monitor if correction is effective and sustained. QAPI Committee will recommend additional corrective actions as needed.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		6/15/23

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K 920	Continued From page 10 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: 40597 Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by surge protectors that were plugged into another surge protector, and by using an extension cord as a substitute for the fixed wiring. This could increase the risk of electrical fire, and this affected 46 of 95 residents in one of two smoke compartments. Findings: During a facility tour and interview with the	K 920	K 920 POWER CORDS AND EXTENSION CORDS How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Corporate maintenance crew reorganized all electrical connection in the mechanical room on 5-31-23 eliminating the use of surge protector. Extension chord in rehab room was removed by maintenance supervisor 5-16-23, the day surveyor identified the problem.	

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K 920	Continued From page 11 Maintenance Supervisor on 5/16/23, the electrical equipment was observed, and staff was interviewed. 1. At 11:35 a.m., there was a surge protector that was plugged into a second surge protector in the Mechanical Room located upstairs. During a concurrent interview, the Maintenance Supervisor stated that a contractor set up the electrical equipment this way. 2. At 12:05 p.m., there was a white extension cord that was used to power a television located in the Physical Therapy Room. The extension cord was mounted on the wall along the door frame. During a concurrent interview, the Maintenance Supervisor stated that he was not aware that the extension cord was used in the room. 3. At 12:09 p.m., there was a surge protector that was plugged into a second surge protector in the Laundry Room. During a concurrent interview, the Maintenance Supervisor stated that the contractor used surge protectors to install a set of ultraviolet lights.	K 920	Extension chord in the laundry room was remove on 5-19-23 by maintenance supervisor and units plugged directly to the wall. How the facility identify other residents having the potential to be affected by the same deficient practice. 46 residents are affected by the deficient practice. Systemic Changes the facility will make to ensure that the deficient practice will not recur. In-service conducted by Administrator on 5-16-23, to Maintenance supervisor regarding the importance of having no extension chord in the building. It was further emphasized that octopus connection (connection of extension cord on top of another extension cord) is none compliance of Life Safety Code. Maintenance supervisor will conduct daily environmental survey to ensure no extension cord being used in the building. Any identified problems will be corrected immediate. How the Facility plans to monitor its performance to make sure the solutions are achieved and sustained. Administrator or designee is responsible for the implementation and monitoring of the correction. Report of non-compliance shall be presented and discussed in the QAPI Committee meeting. The QAPI Committee shall review the correction if it is effective and sustained. QAPI Committee will	

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K 920	Continued From page 12	K 920	recommend additional corrective action as needed.	