POC accepted on 01/02/2020 05373

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY PALMS CARE CENTER	13400 SHERMAN WAY N HOLLYWOOD, CA 91605

(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 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70 (a) Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during a Life Safety Code Survey. Representing the Department of Public Health: Surveyor ID No. 05373, REHS, HFE Highest S/S: F Census: 85	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222	**K 222** **-How corrective action(s) will be accomplished for those residents found to have been affected.** The double action release door lock mechanism on the door to the chart room in Nursing Station A was removed and changed to a single action release door lock mechanism on 12/06/19. The dead bolt lock on the door of the laundry door and screen door were removed and was changed to a single action release door lock mechanism on 12/06/19.	1/06/2020

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

DON 12/30/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222	**-How facility will identify other resident's having potential to be affected and corrective action** Maintenance Supervisor checked all door knobs of doors along the path of egress and no other door knobs were identified to be using a dead bolt lock or a double action release door lock mechanism. No resident was identified to be affected by this alleged deficient practice. **- Measures/systematic changes facility will make to ensure the deficient practice does not recur.** Maintenance staff were in-serviced by DON on 12/06/19 regarding the use of single action release door lock mechanism vs double action release door lock mechanism and dead bolt locks on all doors along the path of egress. Maintenance staff will report to Administrator/Designee any door knob that will be changed to ensure that the correct knob is being installed.	

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K 222	Continued From page 2 NFPA 101, Life Safety Code, 2012 Edition 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.10* A latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.2 The releasing mechanism shall open the door leaf with not more than one releasing operation, unless otherwise specified in 7.2.1.5.10.3, 7.2.1.5.10.4, or 7.2.1.5.10.6. Based on observation and interview, the facility failed to ensure the door and the screen door to the laundry room and the Nursing Station A room were not equipped with dead bolt and lever and more than one action release mechanism. Doors used for egress that open easily and immediately may allow occupants to evacuate the building safely and immediately in the event of a fire emergency. In the event of a need to evacuate the building, locks and latches that obstruct the path of egress may prevent or delay evacuation. The deficient practice affected two of four smoke compartments. Findings: On December 05, 2019, at 10:45 a.m., during a tour of the facility in the presence of the maintenance supervisor, the following was noted: a. There was a double action release door lock mechanism on the door to the chart room located	K 222	**-How facility plans to monitor performance to ensure solutions sustained.** Maintenance staff will confirm compliance that single action release door lock mechanism are installed on all doors along the path of egress. Any non-compliance issues will be reported to Administrator/Designee for follow up. The Administrator/Designee will report findings to the QA committee for monthly review and evaluated for effectiveness for three months or until compliance achieved.	

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K 222	Continued From page 3 on the Nursing Station A. b. There was a dead bolt lock on the door to the laundry door and screen door leading to the east side parking area. The maintenance supervisor confirmed the findings.	K 222		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324	**K 324** **-How corrective action(s) will be accomplished for those residents found to have been affected.** Maintenance Supervisor ordered new grease filters and was delivered on 12/27/19. The 4 grease filters are now properly positioned. **-How facility will identify other resident's having potential to be affected and corrective action** Dietary Supervisor together with Maintenance Supervisor did a visual inspection on 12/30/19 and all grease filters are now properly positioned.	1/06/2020

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K 324	Continued From page 4 by: Based on observation and interview, the facility failed to protect cooking facilities as required by ensuring the grease filters are properly positioned to all the passage of grease through them. Failure to protect cooking facilities as required increases the risk of death or injury due to fire. The deficiency affected one of four smoke compartments. Findings include: On December 05, 2019, at 3 p.m., during observation pf the kitchen accompanied with the maintenance supervisor, it was noted four grease filters were not arranged so that all exhaust air passes through the grease filter and allowing bypass of the grease. Ref: 2012 NFPA 101 Section 19.3.2.5.1, 9.2.3; 2011 NFPA 96 Section 6.2.3.3 The maintenance supervisor was confirmed that the filters were not properly in placed and made an attempt to fix them and stated there was a missing part that needed to hold the filters together.	K 324	**- Measures/systematic changes facility will make to ensure the deficient practice does not recur.** Maintenance staff were in-serviced by DON on 12/09/19 that grease filters needs to be properly positioned at all times. Maintenance staff to maintain an inspection log for grease filters to be inspected once a month or as needed. **-How facility plans to monitor performance to ensure solutions sustained.** Maintenance Supervisor/Designee will confirm compliance that grease filters are properly positioned at all times. Any non-compliance issues will be reported to Administrator/Designee for follow up.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353	The Administrator/Designee will report findings to the QA committee for monthly review and evaluated for effectiveness for three months or until compliance achieved.	

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K 353	Continued From page 5 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: NFPA 25 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provides audible or visual signals shall be tested quarterly. NFPA 72 National Fire Alarm Code 5.11 Sprinkler Waterflow Alarm-Initiating Devices 5.11.1 The provisions of Section 5.11 shall apply to devices that initiate an alarm indicating a flow of water in a sprinkler system. 5.11.2 Activation of the initiating device shall occur within 90 seconds of waterflow at the alarm initiating device when flow occurs that is equal to or greater than that from a single sprinkler of the smallest orifice size installed in the system. 5.11.3 Movement of water due to waste, surges, or variable pressure shall not be indicated. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.3.3.2 * Vane-type and pressure switch-type	K 353	**K353** **-How corrective action(s) will be accomplished for those residents found to have been affected.** The annual valve supervisory switch was tested on October 2019. Maintenance Supervisor/Designee will schedule the semi –annual testing in April 2020. The documentation for the testing of the sprinkler system water flow alarm device will indicate how many seconds the alarm was activated during the testing of the inspector test valve and will also indicate that the alarm was activated within 90 seconds on the next quarterly testing which is due on January 2020.	1/06/2020

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K 353	Continued From page 6 waterflow alarm devices shall be tested semiannually. 13.3.3.5.1 Valve Supervisory switches shall be tested semi-annually. Based on interview and record document review and interview, the facility failed to ensure the sprinkler system's required valve supervisory switch was tested at least semi-annually and failed to ensure the initiation of the alarm signal occurred within 90 seconds of waterflow at the alarm initiating device when flow of water occurs. In the event of a fire, the activation of the fire alarm and effective operation of the sprinkler system is essential. The periodic testing of the valve supervisory switch is essential in identifying if any problems exist that could affect the activation and effective operation of the sprinkler heads for the dispersion of water according to the manufacturer's specifications. This deficiency affected four of four smoke compartments. Findings: On December 05, 2019, at 1:30 p.m., during a review of the sprinkler test reports and concurrent interview with the maintenance supervisor, the following was noted: a. It was determined that there was no semi-annual testing of the valve supervisory switch was conducted by the vendor. During an interview, the maintenance supervisor stated the valve supervisory switch is tested once a year. He stated he was not aware of the requirement to test it twice a year.	K 353	**-How facility will identify other resident's having potential to be affected and corrective action** DON and the Maintenance Supervisor reviewed the quarterly and annual report of the sprinkler system water flow alarm testing that was done in October 2019 both reports showed to be completed. Maintenance Supervisor will add a section where he can indicate how many seconds the alarm was activated during the testing of the inspector test valve and will also indicate that the alarm was activated within 90 seconds.	

K 353

Measures/systematic changes facility will make to ensure the deficient practice does not recur.

DON in-serviced Maintenance Staff on 12/09/19 that the valve supervisory switch testing should be done semi-annually.

DON in-serviced Maintenance Staff on 12/09/19 that the documentation for the testing of the sprinkler system water flow alarm device should indicate how many seconds the alarm was activated during the testing of the inspector test valve instead of writing "OK"and should also indicate that the alarm was activated within 90 seconds.

Administrator/Designee will review quarterly documentation of the sprinkler system water flow alarm testing and will check the semi-annual valve supervisory switch testing to be done in April 2020.

-How facility plans to monitor performance to ensure solutions sustained.

Maintenance Supervisor/Designee will confirm compliance of the sprinkler system water flow alarm testing and the semi-annual valve supervisory switch testing to be done in April 2020. Any non-compliance issues will be reported to Administrator/Designee for follow up.

The Administrator/Designee will report findings to the QA committee for monthly review and evaluated for effectiveness for three months or until compliance achieved.

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K 353	Continued From page 7 b. The documentation of the quarterly sprinkler test completed by the maintenance supervisor indicated "OK" for the testing of the sprinkler system water flow alarm device rather than indicating how many second the alarm was activated during the testing of the inspector test valve and to indicate the alarm was activated within 90 seconds.	K 353		
K 918 SS=F	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 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	K 918	**K 918** **-How corrective action(s) will be accomplished for those residents found to have been affected.** Generator company is scheduled to perform service on January 13, 2020 to include specific gravity reading and/or conductance testing of the storage battery and annual fuel quality test for the diesel operated generator. **-How facility will identify other resident's having potential to be affected and corrective action** Generator Test Logbook was reviewed and all other generator tests and services were done and completed.	01/06/2020

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K 918	Continued From page 8 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: NFPA 101, Life Safety Code, 2012 edition 19.5.1 Utilities, Utilities shall comply with the provisions of section 9.1 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. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition. Chapter 8 Routine Maintenance and Operational Testing 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. Based on interview and record review, the facility failed to ensure the emergency generator monthly inspection included the specific gravity reading and/or the conductance testing in lieu specific gravity when applicable for the storage battery and failed to ensure the annual fuel quality test was conducted for the diesel operated emergency generator. The deficient practice could result in delayed notification of poor fuel quality affected four of four smoke compartments.	K 918	**- Measures/systematic changes facility will make to ensure the deficient practice does not recur.** DON gave in-service on 12/09/19 to Maintenance Staff regarding the monthly specific gravity reading and/or conductance testing of the storage battery and annual fuel quality test for the diesel operated generator that has to be done by the generator company annually and logged in the Generator Test Logbook. Administrator/Designee will review logbook of Maintenance Supervisor and report from generator company every time a service is performed to ensure that specific gravity reading and/or conductance testing of the storage battery and annual fuel quality test were done.	

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K 918	Continued From page 9 A systematic and diligent emergency generator maintenance program will help assure a reliable source of emergency power in case of an unforeseen loss of normal power. Findings: On December 05, 2019, at 09:20 a.m., during a review of the Generator Test Log book the following was noted: a. There was no documentation that the specific gravity reading of the storage batteries were tested. During concurrent interview with the maintenance supervisor, he confirmed that the specific gravity test was not conducted. b. During an interview and observation of the generator area accompanied by the maintenance supervisor, it was revealed that the facility used diesel fuel for their emergency generator. During a review of documentation on generator testing and an interview with the maintenance supervisor, he confirmed that there was no fuel quality test performed by the vendor for the generator.	K 918	**-How facility plans to monitor performance to ensure solutions sustained.** Maintenance Supervisor/Designee will confirm compliance that the specific gravity reading and/or conductance testing of the storage battery and annual fuel quality test will be done annually. Any non-compliance issues will be reported to Administrator/Designee for follow up. The Administrator/Designee will report findings to the QA committee for monthly review and evaluated for effectiveness for three months or until compliance achieved.	

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E 000	Initial Comments 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 Department of Public Health: Surveyor ID No. 05373; REHS, HFE Census = 85 Scope and Severity: C	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the emergency preparedness plan address resident population, including but	E 007	**E 007** **-How corrective action(s) will be accomplished for those residents found to have been affected.** Facility identified and included at risks residents who were receiving dialysis in dialysis facilities in the Emergency Operations Plan (EOP). 16 dialysis facilities that are within the 10 mile radius from the facility were identified to be able to provide continuity of care for the residents who will be in need of dialysis during emergency.	01/06/2020

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

DON 12/30/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. BUILDING _____ B. WING _____	12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 007	Continued From page 1 not limited to persons at risk, the type of services and the facility's ability to provide continuity of operations including delegations of authority and succession plans. The deficient practice has the potential for at risks residents not to be provided with adequate care and treatment. Findings: On December 06, 2019, at 1:40 p.m., during the documentation review with the administrator, it was determined that the facility failed to have an emergency preparedness plan that included resident population and at-risk residents considering the type of services needed in an emergency such as residents who were receiving dialysis in dialysis facilities. The administrator confirmed the findings and stated there were nine residents residing in the facility who receive dialysis in dialysis facilities and acknowledged the need of a plan for continuity of care for the residents who will be in need of dialysis during emergency.	E 007	**-How facility will identify other resident's having potential to be affected and corrective action** All other resident population were reviewed and determined not to be at risk and can be provided with adequate care and treatment at the facility during an emergency.	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff	E 018	**E018** **-How corrective action(s) will be accomplished for those residents found to have been affected.** A Resident Evacuation Tracking form and log and an On-duty Staff/Personnel Evacuation Tracking form and log was included in the facility's Emergency Operations Plan binder on 12/09/19.	01/06/2020

E 007

- Measures/systematic changes facility will make to ensure the deficient practice does not recur.

Facility will continue to coordinate with their affiliated Disaster Resource Center to ensure facility has an updated emergency preparedness plan in their EOP that includes at risk residents.

EOP will be reviewed quarterly to ensure that emergency preparedness plan is updated for at risk residents.

-How facility plans to monitor performance to ensure solutions sustained.

Administrator/Designee will confirm compliance that EOP will be reviewed quarterly to ensure that emergency preparedness plan is updated for at risk residents.

The Administrator/Designee will report findings to the QA committee for monthly review and evaluated for effectiveness for three months or until compliance achieved.

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E 018	Continued From page 2 and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff	E 018	**-How facility will identify other resident's having potential to be affected and corrective action** Emergency Operations Plan binder was reviewed by DON and Maintenance Supervisor on 12/10/19 and confirmed a tracking system and availability of the evacuations forms and log for both residents and staff. **- Measures/systematic changes facility will make to ensure the deficient practice does not recur.** Administrator/Designee will review the Emergency Operations Plan binder annually and update as needed to ensure tracking system is in place.	

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E 018	Continued From page 3 responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness plan that includes a means to track the location of on-duty staff during and after an emergency. The deficient practice affected result in the delayed response to an emergency situation. Findings: On December 06, 2019, at 2 p.m., during a review of the documentation with the administrator, it was determined that the facility did not include a means to track on-duty staff and sheltered residents in the [facility's] care during an emergency and after emergency in their emergency plan policies and procedures; and failed to have a system to track the location of on-duty staff and sheltered residents in the care during and after an emergency and if on-duty staff and sheltered residents are relocated during the emergency, a system to document the	E 018	**-How facility plans to monitor performance to ensure solutions sustained.** Administrator/Designee will confirm compliance that Emergency Operations Plan binder has a tracking system and availability of the evacuations forms and log for both residents and staff. The Administrator/Designee will report findings to the QA committee for monthly review and evaluated for effectiveness for three months or until compliance achieved.	

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E 018	Continued From page 4 specific name and location of the receiving facility or other location. The tracking system should ensure the information is readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the resident. The administrator confirmed the findings.	E 018		