STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. BUILDING 01 B. WING	01/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND SUBACUTE CENTER	3034 E HERNDON FRESNO, CA 93720

(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 K3 BUILDING: 01 K6 PLAN APPROVAL: 6/30/99 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 29752. The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 177	K 000	**This plan of correction shall serve as the facility's written credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission by the provider or the truth of the facts set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 1280 and C.F.R.** CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM **K018** 1. During the survey on 1/20/16 an office door was observed propped open with a rubber wedge and was immediately resolved by the surveyor. The stopper was removed from the Physical Therapy room door and the employee who inhabits the office was counseled by the surveyor. 2. All residents in the facility are at risk of being effected by the deficient practice, but no resident was harmed. All rubber stoppers found in the facility will be removed and discarded.	2/9/16 2/9/16
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018	LIFE SAFETY CODE UNIT SAN BERNARDINO	

LA [redacted] NTATIVE'S SIGNATURE TITLE (X6) DATE

Administrator 2-5-16

A[redacted] 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.

POC accepted 2/22/16 per Jared Okimoto

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K 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure there were no obstructions to self closing corridor doors. This was evidenced by a self closing door that was obstructed from closing by a rubber door wedge. This could result in a delay to contain fire or smoke during a fire emergency. This affected one of seven smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3 Corridor Doors. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept	K 018	3. The Director of Maintenance or Designee will conduct weekly rounds, ongoing, throughout the facility to identify areas of non-compliance, such as propped open doors. Any issues of non-compliance will be corrected immediately and staff will be counseled on the spot using a counseling form titled " Employee Counseling" **(Exhibit A)** . This form will be turned into the Administrator for review and then placed in the employee's personnel file. A form titled "Weekly Facility Checklist" **(Exhibit B)** will be used to document findings by the Director of Maintenance or Designee. Non Nursing Facility staff were in-serviced on 2/2/16 and 2/3/16 by Department Heads **(Exhibit C)** on not propping open doors. Nursing staff will be in-serviced on 2/4/16 and 2/9/16 **(Exhibit D)** by the DSD on not propping open doors.	2/9/16

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K 018	Continued From page 2 in service. 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. Findings: During the facility tour and interview with Maintenance Staff 1 on 1/20/16, the corridor self closing doors were observed. At 4:16 p.m., the door to Physical Therapy was obstructed from closing by a rubber wedge that held the door in a fully open position. At 4:17 p.m., Maintenance Staff 1 confirmed the door was obstructed from closing.	K 018	4. Trends of noncompliance, such as doors found propped open, will be reported at the quarterly QA meeting by the Administrator for recommendation and resolution over the next two quarters. 5. Facility will be in substantial compliance by February 9, 2016 **K038** 1. During the survey tour on 1/20/16, two direct exit doors were found to be in noncompliance as evidenced by failure to release or alarm when direct pressure was placed on the panic bars. On 1/27/16 the direct exit corridor door next to rooms 321 and 322 was repaired by the Assistant Director of Maintenance. The direct exit corridor door leading to the service hall was unable to be repaired in house so an outside agency, Key Evidence Lock and Safe, was contacted on 2/2/16 by the Assistant Maintenance Director and they will be out to the facility on 2/4/16 to repair the delayed egress **(Exhibit E)**.	2/9/16 2/4/16
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain exit access to the public way. This was evidenced by an exit access and a direct exit that	K 038	2. All residents in the facility are at risk of being effected by the deficient practice, but no resident was harmed. The door that was repaired in house, next to room 321,	

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K 038	Continued From page 3 were equipped with delayed-egress locks that failed to release the doors. This could result in a delay in evacuation during a fire emergency and greater risk of exposure to smoke. This affected two of seven smoke compartments. NFPA 101 Life Safety Code 2000 Edition 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11 7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of	K 038	was tested by the Assistant Director of Maintenance on 2/2/16 and is in working order. 3. The Maintenance Director or Designee will conduct weekly rounds testing five random doors a week for three months. A record of the tests will be kept by the maintenance department on a log titled "Weekly Door Check" **(Exhibit F)**. Any malfunctions will be repaired immediately in house or contracted out for repair and reported to the Administrator. 4. The log will be reviewed and signed off by the Administrator on a weekly basis for oversight of compliance. Trends of noncompliance will be reported at the quarterly QA meeting by the Administrator for recommendation and resolution over the next two quarters. 5. Facility will be in substantial compliance by February 4, 2016	2/4/16

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K 038	Continued From page 4 the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS Findings: During the facility tour and interview with Maintenance Staff 1 and 2 on 1/20/16, the exit access and direct exit doors were observed. 1. At 1:35 p.m. the pair of exit access doors leading through the service corridor failed to release and open when the panic bars were pushed with a force in excess of 15 pounds of pressure. The doors were equipped with panic hardware and a delayed egress magnetic lock. The panic hardware was tested for three times for 60 seconds. There was no audible alarm and the magnetic lock failed to release on all three attempts. At 1:39 p.m., Maintenance Staff 1 acknowledged that the panic bar lock release was non operational. 2. At 4:39 p.m. the direct exit corridor door next to Rooms 321 and 322 failed to release and open when the panic bars were pushed with a force in excess of 15 pounds of pressure. The door was equipped with panic hardware and a delayed egress magnetic lock. The panic	K 038		

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K 038	Continued From page 5 hardware was tested three times for 60 seconds. There was no audible alarm and the magnetic lock failed to release on all three attempts. At 4:40 p.m., Maintenance Staff 1 explained that the panic hardware had to be pushed on the left corner in order to operate the door. He acknowledged that the lock release should operate whenever any part of the panic hardware bar was depressed.	K 038		
K 039 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain an unobstructed corridor. This was evidenced by a service corridor that was obstructed by soiled linen containers. This affected two of seven smoke compartments and could result in a delay in evacuation during a fire emergency. 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed	K 039	**K039** 1. a) On 1/21/16 the Assistant Director of Maintenance cleared the corridor next to the laundry of all barrels upon instruction from the Administrator. Signs were posted **(Exhibit G)** in the service corridor next to the laundry area restricting placement of barrels stating "KEEP THIS AREA CLEAR". This signs will remain in place ongoing. b) During the survey on 1/20/16 the Director of Maintenance removed	2/9/16

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K 039	Continued From page 6 width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5. Findings During the facility tour with Maintenance Staff 1 on 1/20/16, the exit access corridors were observed. 1. At 12:03 p.m. and at 4:55 p.m., there were five soiled linen containers located along the east wall of the exit access service corridor next to the laundry area. The five foot wide corridor was reduced to a clear width of thirty inches of clearance. 2. At 3:37 p.m., there was a green linen cart that obstructed egress access through the automatic closing corridor doors next to room 122. The cart reduced the clearance to three feet when the opposite direction door leaf was closed. At 3:38 p.m., Maintenance Staff 1 acknowledged that if the opposite door was closed there would be an obstruction created by the linen cart.	K 039	the green linen cart that was obstructing the egress access through the automatic closing corridor door next to room 122 and moved it to a proper clearance distance. 2. All residents have the potential to be effected by both the deficient practices, but no resident was harmed. Deficient findings were resolved immediately upon discovery. 3. Housekeeping and Laundry staff were in-serviced on 2/2/16 and 2/3/16 **(Exhibit H)** by the Director of Housekeeping and Laundry on keeping the back service hall free from barrels and another obstructions. They will be instructed to place barrels along the South wall of the main service hall. Nursing staff will be in-serviced on 2/4/16 and 2/9/16 **(Exhibit I)** by the DSD on proper barrel placement in back service hall and on keeping automatic closing corridor doors unobstructed. They will be instructed to place barrels along the South wall of the main service hall.	2/9/16
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain their emergency power generator. This was evidenced by no engine exhaust gas temperature readings, hour meter readings that indicated the generator did not meet the minimum run time requirement for a monthly load test, a failure to perform a supplemental two hour load bank test for the diesel powered generator, and by no records available for periodic inspections and maintenance services by an authorized mechanic per the equipment manufacturers recommendations. NFPA 101, Life Safety Code, 2000 Edition. 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power System. NFPA 99, Standard for Health Care Facilities, 1999 Edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 3-6.4.1.1 Maintenance and Testing of Alternate	K 144	4. Director of Housekeeping and Laundry or Designee will conduct daily rounds, ongoing, of the facility identifying areas of deficient practice. Any identified issues such as obstructed hallways or fire doors will be immediately resolved and staff will be in-serviced on the spot using a counseling form titled "Employee Counseling" **(Exhibit A)** by Director of Housekeeping and Laundry or Designee conducting rounds. This form will be turned into the Administrator for review and then placed in the employee's personnel file. Rounds will be documented on a log titled "Daily Facility Rounds" **(Exhibit J)** and will be kept by the Director of Housekeeping and Laundry. The log will be reviewed and signed off by the Administrator on a weekly basis for oversight of compliance. Trends of noncompliance will be reported at the quarterly QA meeting by the Administrator for recommendation and resolution over the next two quarters. 5. Facility will be in substantial compliance by February 9, 2016	2/9/16

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K 144	Continued From page 8 Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-6.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1 (b) 3-6.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, Standard for Emergency and Standby Power Systems 1999 Edition 6-3 Maintenance and Operational Testing. 6-3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 6-3.2 A routine maintenance and operational testing program shall be initiated immediately after the EPSS has passed acceptance tests or after completion of repairs that impact the operational reliability of the system. 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel	K 144	**K144** 1. On 1/20/16 Maintenance was in-serviced during the survey process regarding the requirements for 30-minute weekly generator test, two hour annual load bank test and documented evidence of an inspection from an authorized mechanic per the equipment manufacturers recommendations. 2. All residents in the facility are at risk of being effected by the deficient practice, but no resident was harmed. On 2/5/16 the Administrator will in-service the Maintenance department on generator requirements which include weekly exhaust gas temperature readings logged on the generator log, thirty minute generator weekly test, two hour annual load bank test, and documented evidence of inspections and maintenance services by an authorized generac mechanic	2/8/16

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K 144	Continued From page 9 (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous	K 144	according to manufacturer requirements. 3. The Assistant Director of Maintenance contacted Quinn Engine Systems and has a service scheduled for 2/8/16 for the recommended manufacture inspection and maintenance. In addition, items discussed above will be placed in the preventative maintenance binder to ensure accurate scheduling and instruction. 4. Trends of noncompliance such as, incomplete weekly exhaust gas temperature readings on the generator log, failure to conduct thirty-minute generator weekly test, failure to conduct two hour annual load bank test, and failure to schedule and document evidence of inspections and maintenance services by an authorized generac mechanic according to manufacturer requirements. 5. Trends of noncompliance will be reported at the quarterly QA meeting by the Director of Maintenance for recommendation and resolution over the next two quarters. 6. Facility will be in substantial compliance by February 8, 2016	2/8/16

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K 144	Continued From page 10 hours. Findings: During record review and interview with the Maintenance Staff 1 and Facility Staff 1 on 1/20/16 from 12:05 p.m. to 1:25 p.m., the monthly and annual load tests, the weekly visual inspections of the emergency generator, the records of periodic servicing of the generator, and the operating and maintenance manuals were requested. 1. At 12:20 p.m., Maintenance Staff 1 provided the generator run log and explained that the emergency power tests were programmed to automatically start and run the same way each week for the same amount of time. There were no exhaust gas temperature readings indicated on the generator log. It did include occasional hour meter readings. When calculated these reading, it indicated that the generator was run weekly for 21 minutes instead of 30 minutes, during the last two years. At 12:15 p.m., during a telephone interview, Facility Staff 1 explained that the records provided included programmed run times that had not changed in many years. At 3:50 p.m., Maintenance Staff 1 acknowledged that the current hour meter reading on the emergency generator was 285.5 hours. The generator maintenance log indicated that on 1/21/14 the hour meter reading was 248.0 hours. There were 104 weekly tests programmed for the same run times between these dates over the last two years which averaged out to 21 minutes for each load test. 2. At 12:15 p.m., there was no record of an	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. BUILDING 01 B. WING _____	01/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND SUBACUTE CENTER	3034 E HERNDON FRESNO, CA 93720

(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 144	Continued From page 11 annual two hour load bank test completed during the past 12 months on the generator. 3. At 12:30 p.m., the generator log noted an oil and filter change on 11/12/13 with a 244 hour meter reading. There were no other records available documenting inspections and maintenance services that were required by the equipment manufacturer. During two telephone interviews from 12:32 to 1:15, Facility Staff 1 explained that the weekly run logs were the only service records available and there was no documentation for periodic vendor servicing of the emergency generator. At 1:20 p.m., the Owner's Manual stated "the equipment is checked by an authorized Generac Power Systems service facility periodically." Page 27 of the Owners Manual included semi-annual, annual, and two year maintenance schedules which were to be performed by an authorized mechanic. Page 26 of the Owners Manual stated "Every six months, have an authorized mechanic or service technician perform a system operational test.	K 144		
			K147	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their electrical equipment. This was evidenced by electrical panels that were obstructed by storage of light bulb boxes in the	K 147	1. At the time and during the survey on 1/20/16 it was observed by the surveyor that access to electrical panels in the Maintenance office was obstructed by boxes. The boxes	1/21/16

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K 147	Continued From page 12 main electrical room. This affected one of seven smoke compartments and could result in electrical. NFPA 101 Life Safety Code, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 110-26(a)Working Space (1) Depth of Working Space. The depth of the working space in the direction of access to live parts shall not be less than indicated in Table 110-26(a). Distances shall be measured from the live parts if such are exposed or from the enclosure front or opening if such are enclosed. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 30 inches (762 mm), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. Findings: During the facility tour with Maintenance Staff 1 on 1/20/16, the access to electrical panels were observed. At 1:30 p.m., there were four cases of fluorescent bulb boxes stored within two feet of the front of electrical panels B, panel LC1, and panel ELS in the Main Electrical Room. Maintenance Staff 1 acknoledged the items obstructing the safe access to electrical panels.	K 147	were removed by the Maintenance Director on 1/21/2016 and clear access was made per the instruction of the Administrator. 2. All residents have the potential to be effected by the deficient practice, but no resident was harmed. Deficient findings were resolved promptly and the area will remain clear of any obstructions. 3. Red tape was placed in a radius of three feet around the electrical panel creating an area that needs to remain clear at all times. A sign was placed above the electrical panel saying "KEEP THIS ARE CLEAR" **(Exhibit K)**. This area will be monitored by the Maintenance Director on a daily basis, ongoing, to be sure it remains clear of obstruction. A check off sheet **(Exhibit L)** will be placed in the Maintenance office to record a daily visual check of the area. This practice will remain in place for a daily checkoff for three months. Any items placed within the red tape area will be immediately removed by the Maintenance Director and recorded on the log.	1/21/16

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		K 147	4. A random visual check of the area will be done, ongoing, by the Administrator on a monthly basis during routine facility rounds. The daily log will then be reviewed by Administrator and signed and dated. Trends of noncompliance will be reported at the quarterly QA meeting by the Administrator for recommendation and resolution over the next two quarters. 5. Facility will be in substantial compliance by January 21, 2016 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM LIFE SAFETY CODE UNIT SAN BERNARDINO	1/21/16