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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following reflects the findings of the California Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: Surveyor #: 48267, HFE I Bed capacity: 81 Resident census: 73	K 000		
K 211 SS=D	Highest Scope & Severity: F Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a path of exit discharge used for emergency evacuation was clear of obstructions. This failure had the potential to result in impeding a clear pathway used for exit discharge that would allow for safe and immediate evacuation away from the building.	K 211	K211 On 2/29/24 the Maintenance Director inspected the hall ways and had all the linen carts placed on the same side of the hall way when not being used. The Maintenance Director was in-serviced on 3/12/24 regarding the importance of having the pathway to an emergency exit clear. The Maintenance Director/ Designee will conduct randomly monthly inspections to ensure clear hallways leading to emergency exits. Written records of visual inspection will also be kept by the Maintenance Director.	3/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — 3/15/24 — (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 211	Continued From page 1 This deficient practice affected one of three smoke compartments. Findings: During an observation on 2/29/24 at 9:32 AM with the maintenance supervisor, it was observed that spare nurse stations and linen carts being stored on both sides of the hallway across from each other blocking the path of egress next to resident room #131. During an interview on 2/29/24 at 9:35 AM with the maintenance supervisor regarding the egress, he stated he could see how the storage of these items could block an exit pathway and stated the items shouldn't have been there.	K 211	Findings of these inspections will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321	K321 The Maintenance Director inspected and corrected all areas of the building needing automatic self-closing doors. The affected areas were fixed on 3/1/24. The Maintenance Director was in-serviced on 3/12/24 regarding the importance of having the automatic self-closing doors on the appropriate doors. The Maintenance Director/ Designee will conduct monthly inspections to ensure self-closing doors are working properly and on correct doors. Written records of visual inspection will also be kept by the Maintenance Director. Findings of these inspections will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 321	Continued From page 2 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that doors to hazardous areas were automatically self-closing and positive latching. This failure had the potential to result in the inability to separate hazardous areas from other smoke compartments in the event of fire and/or smoke emergency. This deficient practice affected one of three smoke compartments. Findings: During an observation on 2/29/24 at 9:44 AM with the maintenance supervisor, it was observed that the laundry room door was missing a self-closing device, which would automatically close, latch, and maintain the door in the closed position. According to NFPA 101, Life Safety Code Handbook, 2012 Edition, Protection from Hazards, 19.3.2.1.5, all hazardous areas are rooms and spaces larger than 50 sq ft., used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction, and shall have doors that are self-closing. During an interview on 2/29/24 at 10:43 AM with	K 321		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 321	Continued From page 3 the maintenance supervisor, he stated that he was not aware that the door was not positively latching and automatically closing.	K 321		
K 331 SS=D	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: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of walls and ceilings by having penetrations at one room, thereby compromising the fire rated surfaces. This failure had the potential to result in the penetrations to allow smoke and/or fire to travel from one area to another. This deficient practice affected one of three smoke compartments. Findings: During an observation on 2/29/24 at 9:54 AM with the maintenance supervisor, it was observed that there was a four square-inch penetration where an electrical outlet cover plate was missing extending through one wall, inside the medical records office.	K 331	K331 The Maintenance Director inspected and corrected all areas of the building needing electric outlet coverings replaced. The affected areas were fixed on 3/1/24. The Maintenance Director was in-serviced on 3/12/24 regarding the importance of having the electric outlets covers not cracked or missing. The Maintenance Director/ Designee will conduct monthly inspections to ensure electrical outlets are properly covered. Written records of visual inspection will also be kept by the Maintenance Director. Findings of these inspections will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	3/15/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 331	Continued From page 4 During an interview on 2/29/24 at 9:56 AM with the maintenance supervisor, he stated that he was not aware about the missing cover plate and penetration.	K 331		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: NFPA 10: Standard for Portable Fire Extinguishers, 2010 Edition 7.1.1 Responsibility. The owner or designated agent or occupant of a property in which fire extinguishers are located shall be responsible for inspection, maintenance, and recharging. 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. 7.2.2 Procedures. Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility	K 355	K355 The Maintenance Director inspected all the fire extinguisher inspection dates. No other issues were found. The Maintenance Director was in-serviced on 3/12/24 regarding fire extinguisher inspections. All facility fire extinguishers were serviced and dated 3/5/24. The Maintenance Director/ Designee will conduct monthly inspections to ensure proper fire extinguisher inspections. Written records of visual inspection will also be kept by the Maintenance Director. Findings of these inspections and testing will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 355	Continued From page 5 (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for non-rechargeable extinguishers using push to-test pressure indicators 7.2.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. Based on observation and interview, the facility failed to ensure that the fire extinguishers were inspected monthly. This failure had the potential to result in portable fire extinguishers not performing as intended during an actual fire emergency. This deficient practice affected one of three smoke compartments. Findings: During an observation on 2/29/24 at 8:54 AM with the maintenance supervisor, the documentation tag on the fire extinguisher at the front skilled nursing facility (SNF) nurse station indicated no monthly inspection documentation for December of 2023. During an interview on 2/29/24 at 8:55 AM with the maintenance supervisor, he stated he was not aware the fire extinguisher was missing December's monthly inspection. All other fire extinguishers had complete and up-to-date monthly inspection documentation.	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 918 K 918 SS=F	Continued From page 6 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 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:	K 918 K 918	K918 The Maintenance Director called the generator service company on 3/1/24 to have the four-hour load test conducted on the next scheduled visit. The Maintenance Director was in-serviced on 3/12/24 regarding the importance of making sure the four-hour load test is completed. The Maintenance Director/ Designee will conduct monthly inspections to ensure all generator testing was completed and current. Written records of visual inspection will also be kept by the Maintenance Director. Findings of these inspections and testing will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 918	Continued From page 7 Based on interview and record review, the facility failed to provide documentation the facility's generator had a four-hour continuous exercise every 36 months, in accordance with NFPA 110, Standards for Emergency and Standby Power Systems, 2010 Edition, Routine Maintenance and Operational Testing. This failure had the potential of the facility's generator not being capable of powering the facility for an extended period and having a negative effect on the health, safety, and well-being of the residents, staff, and visitors during an emergency. This deficient practice affected three of three smoke compartments. Findings: During a review of the facility's emergency inspection reports and documentation, dated 1/5/24, it indicated that the facility did not have any documentation to show that their generator has undergone a four-hour load test during the past 36 months. During an interview on 2/29/24 at 1:35 PM with the maintenance supervisor, a request for written documentation for the most recent "Four-hour load test" was verbally requested along with a written request. The maintenance supervisor stated he did not have the requested documentation and was not able to provide the requested documentation before the end of the survey.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 920	Continued From page 8 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: Based on observation and interview, the facility failed to plug electrical equipment directly into electrical outlets without the use of unapproved power strips without a surge protector (a device that protects electrical devices from voltage spikes, which can burn through wiring and cause a fire). This failure had the potential to result in an electrical overload and/or possible fire. This deficient practice affected two of three smoke compartments. Findings: During an observation on 2/29/24 at 8:47 AM with the maintenance supervisor, it was noted a domestic, unapproved power strip without surge	K 920	K920 The Maintenance Director inspected all electrical equipment in facility. The approved power strip was installed 3/1/24 in all locations. The Maintenance Director was in-serviced on 3/12/24 regarding the importance of making sure the approved Power Strip is being used. The Maintenance Director/ Designee will conduct monthly inspections to ensure all approved power strips are being used. Written records of visual inspection will also be kept by the Maintenance Director. Findings of these inspections and testing will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 920	Continued From page 9 protection was used connecting a phone charger and telephone, inside the Payroll/Administrator Assistant's office. During an observation on 2/29/24 at 10:03 AM with the maintenance supervisor, it was noted a domestic, unapproved power strip without surge protection was used connecting to computer systems, inside the food storage office. During an interview on 2/29/24 at 10:08 AM with the maintenance supervisor regarding these electrical problems, the maintenance supervisor stated that he was unaware of the use of the power strips.	K 920		

PRINTED: 03/11/2024
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness Recertification survey. The findings are in accordance with Title 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the Department of Public Health: Surveyor #: 48267, HFE I Bed capacity: 81 Resident census: 73	E 000		
E 041 SS=C	Highest Scope & Severity: C Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location	E 041	E041 The Maintenance Director inspected the rest of the Emergency Preparedness policy for any other outdated information and made the correct updates. The Maintenance Director was in-serviced on 3/12/24 regarding the importance of making sure the Emergency Preparedness policy is updated regularly when changes happen in the facility. The Maintenance Director/ Designee will conduct monthly inspections to ensure Emergency Preparedness policy is current. Written records of visual inspection will also be kept by the Maintenance Director.	3/15/24

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

Administrator — 3/18/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 041	Continued From page 1 requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD	E 041	Findings of these inspections and testing will be brought to monthly QA Meeting, by the Maintenance Director, for 3 months or until a lesser frequency deemed appropriate. The Administrator will ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 041	Continued From page 2 or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a detailed emergency	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 041	Continued From page 3 preparedness policy regarding how the facility would maintain an onsite fuel source to power the emergency generator and keep the emergency power systems operational, during an emergency. This failure had the potential to result in delay in care and services or cause harm to the residents, during an emergency. Findings: During a concurrent observation and interview on 2/29/2024 at 8:41 AM, at the Generator Area outside, with the maintenance supervisor, the facility's generator was observed with 89 gallons of diesel fuel in the tank. The maintenance supervisor stated an additional 10 gallons of diesel fuel were on site at the facility and would have staff collect diesel fuel at the gas station as needed. During a review of the record titled "Alternate Sources of Energy" dated 1/5/24, the policy did not indicate details of how the facility will maintain an onsite fuel source to power emergency generators. Furthermore, the policy did not detail a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. The policy indicates that the facility utilizes a generator "fueled by diesel with a tank that holds 6 hours of fuel" and that propane is an alternate fuel source. During an interview on 2/29/2024 at 1:10 PM with the maintenance supervisor, he stated the policy is outdated and that the facility does not utilize propane.	E 041		