STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555297	A. BUILDING **02** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-HEMET	**1717 WEST STETSON AVENUE** **HEMET, CA 92545**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 46410 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 46410 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 112	E 000		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		5/25/23

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

Electronically Signed | 05/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 1 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not	E 039		

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E 039	Continued From page 2 accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 3 based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 4 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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E 039	Continued From page 5 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 6 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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E 039	Continued From page 7 a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 8 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 9 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on document review and interview, the facility failed to participate in a full-scale exercise that was community-based. This was evidenced by the failure to provide documentation that indicated participation in a full-scale community-based exercise. This could result in not having the necessary planning and preparation in place in the event of an emergency. This affected staff and 112 of 112 residents in six of six smoke compartments. Findings: During document review and interview with the Maintenance Director (MD) and Administrator on 4/27/23, the facility's Emergency Preparedness Plan (EPP) was reviewed. At 12:15 p.m., the EPP failed to include documentation that indicated that the facility participated in an annual full-scale exercise that is community-based. Upon interview, the Administrator stated that they did not participate in a full-scale community-based exercise.	E 039	The statements made in this Plan of Correction are not an admission to or an agreement with the stated deficiencies. To remain in compliance with all Federal and State Regulations, the facility has taken or will take actions set forth in the following Plan of Correction. This Plan of Correction constitutes the facility's Allegation of Compliance such that all stated deficiencies have been or will be corrected by the specified date/s. E039 It is the practice of this facility to ensure an after-action report is maintained for community-based exercises and/or tabletop exercises to evaluate the effect and identify any needed revisions. 1. A tabletop exercise was completed 5/25/2023 with department managers. 2. This practice has the potential to affect facility residents. Education provided. 3. In-service education was provided by Administrator to Human Resources Director and Director of Staff	

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E 039	Continued From page 10	E 039	Development regarding the need to follow the community-based full-scale exercise and evaluate the event effectiveness. In-service includes the need to document the outcomes, recommendations, event summary and other pertinent information in the facility safety committee reports. 4. Compliance will be monitored by Administrator and/or designee monthly to ensure the requirement is met on an annual basis via review of safety committee reports submitted by Human Resources Director. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	
K 000	INITIAL COMMENTS Surveyor: 46410 K3 BUILDING: 01 K6 PLAN APPROVAL: 2/19/89 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. Resident Certified Beds: 178 Resident Census: 112 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of	K 000		

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K 000	Continued From page 11 Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 46410 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161		5/25/23

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K 161	Continued From page 12 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by penetrations and damage to the building's wall and ceiling. This could result in the passage of smoke and gases from one part of the building to another. This affected 2 of 112 residents in one of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition. 8.1 General. 8.1.1 Application. The features of fire protection set forth in this chapter shall apply to both new construction and existing buildings. 8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing	K 161	The statements made in this Plan of Correction are not an admission to or an agreement with the stated deficiencies. To remain in compliance with all Federal and State Regulations, the facility has taken or will take actions set forth in the following Plan of Correction. This Plan of Correction constitutes the facility's Allegation of Compliance such that all stated deficiencies have been or will be corrected by the specified date/s. K161 It is the practice of this facility to ensure that the building construction is maintained. 1. The leak in the closet in Room 100 was repaired on 4/28/2023. The water damage to the ceiling in the restroom in Room 230 was repaired on 4/28/2023.	

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	555297	A. BUILDING **02** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-HEMET	**1717 WEST STETSON AVENUE** **HEMET, CA 92545**

(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 161	Continued From page 13 through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43 Findings: During facility tour and interview with the Maintenance Director (MD) on 4/26/23, the building construction was inspected. 1. At 1:38 p.m., in the closet of Room 100, water damage was observed on the ceiling panel surrounding a sprinkler. A leak was observed coming from a copper pipe above the ceiling tiles. Upon interview, the MD stated the facility had just repaired the roof and would have a plumber come out. 2. At 2:55 p.m., in the restroom of Room 230, water damage was observed on the ceiling surrounding a sprinkler. Upon interview, the MD stated the facility had just repaired the roof and would have a plumber check pipes in case of a leak. 3. At 3:01 p.m., in Room 232 there was an approximately 2 inch by 2 inch penetration in the ceiling panel near the entry way of the room. Upon interview, the MD stated he was not sure how the penetration happened. 4. At 3:02 p.m., in the restroom of Room 232, there were five penetrations in the wall near the toilet paper holder. Three penetrations measured approximately half inch and two penetrations measured approximately quarter inch. Upon interview, the MD stated the toilet paper holder was moved which caused the penetrations.	K 161	The penetration in the ceiling panel in Room 232 was repaired on 4/28/2023. The penetrations in the restroom wall in Room 232 were repaired on 4/28/2023. 2. This practice has the potential to affect facility residents. The Maintenance Director and/or designee completed an inspection to identify any additional penetrations. No further issues noted. 3. In-service education was provided to the Maintenance Director by the Administrator regarding the need to promptly identify and repair any leaks or penetrations. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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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 by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the kitchen's fire suppression system. This was evidenced by the blow-off caps to the sprinkler nozzles above the stove not installed as required per manufacture and NFPA 17A. This could result in grease build-up and clogging of the nozzles that could delay the	K 324	K324 It is the practice of this facility to ensure the kitchen□s fire suppression system is maintained. 1. The blow-off caps to the sprinkler nozzles above the kitchen stove were immediately secured in place.	5/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 324	Continued From page 15 extinguishing of a stove top fire. This affected staff in one of six smoke compartments. NFPA 96: Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (4) NFPA 17A 12.1.2.3 The fire-extinguishing system shall not require re-evaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 2009 Edition 4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. Findings: During tour with the Maintenance Director (MD) on 4/26/23, the kitchen equipment was observed. 1. At 2:17 p.m., the blow-off caps to the sprinkler nozzles above the kitchen stove were not properly secured. Upon interview the MD stated staff had forgot to secure them after cleaning.	K 324	2. This practice has the potential to affect facility residents. Dietary staff received education. 3. In-service education was provided to the Dietary Staff by the Administrator regarding the need to ensure the blow-off caps to the sprinkler nozzles above the kitchen stove are securely in place. 4. Compliance will be monitored by the Food Service Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 345	Continued From page 16	K 345		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the fire alarm system. This was evidenced by missing fire alarm system testing records. This could result in a delay during an emergency and malfunction of the fire alarm system. This affected staff and 112 of 112 residents in six of six smoke compartments. NFPA 101 - Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72 - National Fire Alarm and Signaling Code, 2010 Edition 14.3.1* Unless otherwise permitted by 14.3.2,	K 345	K345 It is the practice of this facility to ensure the fire alarm system is maintained. 1. The fire alarm company was contacted and requested to send the report from 9/23/2022. The next scheduled fire alarm system test is scheduled for 5/23/2022. A load voltage test was completed on 4/28/2023 for the fire alarm control panel sealed lead acid batteries. 2. This practice has the potential to affect facility residents. Education provided. 3. In-service education was provided to the Maintenance Director by the Administrator regarding the need to ensure the fire alarm system is maintained and necessary testing is completed timely. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3	5/25/23

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	555297	A. BUILDING **02** B. WING _____	**04/27/2023**

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K 345	Continued From page 17 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1: 3. Batteries (d) Sealed lead-acid: Semiannually 9. Initiating devices (b) Duct detectors: Semiannually (e) manual fire alarm boxes: Semiannually (f) Heat detectors: Semiannually (h) Smoke detectors: Semiannually 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5: 6. Batteries - fire alarm system (d) Sealed lead-acid type (1) Charger test (Replace battery within 5 years after manufacture or more frequently as needed.): Initial/Reacceptance, Annually (2) Discharge test (30 minutes): Initial/Reacceptance, Annually (3) Load voltage test: Initial/Reacceptance, Semiannually Findings: During document review and interview with the Maintenance Director (MD) on 4/27/23, the fire alarm system maintenance and testing records were reviewed. 1. At 11:25 a.m., the fire alarm system maintenance records were missing the	K 345	months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 345	Continued From page 18 semi-annual inspection records for the duct detectors, heat detectors, manual fire alarm boxes and smoke detectors. Upon interview MD stated the fire alarm company had come for the semi-annual maintenance on 9/23/22, but they did not provide a report of the inspection. MD also stated the next date for the fire alarm system maintenance was scheduled for 5/23/23. 2. At 11:26 a.m., the fire alarm system maintenance records were missing one of two semi-annual load voltage tests for the fire alarm control panel sealed lead acid batteries. The date of the last load voltage test record provided was for 12/7/22. Upon interview, the MD stated the batteries load voltage test were done annually.	K 345		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the smoke detectors. This was evidenced by smoke detectors not securely mounted to the ceiling. This could result in a delay during an emergency and malfunction of the smoke detectors. This affected 2 of 112 residents in two of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall	K 347	K347 It is the practice of this facility to ensure smoke detectors are maintained. 1. The smoke detector in the closet in Room 122 was repaired on 4/28/2023. The smoke detector in the restroom in Room 317 was repaired on 4/28/2023. 2. This practice has the potential to affect facility residents. The Maintenance Director and/or designee completed an	5/25/23

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K 347	Continued From page 19 be provided with a fire alarm system in accordance with section 9.6 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72, National Fire Alarm Code, 2010 Edition 14.2.1.2 Impairments. 14.2.1.2.1 The requirements of Section 10.19 shall be applicable when a system is impaired. 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance. 10.19 * Impairments. 10.19.1 The system owner or their designated representative shall be notified when a fire alarm system or part thereof is impaired. Impairments to systems shall include out-of-service events. 10.19.2 A record shall be maintained by the system owner or designated representative for a period of 1 year from the date the impairment is corrected. 10.19.3 * Where required, mitigating measures acceptable to the authority having jurisdiction shall be implemented for the period that the system is impaired. 10.19.4 The system owner or owner's designated representative shall be notified when an impairment period is completed or discontinued. Findings: During facility tour and interview with the Maintenance Director (MD) on 4/26/23, the smoke detectors were observed.	K 347	inspection to identify any additional unsecured smoke detectors. No further issues noted. 3. In-service education was provided to the Maintenance Director by the Administrator regarding the need to ensure smoke detectors are maintained. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 347	Continued From page 20 1. At 1:16 p.m., in Room 122, a smoke detector in the closet was detached and hanging from the ceiling. Upon interview, the MD stated he did not know what happened. 2. At 3:36 p.m., in the restroom of Room 317, a smoke detector was hanging lose and ceiling panel was lifted. Upon interview, the MD stated that a screw had probably got lose but didn't know what happened to the ceiling panel.	K 347		
K 353 SS=D	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, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility	K 353	K353 It is the practice of this facility to ensure the automatic fire sprinkler system is	5/25/23

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K 353	Continued From page 21 failed to maintain the automatic fire sprinkler system. This was evidenced by dirt debris build up on sprinkler head deflectors, a sprinkler detached from ceiling, and a crescent shape penetration around sprinkler . This could result in the malfunction and delay on the sprinkler system during an emergency or fire. This affected staff and 112 of 112 residents in six of six smoke compartments. NFPA 101: Life Safety Code, 2012 Edition 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.2.1.1.1 * Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1)Leakage (2)Corrosion (3)Physical damage (4)Loss of fluid in the glass bulb heat responsive element	K 353	maintained. 1. The sprinkler plate in the closet of Room 122 was repaired on 4/28/2023. The sprinkler in the closet of Room 112 was repaired on 4/28/2023. The sprinkler in Room 320 was cleaned on 4/28/2023. The sprinkler in Room 323 was cleaned on 4/28/2023. 2. This practice has the potential to affect facility residents. The Maintenance Director and/or designee completed an inspection to identify any additional unsecured or dirty sprinklers. No further issues noted. 3. In-service education was provided to the Maintenance Director by the Administrator regarding the need to ensure fire sprinklers are maintained. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 353	Continued From page 22 (5)Loading (6)Painting unless painted by the sprinkler manufacturer 5.2.1.1.3 * Any sprinkler that has been installed in the incorrect orientation shall be replaced. 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation. Findings: During a facility tour and interview with the Administrator and Maintenance Director (MD) on 4/26/23, the sprinklers were observed and interviews were conducted. 1. At 1:16 p.m., in the closet of Room 122, a sprinkler plate was pushed out of place creating a crescent shaped penetration. Upon interview, the MD stated the sprinkler needed to be adjusted. 2. At 1:27 p.m., in the closet of Room 112, a sprinkler was detached and hanging from ceiling. MD stated he did not know what happened. 3. At 3:42 p.m., in Room 320 a sprinkler was covered with dirt build up on deflector and glass bulb. Upon interview, the MD stated the sprinkler head needed to be dusted. 4. At 3:49 p.m., in Room 323 a sprinkler was covered with dirt build up on deflector and glass bulb. Upon interview, the MD stated the sprinkler head needed to be dusted.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363		5/25/23

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K 363	Continued From page 23 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363		

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K 363	Continued From page 24 Surveyor: 46410 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a corridor door that was obstructed from closing. This could delay the containment of smoke and fire in the event of an emergency. This affected staff in one of six smoke compartments. Findings: During facility tour and interview with Maintenance Director (MD) on 4/26/23, the corridor doors were observed. At 2:14 p.m., the Kitchen pantry door was obstructed from closing by a utility dolly. Upon interview, the MD stated that the kitchen had just received a shipment of supplies and the utility dolly was used to hold the door open while bringing in the supplies.	K 363	K363 It is the practice of this facility to ensure corridor doors are not obstructed from closing. 1. The utility dolly was immediately removed from kitchen pantry door. 2. This practice has the potential to affect facility residents. The Maintenance Director and/or designee completed an inspection to ensure all corridor doors were free from obstructions. No further issues noted. 3. In-service education was provided to the Dietary Staff by the Administrator regarding the need to have corridor door free from obstructions. 4. Compliance will be monitored by the Food Service Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	
K 500 SS=D	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard	K 500		5/25/23

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	555297	A. BUILDING **02** B. WING _____	**04/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-HEMET	**1717 WEST STETSON AVENUE** **HEMET, CA 92545**

(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 500	Continued From page 25 citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain their electrical appliances per manufacturer. This was evidenced by operating a washer machine while it was leaking water. This created a hazardous condition in the Laundry Room. This affected staff in one of six smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.5.1.2 Existing installations shall be permitted to be continued in service, provided that the systems do not present a serious hazard to life. Findings: During facility tour and interview with the Maintenance Director (MD) on 4/26/23, the building services were observed. At 2:07 p.m., in the Laundry Room there was a front-loading washer machine leaking water around the loading door. The front-loading washer machine was observed to be manufactured by Girbau. Upon interview, the MD stated the washer probably needed to have the seal around the loading door replaced. The manufacture's Operating Instructions Manual for Girbau, dated 12/12/18, was reviewed. Page six, number 22, it states "Do Not Use the	K 500	K500 It is the practice of this facility to ensure electrical appliances are maintained according to manufacturer guidelines. 1. The seal on the front-loading washing machine was replaced on 5/19/2023. 2. This practice has the potential to affect facility residents. Education provided. 3. In-service education was provided to the Laundry Staff and Maintenance Director by the Administrator regarding the need to use electrical appliances according to manufacturer guidelines. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 500	Continued From page 26 machine if you notice any abnormal noise or smell or if you suspect that the machine is faulty or defective." On page 43 of the operating instructions manual, it also states: "If the door is leaking to clean the door seal of any possible deposits or remains of linen ... If problem persists, seal all of the water inlets and contact the Authorized Technical Services."	K 500		
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on document review and interview, the	K 914	K914 It is the practice of this facility to ensure electrical receptacles are maintained per	5/25/23

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K 914	Continued From page 27 facility failed to maintain the electrical receptacles per manufacturer. This was evidenced by missing monthly testing records for electrical receptacles. This could result in electrical shock or fire due to malfunction. This affected six of six smoke compartments and 112 of 112 residents. Findings: During facility tour, document review, and interview with the Maintenance Director (MD) on 4/26/23, the electrical receptacles were observed. At 11:28 a.m., the facility failed to provide monthly testing documentation of the Ground Fault Circuit Interrupter (GFCI) receptacles. The GFCI receptacles located in resident restrooms were marked by the manufacture to test every 30 days. The last GFCI test was completed on 6/27/22. Upon interview, the MD stated the GFCIs were tested yearly.	K 914	manufacturer guidelines. 1. Testing was completed on the Ground Fault Circuit Interrupter receptacles on 4/28/2023. 2. This practice has the potential to affect facility residents. Education provided. 3. In-service education was provided to the Maintenance Director by the Administrator regarding the need to maintain electrical receptacles according to manufacturer guidelines. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		5/25/23

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K 918	Continued From page 28 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: Surveyor: 46410 Based on document review and interview, the facility failed to maintain the emergency standby generator. This was evidenced by the failure to provide generator maintenance records. This could result in a delay in the generator back up response in the case of a power outage. This affected staff and 112 of 112 residents in six of six smoke compartments. NFPA 101 Life Safety Code, 2012 Edition 19.5.1.1 Utilities shall comply with the provisions of section 9.1	K 918	K918 It is the practice of this facility to ensure the emergency standby generator is routinely maintained. 1. The battery electrolyte specific gravity test was completed on 5/1/2023. The 4-hour load test was completed on 5/15/2023. 2. This practice has the potential to affect facility residents. Education provided. 3. In-service education was provided to	

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K 918	Continued From page 29 9.1.3.1 Emergency Generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. 8.4.9 * Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. Findings: During document review and interview with the Maintenance Director (MD) on 4/26/23, the generator records were reviewed.	K 918	the Maintenance Director by the Administrator regarding the need to maintain the emergency standby generator. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 918	Continued From page 30 1. At 11:40 a.m., the facility failed to provide documentation indicating that the monthly battery electrolyte specific gravity test was conducted on the 80-kilowatt diesel generator. The date of the last battery electrolyte specific gravity test was unknown. Upon interview, the MD stated he did not have the electrolyte specific gravity test records. 2. At 11:43 a.m., the facility failed to provide a three-year 4-hour load test for the 80-kilowatt diesel generator. The last 4-hour load test was unknown. Upon interview, the MD stated he did not have the 4-hour load test records.	K 918		
K 920 SS=D	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 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	K 920		5/25/23

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K 920	Continued From page 31 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by the use of extension cords. This could result in an electrical fire. This affected 46 of 112 residents in one of six smoke compartments. NFPA 101 Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70 National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure Findings: During facility tour and interview with the Maintenance Director (MD) on 4/26/23, the electrical equipment was observed. At 3:17 p.m., in Room 301 there was an	K 920	K920 It is the practice of this facility to ensure extension cords are not utilized. 1. The extension cord was removed from Room 301 on 4/28/2023. 2. This practice has the potential to affect facility residents. The Maintenance Director completed a visual inspection of resident rooms to ensure no extension cords were in use. No findings noted. 3. In-service education was provided to the Maintenance Director and facility staff by the Administrator to ensure extension cords are not utilized. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 920	Continued From page 32 approximately 14 inch by 7 inch Christmas tree plugged into a white extension cord on top of the resident's night stand. Upon interview, the MD stated he did not know that the extension cord was being used by the resident in Room 301.	K 920		
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	K 921		5/25/23

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K 921	Continued From page 33 This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on document review and interview, the facility failed to maintain the Patient-Care Related Electrical Equipment (PCREE). This was evidenced by electrical equipment not meeting testing and maintenance requirements. This could result in a malfunction of the electrical equipment. This affected 112 of 112 residents in six of six smoke compartments. NFPA 99 - Health Care Facilities Code, 2012 Edition 10.3.1* Physical Integrity. The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. 10.5.5.2* The physical integrity of the power cord, attachment plug, and cord-strain relief shall be confirmed at least annually by visual inspection and other appropriate tests. 10.5.2.1 Testing Intervals. 10.5.2.1.1 The facility shall establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment. 10.5.2.1.2 All patient care-related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. 10.5.6.3 Test Logs. A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy.	K 921	K921 It is the practice of this facility to ensure the Patient-Care Related Electrical Equipment is maintained. 1. Testing and maintenance of the oxygen concentrators, hospital beds and power cords will be completed on 5/30/2023. 2. This practice has the to affect facility residents. Education provided. 3. In-service education was provided to the Maintenance Director by the Administrator to ensure the Patient-Care Related Electrical Equipment is tested and maintained. 4. Compliance will be monitored by the Maintenance Director and/or designee weekly x 3 weeks then monthly x 3 months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliance and make recommendations.	

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K 921	Continued From page 34 Findings: During document review and interview with the Maintenance Director (MD) on 4/27/23, the PCREE maintenance documents were requested. At 11:27 a.m., the patient electrical equipment maintenance and testing documents were requested for the oxygen concentrators, hospital beds, and power cords. No testing or maintenance documents were provided . Upon interview, the MD stated that they did not have testing or maintenance documents for PCREE.	K 921		