PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING _			04	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ		17	REET ADDRESS, CITY, STATE, ZIP CODE 17 WEST STETSON AVENUE EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Surveyor: 46410 The following reflects Department of Public Emergency Prepared The findings are in acceptance of Federal Regulations for Long Term Care (In Representing the Cal Health: 46410 The facility is not in stance of the facility is not in stance of the facilities. Census = 112 EP Testing Requirem CFR(s): 483.73(d)(2) §416.54(d)(2), §448. §460.84(d)(2), §482. §483.475(d)(2), §484. §485.542(d)(2), §485. §485.920(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "C§485.727, CMHCs at §491.12, and ESRD In Section 1981.	ness recertification survey. coordance with 42 Code of (CFR) 483.73, Requirement LTC) Facilities. ifornia Department of Public ubstantial compliance with ong Term Care (LTC) ents 113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs Organizations" under §485.920, RHCs/FQHCs at		039			5/25/23
	to test the emergency must do all of the follo	y plan annually. The [facility] owing: -scale exercise that is					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 05/25/2023

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.

	DEFICIENCIES CORRECTION				X3) DATE SURVEY COMPLETED	
		555297	B. WING _		04	/27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	(A) When a communaccessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emerexempt from engaging community-based or ifunctional exercise for actual event. (ii) Conduct an additional exercise for actual event. (iii) Conduct an additional exercise und this section is conducted in the followord of the followord in	ity-based exercise is not facility-based functional s; or experiences an actual emergency that requires gency plan, the [facility] is g in its next required ndividual, facility-based flowing the onset of the lowing the onset of the onal exercise at least every 2 ear the full-scale or of order paragraph (d)(2)(i) of ted, that may include, but is wing: e exercise that is ndividual, facility-based or rill; or e or workshop that is led by les a group discussion using elevant emergency for problem statements, or prepared questions e an emergency plan. Ity's] response to and on of all drills, tabletop ency events, and revise the plan, as needed. 1.113(d):] 1.113(d):]	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED			
		555297	B. WING _		04/27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
E 039	functional exercise expending the hospice expending in its next recommunity-based exercise of the emergency plan, engaging in its next recommunity-based exercise of the emergency plan (ii) Conduct an addition onset of the emergency plan (iii) Conduct an addition onset of the emergency of the exercise under paragest is conducted, that may to the following: (A) A second full-scarcommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercise a facilitator and include a narrated, clinically-scenario, and a set of directed messages, of designed to challenged. (3) Testing for hospic care directly. The home exercises to test the expear. The hospice modification in an analysis community-based; (A) When a community facility-based function (B) If the hospice expension of the emergency plan, the service of the emergency plan and the emergency plan and the emergency plan and the service of the emergency plan and the emergency pla	an individual facility based very 2 years; or eriences a natural or by that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section have include, but is not limited the exercise that is a facility based functional drill; or see or workshop that is led by the des a group discussion using relevant emergency of problem statements, or prepared questions eran emergency plan. The est that provide inpatient espice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that or ty-based exercise is not an annual individual hal exercise; or	EO	39	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 WEST STETSON AVENUE IEMET, CA 92545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
E 039	(ii) Conduct an additimay include, but is not (A) A second full-scal community-based or exercise; or (B) A mock disaster (C) A tabletop exercifacilitator that include narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentati exercises, and emerge hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an ais community-based; (A) When a community accessible, conduct a facility-based function (B) If the [PRTF, Hospital actual natural or man requires activation of [facility] is exempt fro required full-scale contents.	d functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. oice's response to and ion of all drills, tabletop pency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise; or pital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next mmunity based or individual, hal exercise following the	E	039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		555297	B. WING _			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ	·	171	REET ADDRESS, CITY, STATE, ZIP CODE 7 WEST STETSON AVENUE MET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	and that may include, following: (A) A second full-sca community-based or functional exercise; o (B) A mock of (C) A tabletop existed by a facilitator and discussion, using a net emergency scenario, statements, directed questions designed to plan. (iii) Analyze the [maintain documentati exercises, and emerge [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE of following: (i) Participate in an an is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experimentation (C) If the PACE experimentation (B) If the PACE experimentation (C) If the PACE experimentation (B) If the PACE experimentation (C) If the PACE experimentation (B) If the PACE experimentation (B) If the PACE experimentation (C) If the PACE experimentation (B)	additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based or disaster drill; or ercise or workshop that is dincludes a group arrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency facility's] response to and on of all drills, tabletop lency events and revise the plan, as needed. (4(d):] Torganization must conduct emergency plan at least organization must do the mual full-scale exercise that or ty-based exercise is not an annual individual,	E	039			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	LE CONSTRUCTION 5 02	(X3) DATE SURVEY COMPLETED	
		555297	B. WING		04/27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-HEMET		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
E 039	is conducted that may the following: (A) A second full-so community-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clinscenario, and a set of directed messages, designed to challeng (iii) Analyze the PAG maintain documental exercises, and emer PACE's emergency *[For LTC Facilities at (2) The [LTC facility] test the emergency including unannounce emergency procedus ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based (A) When a community-based (B) If the [LTC facility actual natural or may required a full-scale individual, facility-based following the onset of (ii) Conduct an additional following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based following the onset of (iii) Conduct an additional facility-based facility-bas	graph (d)(2)(i) of this section ay include, but is not limited to alle exercise that is individual, a facility based or drill; or cise or workshop that is led by ides a group discussion, nically-relevant emergency of problem statements, or prepared questions are an emergency plan. CE's response to and tion of all drills, tabletop regency events and revise the plan, as needed. at §483.73(d):] must conduct exercises to plan at least twice per year, ced staff drills using the res. The [LTC facility, following: annual full-scale exercise that it; or nity-based exercise is not an annual individual,	E 03	9	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII		CONSTRUCTION 2	(X3) DATE COMP	SURVEY LETED
		555297	B. WING _			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 WEST STETSON AVENUE EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	functional exercise; o (B) A mock disaster o (C) A tabletop exercise a facilitator includes a narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/I to test the emergency The ICF/IID must do t (i) Participate in an ar- is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the ICF/IID exper man-made emergency the emergency plan, engaging in its next re community-based or functional exercise fo emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scal community-based or functional exercise; o (B) A mock disaster de-	le exercise that is an individual, facility based or drill; or see or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to incy plan. facility] facility's response to entation of all drills, tabletop ency events, and revise the emergency plan, as needed. 8.475(d)]: ID must conduct exercises or plan at least twice per year. The following: Innual full-scale exercise that or ty-based exercise is not in annual individual, ital exercise; or. eriences an actual natural or yethat requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based exercise that or limited to the following: exercise that is an individual, facility-based individual, facility-based individual, facility-based exercise that is an individual, facility-based in individual, facility-based	E	039			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING_			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ	•	171	REET ADDRESS, CITY, STATE, ZIP CODE 17 WEST STETSON AVENUE EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI: TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the ICF/III maintain documentatie exercises, and emerging ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The H (i) Participate in a full-community-based; or (A) When a community-based function or. (B) If the HHA export of the emergency planengaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paraging is conducted, that limited to the following (A) A second full-community-based or functional exercise; of the exercise is given the exercise; of the exercise; of the following (B) A mock disasterior and the following (B) A mock disasterior and a set of the following (des a group discussion, cally-relevant emergency is problem statements, reprepared questions an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the plan, as needed. O2] HA must conduct exercises of plan at HA must do the following: -scale exercise that is munity-based exercise is not an annual individual, all exercise every 2 years; experiences an actual natural ency that requires activation and, the HHA is exempt from equired full-scale individual, facility based endividual, facility based exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section at may include, but is not escale exercise that is an individual, facility-based recise or workshop that is	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CON A. BUILDING 02		PLE CONSTRUCTION G 02	(X3) DATE SURVEY COMPLETED		
		555297	B. WING		04/27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-HEMET	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 039	emergency scenario statements, directed questions designed plan. (iii) Analyze the HHA documentation of all emergency events, a emergency plan, as *[For OPOs at §486. (d)(2) Testing. The Oto test the emergency following: (i) Conduct a paper-workshop at least ar led by a facilitator ar discussion, using a remergency scenario statements, directed questions designed plan. If the OPO expman-made emergency plan, engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, a OPO's] emergency plan, engaging in the open companies of the open companies	narrated, clinically-relevant, and a set of problem messages, or prepared to challenge an emergency A's response to and maintain drills, tabletop exercises, and and revise the HHA's needed. 360] DPO must conduct exercises by plan. The OPO must do the chased, tabletop exercise or anually. A tabletop exercise is ad includes a group marrated, clinically relevant, and a set of problem messages, or prepared to challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from required testing exercise of the emergency event. It's response to and maintain tabletop exercises, and and revise the [RNHCI's and olan, as needed. 48]: RNHCI must conduct emergency plan. The RNHCI	E 03	39	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		555297	B. WING		04/27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-HEMET	1	BUILDING 02 COM	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
E 039	of problem statement prepared questions of emergency plan. (ii) Analyze the RNH maintain documenta and emergency every emergency plan, as This REQUIREMEN by: Surveyor: 46410 Based on document facility failed to particulated that was community by the failure to provindicated participation community-based expreparation in place emergency. This afferesidents in six of six Findings: During document revision Maintenance Director 4/27/23, the facility's Plan (EPP) was revision that it participated in an an community-based. Under the community-based.	nergency scenario, and a set ats, directed messages, or designed to challenge an CI's response to and tion of all tabletop exercises, and revise the RNHCI's needed. T is not met as evidenced review and interview, the cipate in a full-scale exercise abased. This was evidenced ide documentation that an in a full-scale exercise. This could result in escary planning and in the event of an excted staff and 112 of 112 of smoke compartments. View and interview with the or (MD) and Administrator on Emergency Preparedness ewed. PP failed to include ndicated that the facility nual full-scale exercise that is	E 039	The statements made in this Plan of Correction are not an admission to or agreement with the stated deficiencie. To remain in compliance with all Fede and State Regulations, the facility has taken or will take actions set forth in the following Plan of Correction.	s. eral s he an of l be re re r fect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		555297	B. WING _			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET		17	TREET ADDRESS, CITY, STATE, ZIP CODE 117 WEST STETSON AVENUE EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page			000	Development regarding the need to foll the community-based full-scale exercis and evaluate the event effectiveness. In-service includes the need to docume the outcomes, recommendations, even summary and other pertinent information in the facility safety committee reports. 4. Compliance will be monitored by Administrator and/or designee monthly ensure the requirement is met on an annual basis via review of safety committee reports submitted by Humar Resources Director. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for the purpose of analyzing and identifying trends, monitor for compliant and make recommendations.	ent t on to	
	Surveyor: 46410 K3 BUILDING: 01 K6 PLAN APPROVAL K7 SURVEY UNDER STRUCTURE TYPE: CONSTRUCTION TY SPRINKLERED. Resident Certified Be Resident Census: 112 The following reflects Department of Public Life Safety Code rece	.: 2/19/89 : 2012 EXISTING ONE STORY, 'PE V, FULLY ds: 178					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
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K 000 K 161 SS=D	National Fire Protecti Life Safety Code, 201 Health Care Facilities Representing the Cal Health: 46410 The facility is not in so	(CFR) §483.90(a)(b)(c)(j), on Association (NFPA) 101 - 2 Edition, and NFPA 99 - 5 Code, 2012 Edition. ifornia Department of Public ubstantial compliance with Long Term Care Facilities.		1161			5/25/23
35=D	Building Construction 2012 EXISTING Building construction	type and stories meets so therwise permitted by .6.7					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G 02	(X3) DATE SURVEY COMPLETED
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(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
K 161	system in accordance 19.3.5) Give a brief description construction, the numbasements, floors on location of smoke or approval. Complete splan of the building a This REQUIREMENT by: Surveyor: 46410 Based on observation failed to maintain the was evidenced by pethe building's wall and the passage of smok of the building to and residents in one of si NFPA 101, Life Safet 8.1 General. 8.1.1 Application. The set forth in this chapt construction and exis 8.3.5 Penetrations. To govern the materials used to protect throum membrane penetratic walls, and fire resistal assemblies. The proving the safet set of the province of	Maximum 1 story sust be sprinklered broved, supervised automatic e with section 9.7. (See on, in REMARKS, of the other of stories, including which patients are located, fire barriers and dates of sketch or attach small floor is appropriate. T is not met as evidenced and interview, the facility building construction. This metrations and damage to d ceiling. This could result in e and gases from one part ther. This affected 2 of 112 ix smoke compartments. Ty Code, 2012 Edition. The features of fire protection er shall apply to both new sting buildings. The provisions of 8.3.5 shall and methods of construction gh-penetrations and ons in fire walls, fire barrier ince-rated horizontal visions of 8.3.5 shall not isting materials and methods	K 10	The statements made in this Plan or Correction are not an admission to agreement with the stated deficienci. To remain in compliance with all Fed and State Regulations, the facility hat taken or will take actions set forth in following Plan of Correction. This P Correction constitutes the facility's Allegation of Compliance such that a stated deficiencies have been or will corrected by the specified date/s. K161 It is the practice of this facility to ensithat the building construction is maintained. 1. The leak in the closet in Room 10 repaired on 4/28/2023. The water damage to the ceiling in the restroom in Room 230 was repaired 4/28/2023.	or an es. Ideral as the Plan of all be Urre O was

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	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-HEMET	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
K 161	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		K 1	DEFICIEN	illing panel in on 4/28/2023. estroom wall in additional issues noted. established to be the need to eair any leaks or entitored by the door designee onthly x 3 presented surance (QAPI) for the lidentifying	
	approximately 2 incl ceiling panel near th Upon interview, the how the penetration 4. At 3:02 p.m., in th there were five pene- toilet paper holder. approximately half in measured approxim interview, the MD st	noom 232 there was an in by 2 inch penetration in the ine entry way of the room. MD stated he was not sure happened. The restroom of Room 232, estrations in the wall near the Three penetrations measured inch and two penetrations ately quarter inch. Upon ated the toilet paper holder aused the penetrations.		recommendations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 WEST STETSON AVENUE IEMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 324 SS=D	with NFPA 96, Standa and Fire Protection of Operations, unless: * residential cooking of appliances such as motoasters) are used for cooking in accordance * cooking facilities operate cooking facilities operate cooking facilities in a sum of the cooking facilities protection of the cooking facilities protection of the cooking facilities protection of the cooking facilities are sum of the cooking facilities protection.	nicrowaves, hot plates, food warming or limited e with 18.3.2.5.2, 19.3.2.5.2 en to the corridor in smoke 0 or fewer patients comply nder 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under 1. ected according to NFPA 96 sired to be enclosed as shall not be open to the 1.3.2.5.4, 19.3.2.5.1 through	K	324			5/25/23
	by: Surveyor: 46410 Based on observation failed to maintain the system. This was evid to the sprinkler nozzle installed as required part of 17A. This could result	is not met as evidenced and interview, the facility kitchen's fire suppression denced by the blow-off caps es above the stove not oper manufacture and NFPA t in grease build-up and es that could delay the			 K324 It is the practice of this facility to ensure the kitchen s fire suppression system maintained. 1. The blow-off caps to the sprinkler nozzles above the kitchen stove were immediately secured in place. 		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING _			04/	27/2023	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ	•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 324	extinguishing of a storstaff in one of six smooth of the protection of Coroperations, 2011 Edit 10.2.6 Automatic firebe installed in accordisting, the manufactur following standards w (4) NFPA 17A 12.1.2.3 The fire-extir require re-evaluation appliances are moved maintenance and clear appliances are return location prior to cooking disconnected fire-extitattached to the appliance accordance with the remanual NFPA 17A, Standard Extinguishing System 4.3.1.5 All discharge with caps or other suitentrance of grease varioreign materials into Findings: During tour with the Noon 4/26/23, the kitched 1. At 2:17 p.m., the blunozzles above the kitch properly secured. Upon the protection of the standard secured.	we top fire. This affected oke compartments. or Ventilation Control and numercial Cooking cion extinguishing systems shall ance with the terms of their rer's instructions, and the here applicable: Inguishing system shall not where the cooking of the purposes of aning, provided the ed to approved design no operations, and any inguishing system nozzles inces are reconnected in manufacturer's listed design for Wet Chemical s, 2009 Edition nozzles shall be provided table devices to prevent the apors, moisture, or other the piping. Indintenance Director (MD) in equipment was observed.	K3	324	2. This practice has the potential to affe 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 blowcaps 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 ma recommendations.	off		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING			04/	27/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	717 WEST STETSON AVENUE		
MANORCA	ARE HEALTH SERVICES	-HEMET		Н	EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODE DEFICIENCY)			(X5) COMPLETION DATE
					DEI ICIENCI)		
K 345	Continued From page	<u> 16</u>	K	345			
	· -						EIDEIDO
K 345 SS=D	CFR(s): NFPA 101	Festing and Maintenance	K	345			5/25/23
	 Fire Alarm System - 1	Testing and Maintenance					
		tested and maintained in					
		pproved program complying					
		s of NFPA 70, National					
		FPA 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, NFP	A 70, NFPA 72					
	This REQUIREMENT	is not met as evidenced					
	by:						
	Surveyor: 46410				K345		
					It is the practice of this facility to ensure	;	
		n and interview, the facility			the fire alarm system is maintained.		
		fire alarm system. This was					
		fire alarm system testing			The fire alarm company was contacted.	ed	
		esult in a delay during an			and requested to send the report from		
		Inction of the fire alarm			9/23/2022. The next scheduled fire ala		
	system. This affected				system test is scheduled for 5/23/2022.		
	residents in SIX OI SIX	smoke compartments.			A load voltage test was completed on 4/28/2023 for the fire alarm control pane	ام	
	NFPA 101 - Life Safe	ty Code, 2012 Edition			sealed lead acid batteries.	CI	
	<u>.</u>	alth care occupancies shall			odalou loud dold batteries.		
	be provided with a fire	•			2. This practice has the potential to affe	ect	
	accordance with Sect	-			facility residents. Education provided.		
		stem required for life safety			asing reciaemer _aasaasin promasai		
		ted, and maintained in			3. In-service education was provided to		
		applicable requirements of			the Maintenance Director by the		
		ectrical Code, and NFPA 72,			Administrator regarding the need to		
		nd Signaling Code, unless it			ensure the fire alarm system is		
		ng installation, which shall be			maintained and necessary testing is		
	permitted to be contir				completed timely.		
	 NFPA 72 - National F	ire Alarm and Signaling			4. Compliance will be monitored by the		
	Code, 2010 Edition				Maintenance Director and/or designee		
	14.3.1* Unless otherwise permitted by 14.3.2,				weekly x 3 weeks then monthly x 3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED			
		555297	B. WING		04/27/2023		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-HEMET		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
K 345	more often if required jurisdiction. Table 14.3.1: 3. Batteries (d) Sealed lead-acid: 9. Initiating devices (b) Duct detectors: S (e) manual fire alarm (f) Heat detectors: S (h) Smoke detectors: 14.4.5* Testing Frequently Unless otherwise per this Code, testing shad accordance with the more often if required jurisdiction. Table 14.4.5: 6. Batteries - fire alart (d) Sealed lead-acid (1) Charger test (Regafter manufacture or needed.): Initial/Reac (2) Discharge test (3) Initial/Reacceptance, (3) Load voltage test Semiannually Findings: During document revision and services of the purison of the puris	all be performed in schedules in Table 14.3.1 or d by the authority having Semiannually emiannually boxes: Semiannually emiannually semiannually semiannually uency. mitted by other sections of all be performed in schedules in Table 14.4.5, or d by the authority having m system type blace battery within 5 years more frequently as cceptance, Annually minutes): Annually Initial/Reacceptance,	K 345	months. Findings will be presented monthly to the Quality Assurance Performance Committee (QAPI) for purpose of analyzing and identifyin trends, monitor for compliance and recommendations.	r the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED	
		555297	B. WING		04/2	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 345 K 347 SS=D	detectors, heat detect boxes and smoke detectors and smoke detectors are semi-annual maintent did not provide a repostated the next date from a maintenance was school and the last load voltage for 12/7/22. Upon interpretation of the last load voltage for 12/7/22. Upon interpretation of the last load voltage Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systopen to corridors as residents in the evidenced by smoke mounted to the ceiling delay during an emer the smoke detectors. residents in two of six NFPA 101, Life Safetty	on records for the duct tors, manual fire alarm sectors. Upon interview MD company had come for the ance on 9/23/22, but they out of the inspection. MD also for the fire alarm system seduled for 5/23/23. The alarm system were missing one of two age tests for the fire alarm ead acid batteries. The date the etest record provided was erview, the MD stated the etest were done annually. The and interview, the facility smoke detectors. This was detectors not securely go and malfunction of this affected 2 of 112 a smoke compartments. Y Code, 2012 Edition	K 345	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 affer facility residents. The Maintenance	e	5/25/23
	19.3.4.1 General. He	alth care occupancies shall		Director and/or designee completed an	1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G 02	(X	(X3) DATE SURVEY COMPLETED	
		555297	B. WING			04/27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET		STREET ADDRESS, CITY, STATE, ZIP CO 1717 WEST STETSON AVENUE HEMET, CA 92545	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 347	be provided with a fire accordance with sect 9.6.1.3 A fire alarm syshall be installed, test accordance with the a NFPA 70, National Ele National Fire Alarm a is an approved existir permitted to be continually in the secondary of the secondary	e alarm system in ion 9.6 (stem required for life safety ted, and maintained in applicable requirements of ectrical Code, and NFPA 72, and signaling Code, unless it ag installation, which shall be nued in use. The Alarm Code, 2010 Edition of the period that the impairment so system is impaired. The period when a fire alarm of is impaired. Impairments to out-of-service events. If the maintained by the gnated representative for a the date the impairment is ired, mitigating measures mority having jurisdiction for the period that the completed or discontinued. The discontinued in the interview with the completed or discontinued.	К 3	inspection to identify any adunsecured smoke detectors issues noted. 3. In-service education was the Maintenance Director by Administrator regarding the ensure smoke detectors are 4. Compliance will be monit Maintenance Director and/o weekly x 3 weeks then mon months. Findings will be premonthly to the Quality Assur Performance Committee (Qurpose of analyzing and id trends, monitor for complian recommendations.	provided to y the need to e maintained. ored by the r designee thly x 3 esented rance API) for the entifying	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING _			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545		17 WEST STETSON AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 347	the closet was detach	om 122, a smoke detector in ned and hanging from the w, the MD stated he did not	K	347			
K 353 SS=D	smoke detector was he panel was lifted. Upon that a screw had probknow what happened Sprinkler System - March 1985.	e restroom of Room 317, a nanging lose and ceiling n interview, the MD stated pably got lose but didn't to the ceiling panel. aintenance and Testing	к	353			5/25/23
	Automatic sprinkler a inspected, tested, and with NFPA 25, Standa Testing, and Maintain Protection Systems. I maintenance, inspect	ing of Water-based Fire Records of system design, ion and testing are re location and readily					
	any non-required or p system. 9.7.5, 9.7.7, 9.7.8, an This REQUIREMENT by: Surveyor: 46410	oply source S information on coverage for partial automatic sprinkler			K353 It is the practice of this facility to ensure the automatic fire sprinkler system is)	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING _			04	/27/2023	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-HEMET		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTIO			(X5) COMPLETION DATE	
K 353	failed to maintain the system. This was evi up on sprinkler head detached from ceiling penetration around sithe malfunction and during an emergency and 112 of 112 resid compartments. NFPA 101: Life Safet 19.3.5.1 Buildings cobe protected through supervised automatic accordance with Sec permitted by 19.3.5.5 9.7.5 Maintenance at All automatic sprinkler required by this Code and maintained in ac Standard for the Insp Maintenance of Water Systems. NFPA 25: Standard from the Insp Maintenance of Water Systems. NFPA 25: Standard from Maintenance of Water Systems, 2011 Edition 5.2.1.1.1 * Sprinklers leakage; shall be free materials, paint, and be installed in the colupright, pendent, or standard for standard for the Insp Maintenance of Water Systems.	automatic fire sprinkler denced by dirt debris build deflectors, a sprinkler grand a crescent shape orinkler. This could result in delay on the sprinkler system or fire. This affected staff ents in six of six smoke y Code, 2012 Edition ntaining nursing homes shall out by an approved, e sprinkler system in tion 9.7, unless otherwise or and standpipe systems e shall be inspected, tested, cordance with NFPA 25, ection, Testing, and r-Based Fire Protection or the Inspection, Testing, Water-Based Fire Protection n shall not show signs of e of corrosion, foreign physical damage; and shall rect orientation (e.g., idewall). er that shows signs of any of	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 affer 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 ma recommendations.	d d ect er		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING _			04/	27/2023
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-НЕМЕТ		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 WEST STETSON AVENUE EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 363	the incorrect orientatic 5.2.1.1.4 Any sprinkles signs of leakage; is particularly sprinkles and signs of leakage; is particularly sprinkler manufacture loaded; or is in the important of the im	ler that has been installed in on shall be replaced. It shall be replaced that has a ainted, other than by the er, corroded, damaged, or proper orientation. and interview with the intenance Director (MD) on so were observed and fucted. closet of Room 122, a shed out of place creating a petration. Upon interview, the er needed to be adjusted. closet of Room 112, a ed and hanging from ceiling. It know what happened. com 320 a sprinkler was a up on deflector and glass the MD stated the sprinkler usted.		353			5/25/23
SS=D	CFR(s): NFPA 101						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG 02	I	(X3) DATE SURVEY COMPLETED	
		555297	B. WING _		 	04	/27/2023
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS,	, CITY, STATE, ZIP CODE		
MANORO	ADE LIEALTH SEDVIC	SEC LIEMET		1717 WEST STETS	SON AVENUE		
MANORC	ARE HEALTH SERVIC	ES-HEMEI		HEMET, CA 925	i45		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 363	required enclosure hazardous areas rand are made of 1 wood or other mat at least 20 minutes smoke compartmenthe passage of smoto rooms containing materials have postatches are prohib requirements do not contain fland Clearance betwee covering is not excomplying with 7.2 with a device capa when a force of 5 impediment to the devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6 shall be labeled are materials in compliance smoke compartmenthal window assemblies prinklered comparestrictions in area frames in window 19.3.6.3, 42 CFR and 485 Show in REMARK protection ratings, etc.	orridor openings in other than as of vertical openings, exits, or esist the passage of smoke 3/4 inch solid-bonded core erial capable of resisting fire for a Doors in fully sprinklered ents are only required to resist oke. Corridor doors and doors and floor set to be comply to auxiliary spaces that smable or combustible material. In bottom of door and floor seeding 1 inch. Powered doors 1.9 are permissible if provided able of keeping the door closed by the doors. Hold open see when the door is pushed or ed. Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors are permitted. Door frames are permitted. Door frames are permitted. Door frames are permitted. Fixed fire are allowed per 8.3. In ritments there are no	K	363			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 02 555297 B. WING 04/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE MANORCARE HEALTH SERVICES-HEMET **HEMET, CA 92545** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 363 Continued From page 24 K 363 Surveyor: 46410 K363 It is the practice of this facility to ensure Based on observation and interview, the facility corridor doors are not obstructed from failed to maintain the corridor doors. This was closing. evidenced by a corridor door that was obstructed from closing. This could delay the containment of 1. The utility dolly was immediately smoke and fire in the event of an emergency. removed from kitchen pantry door. This affected staff in one of six smoke compartments. 2. This practice has the potential to affect facility residents. The Maintenance Director and/or designee completed an Findings: inspection to ensure all corridor doors During facility tour and interview with were free from obstructions. No further Maintenance Director (MD) on 4/26/23, the issues noted. corridor doors were observed. 3. In-service education was provided to At 2:14 p.m., the Kitchen pantry door was the Dietary Staff by the Administrator obstructed from closing by a utility dolly. Upon regarding the need to have corridor door interview, the MD stated that the kitchen had just free from obstructions. received a shipment of supplies and the utility dolly was used to hold the door open while 4. Compliance will be monitored by the bringing in the supplies. 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 | Building Services - Other K 500 5/25/23 SS=D 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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG 02		(X3) DATE SURVEY COMPLETED	
		555297	B. WING _		04	/27/2023
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 500	' '	e 25 Cluded on Form CMS-2567.	K 5	00		
	by: Surveyor: 46410 Based on observation failed to maintain the manufacturer. This w washer machine whill created a hazardous Room. This affected compartments. NFPA 101, Life Safet 19.5.1.2 Existing instate to be continued in seasystems do not present to be continued in seasystems do not present principles. During facility tour and Maintenance Director building services were at 2:07 p.m., in the Lafront-loading washer around the loading downsher machine was manufactured by Girt stated the washer proseal around the loading the manufacture's O	allations shall be permitted rvice, provided that the ent a serious hazard to life. In dinterview with the r (MD) on 4/26/23, the e observed. In aundry Room there was a machine leaking water por. The front-loading observed to be pau. Upon interview, the MD obably needed to have the ng door replaced. In aundry Room there was a machine leaking water por. The front-loading observed to be pau. Upon interview, the MD obably needed to have the ng door replaced. In aundry Room there was a machine leaking water por. The front-loading observed to be pau. Upon interview, the MD obably needed to have the ng door replaced.		K500 It is the practice of this facility to electrical appliances are maintal according to manufacturer guide. 1. The seal on the front-loading machine was replaced on 5/19. 2. This practice has the potential facility residents. Education processed to the Laundry Staff and Maintena Director by the Administrator responded to use electrical appliance according to manufacturer guide. 4. Compliance will be monitore Maintenance Director and/or deweekly x 3 weeks then monthly months. Findings will be presessed monthly to the Quality Assurant Performance Committee (QAP purpose of analyzing and ident trends, monitor for compliance recommendations.	ained delines. g washing /2023. al to affect ovided. ovided to ance egarding the es delines. d by the esignee / x 3 ented ce l) for the ifying	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED		
		555297	B. WING		04/27/2023	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.	
K 500 K 914 SS=D	smell or if you suspect or defective." On page instructions manual, it leaking to clean the disposits or remains of persists, seal all of the the Authorized Technical or defective.	any abnormal noise or it that the machine is faulty e 43 of the operating t also states: "If the door is oor seal of any possible f linen If problem e water inlets and contact	K 50		5/25/23	
	Hospital-grade recept locations and where canesthesia is adminis installation, replacementesting is performed a documented performalisted as hospital-graditested at intervals not isolation monitors (LII intervals of less than actuating the LIM test which activates both valued LIM circuits with automanual test is performed and to 12 months. Line Line Line 12 months. Line 13.3.3.2 after any regulation of require repairs or modification area tested, and results (NFPA 99). This REQUIREMENT by: Surveyor: 46410	deep sedation or general tered, are tested after initial ent or servicing. Additional at intervals defined by ance data. Receptacles not de at these locations are exceeding 12 months. Line M), if installed, are tested at or equal to 1 month by switch per 6.3.2.6.3.6, visual and audible alarm. For mated self-testing, this ned at intervals less than or IM circuits are tested per pair or renovation to the stem. Records are ditests and associated as, containing date, room or		K914 It is the practice of this facility to ensur electrical receptacles are maintained p		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED	
		555297	B. WING _	B. WING		04/	27/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERVICES-HEMET				717 WEST STETSON AVENUE			
				Н	EMET, CA 92545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 914	Continued From page	e 27	K	914			
	per manufacturer. Thi monthly testing record This could result in el malfunction. This affe compartments and 11 Findings: During facility tour, do interview with the Mai 4/26/23, the electrical At 11:28 a.m., the fact testing documentation Interrupter (GFCI) record receptacles located in marked by the manufication The last GFCI test was	ocument review, and intenance Director (MD) on receptacles were observed.			 Testing was completed on the Grou Fault Circuit Interrupter receptacles on 4/28/2023. This practice has the potential to affer facility residents. Education provided. In-service education was provided to the Maintenance Director by the Administrator regarding the need to maintain electrical receptacles according to manufacturer guidelines. 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 	ect o	
		Essential Electric Syste	K	918	trends, monitor for compliance and ma recommendations.	ke	5/25/23
SS=D	Maintenance and Tes The generator or oth and associated equip service within 10 seco criterion is not met du process shall be prov capability for the life s Maintenance and test	Essential Electric System sting er alternate power source ment is capable of supplying onds. If the 10-second uring the monthly test, a sided to annually confirm this safety and critical branches. ting of the generator and performed in accordance					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
MANORCARE HEALTH SERVICES-HEMET (XA] ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			555297	B. WING _	WING		04/27/2023		
CA 92545 SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY	NAME OF PROVIDER OR SUPPLIER			·	STREET ADDRESS, (CITY, STATE, ZIP CODE			
CAJ ID SUMMARY STATEMENT OF DEFICIENCIES PREVIDER'S PLAN OF CORRECTION (AS)	MANORC	ADE HEALTH SEDVICE	C LIEMET		1717 WEST STETS	ON AVENUE			
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	WANORCA	ARE HEALIH SERVICE	3-HEIME I		HEMET, CA 9254	1 5			
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	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI)	(EACH	CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
This REQUIREMENT is not met as evidenced by: Surveyor: 46410 K918 It is the practice of this facility to ensure 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 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	K 918	Generator sets are i under load 30 minut day intervals, and exmonths for 4 continuunder load condition simulated cold start transfer of all EES locompetent personnes stored energy powe accordance with NF circuit breakers are program for periodic components is estalt manufacturer requiremaintenance and tereadily available. EE circuits are marked, separate from normathe possibility of dar source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (Name 111, 700.10 (NFPA 177). This REQUIREMENT by: Surveyor: 46410 Based on document facility failed to main generator. This was provide generator main could result in a delaresponse in the case affected staff and 11 smoke compartment.	inspected weekly, exercised es 12 times a year in 20-40 kercised once every 36 kercised automatic or manual coads, and are conducted by 21. Maintenance and testing of a sources (Type 3 EES) are in PA 111. Main and feeder inspected annually, and a seally exercising the colished according to ements. Written records of sting are maintained and 25 electrical panels and readily identifiable, and all power circuits. Minimizing mage of the emergency power consideration for new MFPA 99), NFPA 110, NFPA 70) T is not met as evidenced Treview and interview, the stain the emergency standby evidenced by the failure to saintenance records. This ay in the generator back up as of a power outage. This 2 of 112 residents in six of six ts.	KS	K918 It is the pract the emergence routinely mains of the second The 4-hour logold facility resides to the second the second the second facility resides to	ncy standby generator is intained. Ty electrolyte specific gravinpleted on 5/1/2023. Total test was completed or ince has the potential to affect the standard provided.	ity n ect		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		555297	B. WING _	B. WING		04/27/2023	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 WEST STETSON AVENUE EMET, CA 92545			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 918	9.1.3.1 Emergency G power systems shall I maintained in accorda Standard for Emerger Systems. NFPA 110, Standard in Power Systems, 2010 8.3.7.1 Maintenance of include the monthly to electrolyte specific gratesting shall be permi specific gravity when 8.3.8 A fuel quality testleast annually using to standards. 8.4.9 * Level 1 EPSS within every 36 month 8.4.9.1 Level 1 EPSS for the duration of its 4.2). 8.4.9.2 Where the ass 4 hours, it shall be perfer 4 continuous how 8.4.9.5 The minimum specified in 8.4.9.5.1, 8.4.9.7 Where the test combined with the an 3 hours shall be at not loading required by 8 hour shall be at not lenameplate kW rating Findings:	enerators and standby the installed, tested, and ance with NFPA 110, they and Standby Power for Emergency and Standby the Edition. The Idea and recording of the EPS. The Installed in Item of Item in Item The Item in Item in Item in Item The Item in Item in Item The Item in It	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 maintenance mendations.	,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		555297	B. WING	B. WING		04/	27/2023
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET		-НЕМЕТ	•		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 918	1. At 11:40 a.m., the f documentation indica electrolyte specific gr. the 80-kilowatt diesel last battery electrolyte unknown. Upon internot have the electroly records. 2. At 11:43 a.m., the f three-year 4-hour load diesel generator. The unknown. Upon internot have the 4-hour local Electrical Equipment.	acility failed to provide ting that the monthly battery avity test was conducted on generator. The date of the e specific gravity test was view, the MD stated he did te specific gravity test acility failed to provide a d test for the 80-kilowatt last 4-hour load test was view, the MD stated he did		918			5/25/23
SS=D	used for components patient-care-related e (PCREE) assembles by qualified personne 10.2.3.6. Power strip may not be used for relectronics), except ir rooms that do not use PCREE meet UL 136 strips for non-PCREE (outside of vicinity) m care rooms, power st standards. All power precautions. Extensio substitute for fixed with Extension cords used immediately upon cor	ent care vicinity are only of movable lectrical equipment that have been assembled I and meet the conditions of s in the patient care vicinity non-PCREE (e.g., personal n long-term care resident e PCREE. Power strips for 3A or UL 60601-1. Power in the patient care rooms eet UL 1363. In non-patient rips meet other UL strips are used with general on cords are not used as a					

PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		555297	B. WING _	B. WING		04/:	27/2023
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 WEST STETSON AVENUE EMET, CA 92545	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 920	(NFPA 70), 590.3(D) This REQUIREMENT by: Surveyor: 46410 Based on observation failed to maintain the was evidenced by the This could result in ar 46 of 112 residents in compartments. NFPA 101 Life Safety 19.5.1 Utilities. 19.5.1.1 Utilities shall of Section 9.1. 9.1 Utilities. 9.1.2 Electrical Systel equipment shall be in National Electrical Co are approved existing permitted to be contin NFPA 70 National Ele 400.8 Uses Not Perm	0.2.4 (NFPA 99), 400-8 (NFPA 70), TIA 12-5 is not met as evidenced and interview, the facility electrical equipment. This e use of extension cords. a electrical fire. This affected one of six smoke Code, 2012 Edition comply with the provisions accordance with NFPA 70, de, unless such installations installations, which shall be eved in service. actrical Code, 2011 Edition itted. unless specifically exible cords and cables shall llowing: the fixed wiring of a d interview with the (MD) on 4/26/23, the vas observed.	KS	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 affer facility residents. The Maintenance Director completed a visual inspection 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 story 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 main recommendations.	ect of aff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		555297	B. WING	B. WING		04/27/2023		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			17	REET ADDRESS, CITY, STATE, ZIP CODE 17 WEST STETSON AVENUE EMET, CA 92545				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 920	plugged into a white or resident's night stand stated he did not kno was being used by the	e 32 h by 7 inch Christmas tree extension cord on top of the l. Upon interview, the MD w that the extension cord e resident in Room 301 Testing and Maintenanc		920			5/25/23	
SS=D	CFR(s): NFPA 101 Electrical Equipment Requirements The physical integrity current, and touch current (PCREE) is performed Testing intervals are uprotocols. All PCREE is tested in accordance before being put into or modification. Any selectrical appliances with NFPA 99 as a commanuals, instructions by the manufacturer required by 10.5.3.1. development of a proequipment maintenari instructions and main available, and safety operating instructions legible. A record of el repairs, and modificat period of time to demaccordance with the responsible for the teof electrical appliance training.	- Testing and Maintenance r, resistance, leakage rrent tests for fixed and related electrical equipment d as required in 10.3. established with policies and used in patient care rooms ce with 10.3.5.4 or 10.3.6 service and after any repair system consisting of several demonstrates compliance emplete system. Service or, and procedures provided include information as and are considered in the igram for electrical ince. Electrical equipment intenance manuals are readily labels and condensed on the appliance are ectrical equipment tests, tions is maintained for a intensity policy. Personnel sting, maintenance and use					0.20,20	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
		555297	B. WING		04/27/2023	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 WEST STETSON AVENUE HEMET, CA 92545			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.	
K 921	by: Surveyor: 46410 Based on document r facility failed to mainta Electrical Equipment evidenced by electrica testing and maintenal could result in a malfu equipment. This affect six of six smoke comp NFPA 99 - Health Car Edition 10.3.1* Physical Integ the power cord assen cord, attachment plug be confirmed by visua 10.5.5.2* The physica attachment plug, and confirmed at least and and other appropriate 10.5.2.1 Testing Inter 10.5.2.1.1 The facility protocols for the type testing for patient care equipment. 10.5.2.1.2 All patient equipment used in pat tested in accordance before being put into after any repair or moc compromised electric 10.5.6.3 Test Logs. A repairs shall be maint	eview and interview, the ain the Patient-Care Related (PCREE). This was all equipment not meeting nee requirements. This unction of the electrical ted 112 of 112 residents in partments. The Facilities Code, 2012 Trity. The physical integrity of ably composed of the power and cord-strain relief shall all inspection. If integrity of the power cord, cord-strain relief shall be aually by visual inspection tests. The visual inspection tests. The visual inspection tests and of test and intervals of e-related electrical tient care rooms shall be with 10.3.5.4 or 10.3.6 service for the first time and diffication that might have all safety. To provide the service and ained and kept for a period with a health care facility's	K 92	It is the practice of this facility to ensur the Patient-Care Related Electrical Equipment is maintained. 1. Testing and maintenance of the oxy 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-Carelated Electrical Equipment is tested and maintained. 4. Compliance will be monitored by the Maintenance Director and/or designed 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 maintenance mendations.	gen er v	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG 02		(X3) DATE SURVEY COMPLETED			
		555297	B. WING _			04/27/2023		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-HEMET			•	STREET ADDRESS, CITY, STATE, ZIF 1717 WEST STETSON AVENUE HEMET, CA 92545	CODE	, 0.2.72020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (((EACH CORRECTIVE A:	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
K 921	Maintenance Director PCREE maintenance requested. At 11:27 a.m., the par maintenance and tes requested for the oxy beds, and power cord maintenance docume interview, the MD sta	iew and interview with the r (MD) on 4/27/23, the e documents were tient electrical equipment ting documents were gen concentrators, hospital	KS	021				