4/5/18
approved
0616

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

PRINTED: 03/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. BUILDING _____ B. WING _____	03/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY OAKS POST ACUTE CARE CENTER	3850 E. ESTHER ST. LONG BEACH, CA 90804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following represents the findings of the Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations 483.73, Requirement for Long Term Care Facilities. Representing the Department of Public Health: Evaluator number: 16279, REHS, HFE I Resident census: 53	E 000	"This plan of correction is prepared as required by law. By submitting the Plan of Correction, **Regency Oaks Post Acute Care Center** does not admit that the deficiency listed in this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that from the basis of the deficiency."	
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its	E 009	**E Tag identifier: E 009** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this practice. -Administrator was able to get in touch with the Emergency Management and Response Information Sharing and Analysis Center on 3-22-18 and the facility is in the division of Homeland Security's data base. The information is also now in the facility's Emergency Preparedness Plan. **Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4-2-18

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

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E 009	Continued From page 1 participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's [illegible] in the event of an emergency. This REQUIREMENT is [illegible] met as evidenced by: Based on interview and record review, the facility failed to provide documentation of the facility's efforts to contact local, Regional, State, and Federal emergency preparedness officials' and its participation in collaborative and cooperative planning efforts. The facility did not have any documentation to verify [illegible] had contact with the State and Federal emergency preparedness officials' regarding any cooperative planning. The lack of a collaborative emergency preparedness cooperative plan could delay or halt any care and services to the residents, during an emergency. Findings: On March 10, 2018, at [illegible], a review of the facility's emergency preparedness documentation was conducted. It was noted that there was no documentation to verify the facility had made contact with the local, State, and Federal emergency preparedness officials' regarding any cooperative planning. On March 10, 2018, at [illegible], an interview was conducted with the Administrator regarding facility's efforts to contact local, State, and Federal emergency preparedness officials' regarding any cooperative planning efforts. It was indicated that there was no documentation to verify the facility had [illegible] contact with the local,	E 009	-All residents have the potential to be affected by the deficient practice. -Administrator educated staff on 3-23-18 on the update to our Facility Emergency Plan. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Administrator will review the Emergency Preparedness Plan quarterly and assure that changes necessary are updated and will alert staff as needed. **Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** -Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Completion Date(s): 4/02/2018**	4-2-18

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E 009 Continued From page 2

State and Federal emergency preparedness officials'. The administrator stated that he did not have any documentation to show the facility contacted the local, State, and Federal emergency preparedness officials'. At the end of the interview, the administrator stated he would contact the local emergency preparedness officials to develop a collaborative and cooperative plan.

E 023 SS=C Policies/Procedures for Medical Documentation
CFR(s): 483.73(b)(5)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

*[For RNHCIs at §483.70(i)] Policies and procedures (5) A system of medical documentation that does the following:
(i) Preserves patient information.
(ii) Protects confidentiality of patient information.
(iii) Secures and maintains the availability of

E 009

E Tag Identifier: E 023

Immediate corrective action(s) for those Residents affected by the deficient practice:

-No residents were affected by this deficient practice.

-Administrator implemented a policy addressing a system of medical documentation to protect confidentiality of patient information which was reviewed and approved by the quality assurance team on 3-27-18.

Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:

-All residents have the potential to be affected by the deficient practice.

-Policy and Procedure was added to the facility's Emergency Preparedness Plan.

Administrator made staff aware of the additional information on 3-23-18

Facility measures and systemic changes to ensure the deficient practice does not recur:

-Administrator will review the Emergency Preparedness Plan quarterly and assure that changes necessary are updated and will alert staff as needed.

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E 023	Continued From page 5 records. *[For OPOs at §486.33...] policies and procedures: (2) A system for medical documentation that protects potential and actual donor information, [illegible] confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop emergency preparedness policies and procedures for the emergency plan that protects and secures the confidentiality of patient information and maintains the availability of records. The lack of this emergency preparedness policy could cause confusion and delay care and services to the residents during an emergency. Findings: On March 10, 2018, at [illegible] a review of the facility's emergency [illegible] documentation was conducted. It was [illegible] there was no documentation to [illegible] facility had a policy addressing a system of medical documentation that protects confidential patient information. On March 10, 2018, at [illegible] an interview was conducted with the administrator regarding the facility's medical [illegible] information, during an emergency. It was [illegible] there was no documentation to verify [illegible] had developed a policy that protects [illegible] confidentiality of patient information. At the conclusion of the interview, the administrator [illegible] develop an emergency preparedness plan that addresses the	E 023	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Date of Compliance: 4/02/18**	4-2-18

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E 023 Continued From page 4
protection and security of the medical documentation.

E 026 SS=C Roles Under a Waiver Declared by Secretary
CFR(s): 483.73(b)(5)

[(b) Policies and procedures. [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (e)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(8) [(6) (6)(C)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[For RNHCIs only. Policies and procedures. (8) The role of an RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care at an alternative care site identified by emergency management officials.]
This REQUIREMENT is not met as evidenced by
Based on interview and document review, the facility failed to develop an emergency preparedness policy to address the facility's role under a waiver declared by the Secretary of Health and Human Services (HHS) in accordance with Section 1135 of the Social Security Act for alternative care and treatment at an alternate care site identified by

E 023

E 026

E Tag Identifier: E 026

Immediate corrective action(s) for those Residents affected by the deficient practice:

-No residents were affected by this deficient practice.

-The facility developed an emergency preparedness policy addressing the facility's role under the waiver declared by the Secretary of Health and Human Services (HHS), in accordance with Section 1135 of the Social Security Act on 3-22-18. This policy states the transfer agreements to alternative care sites identified by emergency management officials. This policy was added to the Facility Emergency Preparedness Plan.

Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:

All residents have the potential to be affected by the deficient practice.

-Administrator educated staff on 3-23-18 on the update to our Facility Emergency Plan.

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E 026	Continued From page 5 emergency management officials. The lack of this emergency policy could delay care and services to the residents, during an emergency. Findings: On March 10, 2018, at 1:30 p.m., a review of the facility's emergency preparedness documentation was conducted. It was noted there was no documentation to indicate the facility had an emergency policy on what the facility's role is under a waiver declared by the Secretary of HHS, in accordance with Section 1135 of the Social Security Act. (When the President of the United States declares a disaster or emergency, under the National Emergencies Act, the Secretary of HHS declares a public health emergency under Section 319 of the Public Health Service Act. Under Section 1135 of the Social Security Act, the Secretary is authorized to temporarily waive or modify certain Medicare and Medicaid requirements to ensure that sufficient health care and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area.) On March 10, 2018, at 3:05 p.m., an interview was conducted with the administrator regarding the facility's emergency preparedness documentation, specifically a policy to address the facility's role when the Secretary of HHS authorizes a temporarily waive or modification to ensure that sufficient health care and services are available to meet the needs of residents, during an emergency. At the end of the interview, the administrator stated that he had not decided whether the facility would develop a policy for this waiver, or decline the waiver. The administrator stated he would decide and write a policy	E 026	**Facility measures and systemic changes to ensure the deficient practice does not recur:** Administrator will review the Emergency Preparedness Plan quarterly and assure that changes necessary are updated and will alert staff as needed. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Date of Compliance: 4/02/18**	4/2/18

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E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an emergency preparedness communication plan to include the proper State agencies. The facility's communication plan did not have the name and telephone number for the State ombudsman's office. The lack of this official contact information could delay or halt any care	E 031	**E Tag Identifier: E 031** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this deficient practice. The State Ombudsman's phone number was updated in the Facility's Emergency Preparedness Communication Plan on 3-22-18. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents have the potential to be affected by the deficient practice. -Administrator educated staff on 3-23-18 on the update to our Facility Emergency Plan. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Administrator will review the Emergency Preparedness Plan quarterly and assure that changes necessary are updated and will alert staff as needed.	

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E 031	Continued From page 7 and services to the residents, during an emergency. Findings: On March 10, 2018, at 1:30 p.m., a review of the facility's emergency preparedness documentation was conducted. It was noted the State ombudsman's office and telephone number were not included in the emergency communication plan (Ombudsman is a public official who represents the interests of the public, or patients, by investigating, addressing and attempting to resolve complaints for the public, or patients.) On March 10, 2018, at 3:05 p.m., an interview was conducted with the administrator regarding facility's emergency preparedness communication plan. It was stated that the State ombudsman's office and telephone number was not included in the emergency communication plan. At the end of the interview, the administrator stated he would revise the communication plan and add the State ombudsman's office and telephone number.	E 031	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Date of compliance: 4/02/18** **E Tag Identifier: E 036** **Immediate corrective action(s) for those Residents affected by the deficient practice:**	4-2-18
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036	-No residents were affected by this deficient practice -The annual trainings from the fire chief was last conducted on 1-16-18 for the 11-7 shift, 2-13-18 for the 7-3 shift and 2-17-18 for the 3-11 shift. A copy of these trainings were added to the Facility's Emergency Preparedness Plan on 3-22-18	

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E 036	Continued From page 8 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an emergency preparedness training and testing program that based on the emergency plan, risk assessment, policies and procedures, and the communication plan. The facility did not have any documentation to verify the facility had an emergency preparedness training and testing program. The lack of an emergency preparedness training and testing program could delay or halt any care and services	E 036	**Plan: Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents have the potential to be affected by the deficient practice. -Emergency Trainings are done on a quarterly basis using different disasters. As they are done, a copy of the training will be added to the Facility's Emergency Preparedness Plan. -Administrator educated staff on 3-23-18 on the update to our Facility Emergency Plan. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Administrator will review the Emergency Preparedness Plan quarterly and assure that necessary changes are updated and will alert staff as needed. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Date of Compliance: 4/02/18** 4-2-18	

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E 036	Continued From page 9 to the residents, during an emergency. Findings: On March 10, 2018, at 1:30 p.m., a review of the facility's emergency preparedness documentation was conducted. It was noted there was no documentation to verify the facility had an emergency preparedness training and testing program. On March 10, 2018, at 3:05 p.m., an interview was conducted with the administrator regarding the facility's emergency preparedness training and testing program. The administrator stated there was no documentation to verify the facility had an emergency preparedness training and testing program. At the end of the interview, the administrator stated he would develop and implement an emergency preparedness training and testing program.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037	**E Tag Identifier: E 037** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this deficient practice Administrator conducted a training on 3-23-18 to staff regarding the Facility's Emergency Preparedness Plan with a demonstration of the different sections as well all of the procedures. Also educated staff on the location of the emergency plan. A copy of the staffs participants were added to the Facility's Emergency Preparedness Plan after the staff meeting.	

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E 037	Continued From page 10 *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037	**Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents have the potential to be affected by the deficient practice. -Emergency Trainings are done upon orientation of new employees. Disaster trainings are also done on a quarterly basis. As they are done, a copy of the training will be added to the Facility's Emergency Preparedness Plan. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Administrator will review the Emergency Preparedness Plan quarterly and assure that necessary changes are updated and will alert staff as needed. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Date of Compliance: 4/02/18**	4-2-18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. BUILDING _____ B. WING _____	03/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 11	E 037		

expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d).](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must

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E 037	Continued From page 12 include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct initial training in emergency preparedness policies and procedures to all new	E 037		

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E 037	Continued From page 13 and existing staff, provide emergency preparedness training at least annually, and maintain documentation of the training. The lack of this emergency training could delay care and services to the residents, during an emergency. Findings: On March 10, 2018, at 1:30 p.m., a review of the facility's emergency preparedness documentation was conducted. It was noted that there was no documentation to indicate the facility had conducted an initial training in emergency preparedness policies and procedures to all staff, provide annual emergency preparedness training, and maintained documentation of this training. On March 10, 2018, at 3:05 p.m., an interview was conducted with the administrator regarding the annual facility's emergency preparedness training and documentation of the training. The administrator stated the facility had conducted disaster drills and thought this met the requirement for this regulation. It was stated that the emergency preparedness policies and procedures training is more specific than disaster training. At the end of the interview, the administrator stated the facility would conduct the initial emergency preparedness policies and procedures training for all the staff, and maintain the documentation of this training.	E 037		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the	E 041		

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E 041	Continued From page 14	E 041		

policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e)
(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)
Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)
Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

E Tag Identifier: E 041

Immediate corrective action(s) for those Residents affected by the deficient practice:

-No residents were affected by this deficient practice.

-Administrator implemented a policy regarding the emergency power's fuel source on 3-22-18 and added it to the Facility Emergency Plan. In the event of an emergency, Dion & Sons, Inc will supply the emergency fuel.

Plan Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:

-All residents have the potential to be affected by the deficient practice.

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E 041	Continued From page 15 *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g)] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.	E 041	Policy and Procedure was added to the facility's Emergency Preparedness Plan. -Administrator made staff aware of the additional information on 3-23-18. **Facility measures and systemic changes to ensure the deficient practice does not recur:** -Administrator will review the Emergency Preparedness Plan quarterly and assure that necessary changes are updated and will alert staff as needed. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Updates to Emergency Preparedness Plan will be discussed and will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Date of Completion: 4/02/18** 4-2-18	

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E 041	Continued From page 16 (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6 2009. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a detailed emergency preparedness policy regarding the emergency power's fuel source. The facility's policy did not have a plan to maintain an onsite fuel source to power the emergency generator and keep the emergency power systems operational, during an emergency. The lack of this emergency preparedness policy could delay care and services or cause harm to the residents, during an emergency. Findings: On March 10, 2018, at 1:30 p.m., a review of the facility's emergency preparedness documentation was conducted. It was noted that the facility's emergency power policy did not indicate how the facility would maintain an onsite fuel source to power the emergency generator to operate during an emergency. On March 10, 2018, at 3:05 p.m., an interview was conducted with the administrator regarding the facility's emergency power policy. It was stated that the facility did not have specific details to indicate how the facility would maintain an onsite fuel source in the event an emergency would occur for an extended period of days. At the end of the interview, the administrator stated	E 041		

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E 041	Continued From page 17 he would revise the emergency generator policy to include a plan to maintain an onsite fuel source to power the emergency generator.	E 041		

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K 000	INITIAL COMMENTS This facility was surveyed under 42 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: Evaluator number: 16279, REHS, HFE I Resident census: 53 Bed capacity: 99 Highest Scope & Severity: F	K 000	"This plan of correction is prepared as required by law. By submitting the Plan of Correction, **Regency Oaks Post Acute Care Center** does not admit that the deficiency listed in this form exists, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that form the basis of the deficiency."	4-2-18
K 300 SS=E	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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 citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Exterior Roofs, Canopies, Porte-Cochere, Balconies, Decks, or Similar Projections, 8.15.7.1: Sprinklers shall be	K 300		

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

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

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K 300	Continued From page 1 installed under exterior roofs, canopies, porte-cochères, balconies, decks, or similar projections exceeding 4 feet (1.2 m) in width. Based on observation and interview, the facility failed to ensure a sprinkler system was installed under two canopies that exceeding 4 feet (ft.) in width. In the event of a fire, an exterior roof, or canopy, that does not have a sprinkler system will not ensure safe evacuation and protection for the occupants of the building. Findings On March 10, 2018, between 8:05 a.m. to 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, the following were observed: 1. At 10:15 a.m., there was a canopy cover observed at the parking lot entrance area. This entrance area was also the facility's designated smoking area. This canopy was a royal blue cloth material that was directly attached to the building and appeared to have a width over 4 feet (ft). A closer observation showed there was no sprinkler system attached to this covering to protect the structure or the occupants, in the event of a fire. It was also noted there was no tag on the canopy to indicate if it was fire resistant. At 10:16 a.m., a brief interview was conducted with the maintenance supervisor regarding this canopy. The maintenance supervisor stated that the canopy appeared to be 6 ft long and 6 ft wide. 2. At 10:20 a.m., there was a canopy cover at the front entrance. This canopy was made of the	K 300	**K Tag identifier: K 300** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this deficient practice. -The blue canopies in front of the building as well as the one in the parking lot were removed on 3-12-18. **Plan: Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All residents have the potential to be affected. -Administrator and Maintenance Director assessed the outskirts of the facility and no other areas of the building were affected.	4-2-18

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K 300	Continued From page 2 same (royal blue) cloth material that was directly attached to the building and appeared to have a width over 4 ft. A closer view revealed there was no sprinkler system attached to this covering to protect the structure or the occupants, in the event of a fire. It was also noted there was no tag on the canopy to indicate if it was fire resistant. At 10:21 a.m., a brief interview was conducted with the maintenance supervisor regarding this canopy. The maintenance supervisor stated that the canopy appeared to be 8 ft. long and 6 ft wide. During this LSC tour, an interview was conducted with the maintenance supervisor regarding these two canopies. The maintenance supervisor stated this canopy had been in place since he started working at the facility, 4 years ago. He further added that he did not have any documentation to show whether the canopies were fire resistant or not. On March 10, 2018, at 12:55 p.m., an interview was conducted with the administrator and the maintenance supervisor regarding this canopy. The administrator and maintenance supervisor was informed that any covering or roofing that had a width which extended beyond 4 ft. from the structure, must have a sprinkler system. During this interview, the administrator stated that the facility will remove these canopies. The deficient practice affected two of three smoke compartments. On March 10, 2018, the above findings were acknowledged during the survey process and during the exit conference, with the administrator.	K 300	**Facility measures and systemic changes to ensure the deficient practice does not recur:** -If canopies are reconsidered, the company will have to provide information that they are fire retardant, or a sprinkler will need to be added. **Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** -Findings from facility rounds and quality assurance checks will be brought forward to the monthly Quality Assurance and Performance Improvement meetings and will be submitted, discussed and documented for further recommendations. **Completion Date(s): 4/02/2018**	4-2-18

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K 300	Continued From page 3 and the maintenance supervisor.	K 300		4-2-18
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321	**K Tag Identifier: K 321**	

Hazardous Areas - Enclosure
Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.
Describe the floor and zone locations of hazardous areas that are deficient in REMARKS 19.3.2.1, 19.3.5.9

Area — Automatic Sprinkler — Separation: N/A
a. Boiler and Fuel-Fired Heater Rooms
b. Laundries (larger than 100 square feet)
c. Repair, Maintenance, and Paint Shops
d. Soiled Linen Rooms (exceeding 64 gallons)
e. Trash Collection Rooms (exceeding 64 gallons)
f. Combustible Storage Rooms/Spaces (over 50 square feet)
g. Laboratories (if classified as Severe Hazard - see K322)
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that hazardous areas were maintained with a one-hour fire rated

Immediate corrective action(s) for those Residents affected by the deficient practice:

-No residents were affected by this deficient practice.

-Maintenance Supervisor installed a self latching device on 3-9-18

Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:

-All other doors were tested by the maintenance director and no other doors were affected by the deficient practice.

Facility measures and systemic changes to ensure the deficient practice does not recur:

-Maintenance Director and Administer will make facility rounds weekly and test doors to assure that they latch appropriately.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY OAKS POST ACUTE CARE CENTER	3650 E. ESTHER ST. LONG BEACH, CA 90804

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 construction, regarding one door missing a self-closing device. In the event of a fire, the separation of the medical record office would not be achieved, which would allow smoke and/or fire to travel from one area to another. Findings: On March 10, 2018, between 8:05 a.m. to 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 10:05 a.m., it was observed that there was a large amount of paper products throughout the medical records office. Upon closer observation, it was noticed that the medical records office door did not have a self-closing device to automatically close, latch and maintain the door in the closed position. During a brief interview with the maintenance supervisor, he stated that the medical records office appeared to be 20 square feet [sq. ft.] by 20 sq. ft. [equaling 400 sq. ft.] (According to NFPA 101, Life Safety Code Handbook, 2012 Edition, Protection from Hazards, 19.3.2.1.5, all hazardous areas are rooms and spaces larger than 50 sq. ft. used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction, and shall have doors that are self-closing.) During this LSC tour, the maintenance supervisor was informed that because of the large amount of paper products in the medical records office, the door needed a self-closing device to keep the door closed. At the end of the interview, the maintenance supervisor stated he would install a self-closing device to this door as soon as	K 321	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Any deficient practice will be corrected immediately, and the findings of the facility rounds will be documented and submitted at the Monthly Quality Assurance and Performance Improvement meeting. **Date of Compliance: 4/02/18**	4-2-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/10/2018

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K 321	Continued From page 5 possible. The deficient practice affected one of three smoke compartments. On March 10, 2018, the above findings were acknowledged during the survey process and during the exit conference with the administrator and the maintenance supervisor.	K 321		4-3-18
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7.5.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure and maintain 18 inch clearances below the sprinkler deflectors at storage areas throughout the facility. Unobstructed areas below the sprinkler deflectors will ensure an effective	K 351	**K Tag Identifier: K 351** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -The two heavy blankets were removed immediately on 3-10-18 -Cardboard boxes were removed from the top of the closet on 3-10-18 -The two spray bottles were removed from the janitors closet on 3-10-18 **Plan Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -Maintenance Director facilitated rounds to assure that no other items were placed within 18 inches of deflectors. No other areas were affected.	

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K 351	Continued From page 6 response of the fire sprinklers to provide water discharge in a horizontal plane and will function as designed in case of fire emergencies. Findings: On March 10, 2018, between 8:05 a.m. to 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, the following were observed: 1. At 9:20 a.m., it was observed that there were two heavy blankets stored on top of the resident closet, inside Room 19 (One resident was inside this room.). These blankets were 8 inches away from the detector. 2. At 9:25 a.m., it was observed that there was a cardboard box (measuring 24 inches by 24 inches by 24 inches) stored on top of the resident closet, inside Room 25 (Two residents were inside this room.). This box was 12 inches away from the detector. 3. At 10:03 a.m., it was observed that were four plastic spray bottles stored on a wall-mounted shelf, inside the janitor's closet (across from the beauty salon). These bottles were 10 inches away from the detector. During the LSC tour, the maintenance supervisor was informed that there should be an 18-inch clearance between the deflectors and the nearest objects. The maintenance supervisor stated these items would be removed, immediately. The deficient practice affected two of three smoke compartments.	K 351	**Facility measures and systemic changes to ensure the deficient practice does not recur:** -Maintenance Director and Administer will make facility rounds weekly and assure that object are within 18 inches from deflectors. -Administrator and Maintenance Director educated staff on the importance of keeping objects 18 inches away from the deflectors. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Any deficient practice will be corrected immediately, and the findings of the facility rounds will be documented and submitted at the Monthly Quality-Assurance and Performance Improvement meeting. **Date of Compliance: 4/02/18**	4-2-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 7 On March 10, 2018, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 351		4-2-18
K 353 SS=F	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: Based on interview and record review, the facility failed to provide documentation that the facility's sprinklers had been replaced or tested by a recognized testing laboratory, in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. Sprinklers that have been in service for 50 years or more should be replaced or tested.	K 353	**K Tag Identifier: K353** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No Residents were affected by the deficient practice. -All sprinkler heads were replaced between October and November 2010 by Fire Fox Protection Inc. per Field Work Order dated 11.3.10 which is within compliance of the 50- year time period. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All 319 sprinkler heads were replaced in 2010. -The documented proof will be kept on file with the Maintenance Director.	

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K 353	Continued From page 8 Findings: On March 10, 2018 at 12:30 p.m., review of the facility's fire inspection reports and documentation was conducted. During this review, it was noticed that the sprinkler inspection report, dated November 6, 2017, was conducted by an approved service company, and stated that the facility was constructed in 1963. It was also noticed that there was no documentation to show the facility's sprinklers were replaced or tested by a recognized testing laboratory. (According to NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.1.1.1 where sprinklers have been in service for 50 years, they shall be replaced or representative samples from one or more sample areas shall be tested by a recognized testing laboratory.) On March 10, 2018, at 1:15 p.m., an interview was conducted with the administrator and the maintenance supervisor regarding the 50-year sprinkler test. It was mentioned that facilities built over 50 years ago are required to test or replace their sprinklers and the testing must be conducted by a recognized testing laboratory. At the end of the interview, the maintenance supervisor stated that he would contact an approved testing laboratory and have the sprinklers tested, as soon as possible. The maintenance supervisor added that he would wait for the test results to see if the sprinklers need to be replaced. The deficient practice affected three of three smoke compartments. On March 10, 2018, the above findings were	K 353	**Facility measures and systemic changes to ensure the deficient practice does not recur:** -Maintenance Director will continue to test the facility sprinkler system monthly. -Facility will continue to utilize the Fire Fox company to do quality assurance tests quarterly on the sprinkler system. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:**	4-2-18

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K 353	Continued From page 9 acknowledged during the survey process and during the exit conference with the administrator and the maintenance supervisor.	K 353		4-2-18
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by Based on observation and interview, the facility failed to maintain portable fire extinguishers in all health care facilities in accordance with NFPA 10 Standard for Portable Fire Extinguishers. The portable fire extinguisher, located at facility's designated smoking area, was the improper type which could harm the residents, visitors and staff, in the event of a fire. Findings: On March 10, 2018, between 8:35 a.m. to 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 10:10 a.m., it was observed that there was a designated smoking area located at the parking lot entrance. It was noticed that there was one portable wall-mounted fire extinguisher at this smoking area. Closer observation showed this portable fire extinguisher was a Class ABC fire extinguisher (an extinguisher that disperses a dry chemical used to put out fires of wood, clothes,	K 355	**K Tag Identifier: K355** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No Residents were affected by the deficient practice -The ABC extinguisher was replaced with a Class A Fire extinguisher immediately on 3-10-18 **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All other extinguishers were examined by the Maintenance Supervisor and no other extinguisher location was affected	

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K 355	Continued From page 10 gas, oil, appliances and heaters. At 10:12 a.m., an interview was conducted with the maintenance supervisor regarding the fire extinguisher at this designated smoking area. The maintenance supervisor was informed that the Class ABC fire extinguisher was the wrong type of fire extinguisher for the smoking area. It was mentioned that if a smoker (resident, staff and/or visitor) got themselves on fire, the Class ABC fire extinguisher would dispense the dry chemical and could have a negative effect on the smoker, possibly suffocating the person. The correct fire extinguisher should be a Class A fire extinguisher (an extinguisher that disperses pressurized water used to put out fires of wood, paper and clothes). The maintenance supervisor stated he would replace the current fire extinguisher with an approved water-based fire extinguisher as soon as possible. The deficient practice affected one of three smoke compartments. On March 10, 2018, the observation findings were acknowledged during the survey process and during the exit conference with the administrator and the maintenance supervisor.	K 355	**Facility measures and systemic changes to ensure the deficient practice does not recur:** -Maintenance Director will continue to monitor the extinguishers on a monthly basis to assure the correct ones are being used. -Facilty will continue to utilize the Fire Fox Inc. company to do quality assurance rounds quarterly. **Facility plan to monitor corrective actions and sustain compliance; integrate QA Process:** -Results from the monthly rounds will be collected for the month and will be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of compliance:** 4/02/18	4-2-18
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of moved & patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified persons and meet the conditions of	K 920	**K Tag Identifier: K 920** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -Electric Fan and adding machine cords were removed on 3-10-18. -The comestic electrical extension cord was removed from the administrative office on 3-10-18.	

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K 920	Continued From page 11 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 1363 or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to plug electrical equipment directly into electrical outlets without the use of domestic electrical extension cords, 6-prong domestic electrical adapters, 3-prong domestic electrical adapters, and medical equipment connected to unapproved power strips. These inappropriate practices could create the possibility of an electrical overload and/or possible fire. In addition, electrical extension cords are not to be substituted for fixed electrical wiring of a structure. Findings: On March 10, 2018 between 8:05 a.m. to 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed:	K 920	-The unapproved power strip was removed from room 6 and was replaced with an approved electrical power strip on 3-10-18 -The 6 prong domestic electrical wall outlet was removed from room 30. -The 3 prong domestic electrical adapter was removed from the beauty salon. **Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -Facility Rounds were made and all unapproved electrical power strips and domestic electrical adapters were removed and replaced with approved electrical wall outlets. -Maintenance Director and Administer will make facility rounds weekly and assure that the correct adapters are used. -Administrator and Maintenance Director educated staff on the importance of using the correct and approved power strips.	4-2-18

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K 920	Continued From page 13 1. At 8:59 a.m., it was observed that an electric fan and an adding machine were plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, at the business office. 2. At 9:01 a.m., it was observed that an air conditioning unit was plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, at an administrative office. 3. At 9:05 a.m., it was observed that an electric bed and an air mattress (an electrical medical pressure relieving device used to prevent pressure sores) were plugged into an unapproved power strip which was plugged into an electrical wall outlet, inside Room 10. One resident was on the air mattress while it was activated. 4. At 9:28 a.m., it was observed that two electric beds were plugged into a 6-prong domestic electrical adapter which was plugged into an electrical wall outlet inside Room 20. One resident was inside the room. 5. At 9:55 a.m., it was observed that a hand-held hair dryer was plugged into a 2-prong domestic electrical adapter which was plugged into an electrical wall outlet inside the beauty salon. During this LSC tour an interview was conducted with the maintenance supervisor regarding the electric beds and the air mattress plugged into the unapproved power strip device. The maintenance supervisor was informed that all medical equipment must be plugged into approved electrical wall outlets or into either a UL	K 920	**Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** facility rounds will be documented and submitted at the Monthly Quality Assurance and Performance Improvement meeting. **Date of Compliance: 4/02/18**	4-2-18

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K 920	Continued From page 13 1363A or UL 60601-1 power strip. It was also mentioned that the use of these unapproved electrical devices could lead to possible fire hazards. At the end of the interview, the maintenance supervisor stated that these electrical problems would be corrected immediately (UL is the Underwriters Laboratories which is an independent American agency that analyzes new technologies to promote new safety standards for electrical devices. This agency tests, inspects, validates and certifies most electrical devices as being safe to use.) The deficient practice affected two of three smoke compartments. On March 10, 2018 the above findings were acknowledged during the survey process and during the exit conference with the administrator and the maintenance supervisor.	K 920		4-2-18
K 923 SS=E	Gas Equipment - Commercial Container Storag CFR(s): NFPA 99	K 923	**K Tag Identifier: K 923** **Immediate corrective action(s) for those Residents affected by the deficient practice:** -No residents were affected by this deficient practice. -"NO SMOKING" signs were placed outside of both medication rooms immediately.	
	Gas Equipment - Commercial Container Storage Greater than or equal to 3,000 cubic feet Storage locations are maintained, constructed, and ventilated in accordance with 5.1.3.2 and 5.1.3.3. >300 but <3,000 cubic feet Storage locations shall be in an enclosure or within an enclosed room made of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.			

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K 923	Continued From page 14 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosed cabinet. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN - NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. Where facility employs cylinders with integral pressure gauges, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post "No Smoking" signs in areas where oxygen tanks are stored in accordance with NFPA 99, Healthcare Facilities Handbook, 2012 Edition, Cylinder and Manifold Storage Requirements. This failure to post "No Smoking" signs where oxygen tanks are stored without "no smoking" signs may increase the risk for fire emergencies. Findings On March 10, 2018 between 8:05 a.m. to 10:30 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed:	K 923	**Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** -All areas where oxygen is stored were assessed for NO SMOKING signs and no other areas were affected. **Facility measures and systemic changes to ensure the deficient practice does not recur:** - Administrator and DON educated staff on 3-23-18 regarding importance of posting NO SMOKING signs outside of all areas where oxygen is stored. -DON, her designee, DSD, Administrator and/or Maintenance Director will do facility rounds weekly to assure that areas where oxygen is stored will have NO SMOKING signs posted outside the door. **Facility plan to monitor corrective actions and sustain compliance; Integrate QA Process:** -Findings from facility rounds will be collected for the month and will then be presented, discussed and documented at the monthly Quality Assurance and Performance Improvement meetings for further review and recommendations. **Date of Completion: 4/02/18**	4-2-18

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K 923	Continued From page 15	K 923		4-2-18

1. At 8:55 a.m., it was observed that a "crash" cart (which was not in use), with a 25 cubic foot (cu. ft.) oxygen tank, was stored inside Station 1's medication room. Closer observation showed that "No Smoking" signs were not posted outside of this medication room.

2. At 9:30 a.m., it was observed that a "crash" cart (which was not in use), with a 25 cu. ft. oxygen tank, was stored inside Station 2's medication room. Closer observation showed that "No Smoking" signs were not posted outside of this medication room.

At 10:50 a.m., an interview was conducted with the administrator and the nursing supervisor regarding the "No Smoking" signs missing outside of the medication rooms, where the "crash" carts were stored. The nursing supervisor stated that "No Smoking" signs should be posted outside of the rooms where oxygen is stored. At the end of the interview, the nursing supervisor stated that a "No Smoking" sign would be posted outside of these medication rooms, immediately.

The deficient practice affected two of three smoke compartments.

On March 10, 2018, the above findings were acknowledged during the survey process and during the exit conference with the administrator and the maintenance supervisor.