4/5/18 approved 06614

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

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

,	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA COENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		056378	B. WING		03	/10/2018	
	PROVIDER OR SUPPLIER CY OAKS POST ACUT	E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CI 3850 E. ESTHER ST. LONG BEACH, CA 90804		·	
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E 009 SS=C	Department of Publi Emergency Prepare The findings are in Federal Regulations Long Term Care Fall Representing the Dievaluator number; Resident census: 5: Local, State, Tribal of CFR(s): 483 73(a)(4) [(a) Emergency Plan and maintain an emitted must be review, annually. The plan in	epartment of Public Health: 16279, REHS, HFE I 3 Collaboration Process 4) n. the (facility) must develop lergency preparedness plan ed, and updated at least must do the following: I stor cooperation and call (fibal, regional, State, and preparetness officials' efforts returness return	€ 04	"This plan of correction is prequired by law. By submitting of Correction, Regency Oak Acute Care Center does not the deficiency listed in this to nor does the center admit to statements, findings, facts of conclusions that form the balleged deficiency. The Centhe right to challenge in legal regulatory or administrative the deficiency statements, factonclusions that from the balled deficiency." E Tag identifier: E OC Immediate corrective action those Residents affected by deficient practice: -No residents were affected by deficient practice: -Administrator was able to gravith the Emergency Manage Response Information Sharif Analysis Center on 3-22-18 facility is in the division of Hose Security's data base. The in also now in the facility's Emergence Plan. Plan / Process to identify cresidents potentially affect same deficient practice an corrective action(s) to be to	ng the Plan s Post t admit that form exists, any sis for the ster reserves I and/or proceedings acts, and sis of the by this by this et in touch formation is ergency other led by the d aken:	NG PATE	
En	W/2	A SOUTH THE REPRESENTATIVE'S SIGNA	1/1/2	ministrator		2-/8	

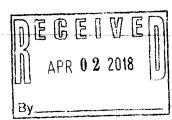
Any deficiency statement ending with an exact denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection is gratients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 a hard available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

FORM CMS-2587(02-98) Previous Versions Objective

Event ID: 83G021

Facility ID. CA940000023

If continuation sheet Page 1 of 18



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€ 009	planning efforts. The local emergency least annually to do of the dialysis facinity emergency. This REQUIREM. Endows the series of the dialysis facinity emergency. This REQUIREM. Endows the series of the dialysis facinity emergency participation in collaplanning efforts to contact for preparedness official planning efforts. In documentation to the with the State and Epreparedness official planning. The lack of preparedness coopeany care and service emergency. Findings: On March 10, 2018, facility's emergency was conducted. It will documentation to we contact with the local emergency prepared cooperative planning. On March 10, 2018, was conducted with facility's efforts to be Federal emergency regarding any cooperating any c	aborative and cooperative educy is facility must contact by pregaredness agency at infirm that the agency is aware yet when he he event of an Milliance met as evidenced want record review, the facility comentation of the facility comentation of the facility sold, replicately state, and prints educes officials and its incoract educes officials and its incoract educes officials and its incoract educe where ency and cooperative educe where ency and contact feduce where gency also acceptance where ency are the educed to the educe of a cellaborative emergency endiverse pain could delay or halt estimate the feduce that there was no entity of a cellity had made at the educationals regarding any coession chicials regarding any	E 009	-All residents have the potential to affected by the delicient practice. -Administrator educated staff on 3- on the update to our Facility Emerginal. Facility measures and systemic changes to ensure the deficient practice does not recur: -Administrator will review the Emery Preparedness Plan quarterly and a that changes necessary are update and will alert staff as needed. Facility plan to monitor corrective actions & sustain compliance; Integrate OA Process: -Updates to Emergency Preparedne Plan will be discussed and will be brought forward to the monthly Oua Assurance and Performance Improvement meetings and will be submitted, discussed and document for further recommendations. Completion Date(s): 4/02:2018	gency ssure d	

	T OF DEFICIENCIES OF CORRECTION	(X1) PHOV DERISUPPLIERICUA (SECULE DATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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E 023 SS=C	officials'. The admir have any document contacted the local personal the interview. The interview of the int	interguency preparedness instrator stated that he did not taken with a facility. State and Federal received and Federal received and retailed he would be regently preparedness a collaborative and Documentation star Medical Documentation star with a gency preparedness which are don't be section, risk regarded to the emergency properties of this section, risk regarded to the emergency properties and procedures must be secured as a section and procedures must be secured as a section and secures and protects. The following protects are the protects are the condition, and secures are the condition, and secures are the condition	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 polic addressing a system of medical documentation to protect confident of patient information which was reviewed and approved by the qual assurance team on 3-27-13. Plan/Process to identify other residents potentially affected by same deficient practice and corrective action(s) to be taken: -All residents have the potential to affected by the deficient practice. -Policy and Procedure was added facility's Emergency Preparedness. Administrator made staff aware of additional information on 3-23-18. Facility measures and systemic changes to ensure the deficient practice does not recur: -Administrator will review the Emen Preparedness Plan quarterly and a that changes necessary are update and will alert staff as needed.	y ratity fity the to the Plan. the	

	OF DEFICIENCIES OF CORRECTION	⇒ LUSS DERISUPPLERICLIA LUSSECA™ ON NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 023	procedures (2) A sy documentation that donor information, potential and actual secures and maintal this REQUIREMENT by: Based on interview failed to develop empolicies and procedurat protects and se information and maintal the lack of this lens could cause confus	0.265, oper olicles and	ΕO	23	Facility plan to monitor corrections and sustain compliance Integrate QA Process: -Updates to Emergency Prepared Plan will be discussed and will be brought forward to the monthly Qi Assurance and Performance Improvement meetings and will be submitted, discussed and docume for further recommendations. Date of Compliance: 4/02/18	ness Jality	4-2-16
The state of the s	facility's emerger by was conducted. It will documentation to an addressing a system that protects confid. On March 10, 2018, was conducted with the facility's medical emergency. It was a documentation to vera policy that protects of patient information the administration to the administration of the second conduction of the administration of the second conducted.	at a review of the months of t					

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documentation. E 026 Roles Under a Wilder SEC OFR(s): 483.73(th) [(b) Policies and proceed plan set forth in parasessment at parameter and the communication of this section. The proviewed and upper minimum, the parameter strength of the provision of care at an accordance with provision of care accordance with provision accordance with provision accordance with provision accor	iver uncharco by Secretary (is) considered by Preparedness dures, paced on the emergency (is) of this section, risk acraph (ar)(1) of this section, risk acraph (ar) acraph (c) of acraph (ar)(1) of this section, (ii) acraph (ar) acraph (ar)(1) of this section, (iii) acraph (ar) acraph (ar)(1) of this section, (iii) acraph (ar) acraph (E 023	· ,	ncy e ared man h / Act care was	
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f Office of the control of the contr	emergency policy Coothe residents, due to the residents, due to the residents, due to the residents, due to the residents of the residents of the resident of	ement officials. The lack of this could delay care and services tring an emergency. It, at 1.30 p.m., a review of the preparedness documentation was noted there was no indicate the facility had an in what the facility's role is lared by the Secretary of HHS. Section 1135 of the Social in the President of the United isaster or emergency, under encies Act, the Secretary of colic health emergency under Public Health Service Act. It is of the Social Security Act, the isaster of the Social Security Act, the isaster of the Social Security act to temporarily waive or care and Medicaid sure that sufficient health care ailable to meet the needs of in Social Security Act.	E	026	Facility measures and systemic changes to ensure the deficient practice does not recur: -Administrator will review the Emer Preparedness Plan quarterly and a that changes necessary are update and will alert staff as needed. Facility plan to monitor correcting actions and sustain compliance integrate QA Process: -Updates to Emergency Prepared Plan will be discussed and will be brought forward to the monthly Quassurance and Performance improvement meetings and will be submitted, discussed and docume for further recommendations. Date of Compliance; 4/02/18	assure ed ive 2; ness ality	4.2.18

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	(ic) The [facility] multiple mergency prepare that complies with fand must be review annually.] The compliance of the following: (2) Contact information (i) Federal, State emergency prepare (ii) Other sources *[For LTC Facilities information for the following of the facility of the fa	ust develop and maintain an edness communication plan Federal, State and local laws wed and updated at least munication plan must include tion for the following: , tribal, regional, and local idness staff. s of assistance at §483.73(c):] (2) Contact following: abal, regional, or local idness staff. sing and Certification Agency, e State Long-Term Care of assistance. 83.475(c):] (2) Contact following: abal, regional, and local idness staff.	EC	Immediate corrective action(s those Residents affected by the deficient practice: -No residents were affected by the deficient practic. The State Ombudsman's phone humber with updated in the Facility's Emerge Preparedness Communication F3-22-18. Plan/Process to identify other residents potentially affected same deficient practice and corrective action(s) to be take. -All residents have the potential affected by the deficient practice. -Administrator educated staff on on the update to our Facility Emerican. Facility measures and systemic changes to ensure the deficient practice does not recur: -Administrator will review the Emericand will alert staff as needed.	his as ncy Plan on by the n: to be 3-23-18 ergency c ut ergency	

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facility's emergency was conducted. It was ombudsman's office not included in the end plan (Ombudsman is represents the interest by investigating, add resolve complaints for the plan (Ombudsman is conducted with a facility's emergency communication plan ombudsman's office not included in the end of the stated he would revision and add the State on telephone number. EP Training and Test SS=C CFR(s) 463 73(d) (d) Training and testif develop and maintain preparedness training paragraph (a) of this paragraph (a) of this paragraph (a) of the communication posection. The training	at 1.30 p.m., a review of the preparedness documentation as noted the State and telephone number were mergency communication is a public official who ests of the public, or patients, ressing and attempting to or the public, or patients.) at 3:05 p.m., an interview the administrator regarding preparedness. It was stated that the State and telephone number was mergency communication in interview, the administrator is the communication plan inbudsman's office and ling. The [facility] must in an emergency gram that is	E 031	Facility plan to monitor cor actions and sustain compliantegrate OA Process: -Updates to Emergency Prep Plan will be discussed and w brought forward to the month Assurance and Performance Improvement meetings and w submitted, discussed and doctor further recommendations. Date of compliance: 4/02/18 E Tag Identifier: E 036 Immediate corrective action those Residents affected by deficient practice:	arce; aredness III be Ity Ouality Vill be cumented (s) for Ithe It the chief It the shift and ony of the	4.275

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEMOLIA IDENTIFICATION NUMBER	(X2) MULTIP A BUILDING	LE CONSTRUCTION		TE SURVEY VPLETED
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€ 036	testing. The ICF/IID an emergency prep program that is bas forth in paragraph (a assessment at para policies and proced section, and the cor paragraph (c) of this testing program mu least annually. The requirements for ev §483 470(h).	83.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk graph (a)(1) of this section ures at paragraph (b) of this munication plan at a section. The training and st be reviewed and updated at ICF/IID must meet the accuation drills and training at	E 036	same deficient practice and corrective action(s) to be taken: -Air residents have the potential to affected by the deficient practiceEmergency Trainings are done or quarterly pasis using different disa. As they are cone, a copy of the trainflibe added to the Facility's Emer Preparedness PlanAdministrator educated staff on 3-on the update to our Facility Emergian.	he a sters. ining rgency 23-18	
	testing, and orientat develop and mainta preparedness trainir orientation program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation progupdated at least and This REQUIREMEN by: Based on interview failed to maintain and training and testing pemergency plan, risk procedures, and the facility did not have at the facility had an entraining and testing procedure and testing pemergency plan, risk procedures, and the facility had an entraining and testing procedure and testing procedures.	that is based on the forth in paragraph (a) of this ment at paragraph (a)(1) of and procedures at paragraph at the communication plan at section. The training, testing ram must be reviewed and		Facility measures and systemic changes to ensure the deficient practice does not recur: -Administrator will review the Emer Preparedness Plan quarterly and a that necessary changes are update and will alert staff as needed. Facility plan to monitor corrective actions and sustain compliance: Integrate QA Process: -Updates to Emergency Preparedness and will be brought forward to the monthly Quarterly and Performance improvement meetings and will be submitted, discussed and document for further recommendations. Date of Compliance: 4/02/18	ssturé ed re : : ess ality	7-2-18

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fa Wa do en	cility's emergency as conducted. It w ocumentation to vi	, at 1:30 p.m. a review of the preparedness documentation was noted there was no erify the facility had an idness training and testing			
the	as conducted with a facility's emerge d testing program ere was no docun d an emergency sting program. At ministrator stated plement an emer	, at 3.05 p.m., an interview the administrator regarding ency preparedness training. The administrator stated nentation to verify the facility preparedness training and the end of the interview, the line would develop and gency preparedness training.			
E 037 EF SS=C OF (1) AS an	Cs, PACÉ organi d dialysis facilities	η	E 03	Immediate corrective action(s) those Residents affected by the deficient practice: -No residents were affected by this deficient practice	
po sta err ex (ii) lea (iii) (iv) pro	licies and procedium iff, individuals pro angement, and viduals proceded role. Provide emergeniust annually. Maintain documination and proceded role.	ures to all new and existing viding services under olunteers, consistent with their acy preparedness training at entation of the training.		Administrator conducted a training 23-18 to staff regarding the Facility Emergency Preparedness Plan will demonstration of the different sect as well all of the procedures. Also educated staff on the location of the emergency plan. A copy of the stall participants were added to the Fac Emergency Preparedness Plan aff staff meeting.	y's thia ions) ne ffs sility's

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	S FOR WEDICARD OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) D/	(X3) DATE SURVEY COMPLETED	
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NAME OF FI	ROVIDER OR SUFFICER			3850 E. ESTHER ST.			
REGENCY	OAKS POST ACUT	E CARE CENTER		LONG BEACH, CA 90804			
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	at § 491.12:] (1) Training at § 491.12:] (1) Training and Proceed Staff, individuals proceed reast annually. (ii) Provide emerge east annually. (iii) Maintain documiny) Demonstrate storocedures. (For Hospices at § nospice must do all indial training in expected roles and procedures under arrain expected roles. (iii) Demonstrate staff, individuals procedures and procedures. (iv) Periodically reviewed annually. (vi) Periodically reviewed annually. (vii) Initial training in expected annually.	482-15(d) and RHCs/FQHCs ining program. The [Hospital st do all of the following: emergency preparedness lures to all new and existing oviding on-site services under volunteers, consistent with their incy preparedness training at itentation of the training. aff knowledge of emergency.	EC	Plan/Process to identify of residents potentially affect same deficient practice an corrective action(s) to be the All residents have the potentifected by the deficient practice. Emergency Trainings are depricated by the deficient practice also done on a basis. As they are done, a curaning will be added to the Emergency Preparedness Practice does not recur: -Administrator will review the Preparedness Plan quarterly that necessary changes are and will alert staff as needed. Facility plan to monitor continued to be described and sustain computers and sustain computers and sustain computers and Performance Plan will be discussed and worought forward to the month Assurance and Performance Improvement meetings and submitted, discussed and defor further recommendations. Date of Compliance: 4/02/7	ed by the d aken: traito be stice. traito be stice. the upon s. Disaster quarterly opy of the Facility's lan. temic icient e Emergency and assure updated f. rrective liance; paredness will be nly Quality e will be ocumented i.	4275	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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€ 037	preparedness trair (iii) Demonstrate s procedures. (iv) Maintain docur preparedness trair *[For PACE at §46 organization must (i) Initial training in policies and proces staff, individuals pr arrangement, cont volunteers, consist (ii) Provide emerge least annually. (iii) Demonstrate st procedures, includi what to do, where t case of an emerge (iv) Maintain docun *[For CORFs at §4 CORF must do all (i) Provide initial tra preparedness polic and existing staff, ii under arrangement with their expected (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned speci the CORF's emerg	ing, provide emergency ing at least annually. Itaff knowledge of emergency mentation of all emergency ing. D. 84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services underractors, participants, and ent with their expected roles, not preparedness training at aff knowledge of emergency informing participants of o go, and whom to contact in ney, mentation of all training. B5.68(d):](1) Training. The of the following: ining in emergency its and procedures to all new individuals providing services, and volunteers, consistent	E 03	7			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A BUILE	LTIPLE CONSTRI	UCTION			TE SURVEY MPLETED
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E 037	alarm systems and equipment. *[For CAHs at §486] The CAH must do a (i) Initial training in policies and procedereporting and exting and where necessal personnel, and gue cooperation with fin authorities, to all ne individuals providing and volunteers, corroles. (ii) Provide emerger least annually. (iii) Maintain docum (iiv) Demonstrate stipprocedures. *[For CMHCs at §44] CMHC must provide preparedness polici and existing staff, in under arrangement, with their expected documentation of the demonstrate staff k procedures. Therea emergency prepare	n the location and use of signals and firefighting 5.625(d):] (1) Training program, all of the following: emergency preparedness lures, including prompt guishing of fires, protection, any, evacuation of patients, sts, fire prevention, and efighting and disaster when and existing staff, green services under arrangement, existent with their expected ancy preparedness training at entation of the training. aff knowledge of emergency estand procedures to all new advisionals providing services and volunteers, consistent	E	037	DEPICIENCY)			
THE STATE OF THE S	by: Based on interview failed to conduct init	IT is not met as evidenced and record review, the facility ial training in emergency es and procedures to all new					TOTAL AND MANAGEMENT AND	

	F OF DEFICIENCIES UF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILO		CONSTRUCTION		ATE SURVEY OMPLETED
		056378	B WING		under place has representational and constructive and a constructive analysis and analysis and a constructive and a constructive analysis and	0;	3/10/2018
	PROVIDER OR SUPPLIER CY OAKS POST ACUI	E CARE CENTER		385	REET ADDRESS, CITY, STATE, ZIP GOD 50 E. ESTHER ST. DNG BEACH, CA. 90804	Œ	
(X4) ID PREF X TAG	(FACH DEFICIENC)	VIEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EAGH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP (DEFICIENCY)	HOULD BE	(x5) COMPLETION DATE
E C41	maintain document of this emergency to services to the resister of the resistency of the resister of the resis	arovide emergency ing at least annually, and atton of the training. The lack raining could delay care and dents, during an emergency. The training could delay care and dents, during an emergency. The preparedness documentation was noted that there was no indicate the facility had training in emergency less and procedures to all staff, ergency preparedness training. The administrator regarding emergency preparedness entation of the training. The late the facility had conducted hought this met the regulation. It was stated that baredness policies and is more specific than disaster of the interview, the the facility would conduct the eparedness policies and for all the staff, and maintain of this training. The ment emergency and standby	EO	037	DEP OR MOTH		
	•	ed on the emergency plan set a) of this section and in the		:			

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTING	PO.TC		TE SURVEY MPLETED
		0 <i>5</i> 6378	B WING		and the second s	03	/10/2018
	PROVIDER ON SUPPLIER BY OAKS POST ACUT	E CARE CENTER		3850 E. ESTH	ess chy state, 21º code Erist. Ch, ca. 90804		
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	paragraphs (b)(1)(i) §483.73(e), §485.62 (e) Emergency and [LTC facility and the emergency and star the emergency plan this section. §482.15(e)(1), §483 Emergency generat must be located in a requirements found Code (NFPA 99 and Amendments TIA 12 12-5, and TIA 12-6), and Tentative Interin 12-2, TIA 12-3, and when a new structur structure or building 482.15(e)(2), §483.7 Emergency generate (hospital, CAH and L the emergency power	ures plan sct forth in and (ii) of this section. 25(e) standby power systems. The CAH] must implement adby power systems based on set forth in paragraph (a) of set forth in paragraph (b) of location. The generator coordance with the location in the Health Care Facilities. Tentative Interim 12-2. TIA 12-3. TIA 12-4. TIA TIA TIA TIA 12-4. TIA TIA TIA TIA 12-4. TIA	E	E Tag Immedia those Redeficient -No resid deficient -Administ regarding source or Facility E an emerg supply the Plan Progresidents same deficients -All reside	Identifier: E 041 ate corrective action(s) fesidents affected by the tipractice:	Cy fuel the vent of ill	
	Health Care Facilities Safety Code. 482.15(e)(3), §483.7 Emergency generate LTC facilities] that ma to power emergency for how it will keep er	quirements found in the s Code, NFPA 110, and Life 3(e)(3), §485.625(e)(3) r fuel. [Hospitals, CAHs and sintain an onsite fuel source generators must have a plan mergency power systems a emergency, unless it					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUILD :	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
	056378	6 WING_			03/10/2018
NAME OF PROVIDER OR SUPPLIER REGENCY OAKS POST ACUT	E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3850 E. ESTHER ST. LONG BEACH, CA 90804	DOE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC .DENTIFYING (NECRYATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE (DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
and CAHs §485 62: The standards inco section are approve reference by the Dir Federal Register in 552(a) and 1 GFR protection are approved reference by the Dir Federal Register in 552(a) and 1 GFR protection and 1 GFR protection at the National Art Administration (NAF availability of this material from the Section 1 GFP of the Campages in the incorporated by reference to the changes of the Change of	182.15(h), LTC at §483.73(g), 5(g)] reported by reference in this ed for incorporation by rector of the Office of the accordance with 5 U S C. part 51. You may obtain the purces listed below. You may e CMS Information Resource ity Boulevard, Baltimore, MD rehives and Records. RAJ. For information on the aterial at NARA, call to to: gov/federal_register/code_of. Sibr_locations. html. is edition of the Code are rence, CMS will publish a deral Register to announce of tection Association, 1. www.nfpa.org. Care Facilities Code, 2012 st 11, 2011. A 99, issued August 9, 2012. A 99, issued March 7, 2013. A 99, issued March 3, 2014. Safety Code, 2012 edition,	€ 04	Policy and Procedure was the facility's Emergency Property - Administrator made staff as additional information on 3-2 Facility measures and systchanges to ensure the defipractice does not recur: -Administrator will review the Emergency Preparedness Figuriterly and assure that nechanges are updated and will as needed. Facility plan to monitor collactions and sustain compliantegrate QA Process: -Updates to Emergency Preplan will be discussed and do for further recommendations. Date of Completion: 4/02/13	caredness vare of the caredness itemic ficient caredness it affect staff diert staff diert staff be caredness will be currented	4-3-18

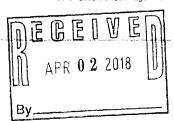
NAME OF PROVIDER OR SUPPLIER REGENCY OAKS POST ACUTE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP GODE	Y'
REGENCY OAKS POST ACUTE CARE CENTER X4) IC SUMMARY STATEMENT OF DEPICIENCES IC PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD	3
FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	
(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.	NOT
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.	
2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems. 2010 edition, including TIAs to chapter 7, issued August 6, 2009.	
Standby Power Systems. 2010 edition, including TIAs to chapter 7, issued August 6, 2009.	
This RECUIDEMENT is not read as guidement	
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 tacility 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 (IRIA CMS-2567/05/09) Previous Visitions Obsolets. Figure ID RIGGS. Figure ID RIGGS.	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A BUIL!		CONSTRUCTION		(X3) DAT GON	E SURVEY APLETED
		056378	B WING				03/	10/2018
	PROVIDER OR SUPPLIER BY OAKS POST ACUT	E CARE CENTER		385	REET ADDRESS CITY STATE ZIF CO 50 E. ESTHER ST. ING BEACH, CA. 90804	D€		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (FACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	GJUCH	8E	(X5) COMPLETION DATE
E 041		emergency generator policy maintain an onsite fuel source	Eι	041				Commission of the Commission o
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	056378	B WING		03/10/2018
NAME OF PROVIDER OR SUPPLIER REGENCY OAKS POST ACUT		38	REET ADDRESS, CITY, STATE, ZIP CODE 50 E. ESTHER ST. DNG BEACH, CA 90804	
PARÉRÍX ::BACH DEFICIENC	OFEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	DE COMPLETIO
K 000 - INITIAL COMMEN	TS	K 000	This play of requestion is present	. + 2-1.
Federal Regulation Code NFPA 101, 2i Existing Health Car approable codes The following repre Department of Pub Safety Code Surve Representing the D Evaluator number. Resident census, 5 Bed capacity, 99 Highest Scope & S. K 300 Protection - Other SS=E OFR(s) NFPA 101	department of Public Health: 16279, REHS, HFE I	K 300	"This plan of correction is prepare required by law. By submitting the Plan of Correction. Regency Oal Post Acute Care Center does on admit that the deficiency listed in form exists, nor does the center atto any statements, lindings, facts conclusions that form the basis for alleged deficiency. The Center reserves the right to challenge in and or regulatory or administrative proceedings the deficiency statements, facts, and conclusion that from the basis of the deficient	e cs control of this control of the legal e
18.3 and 19.3 Prote not addressed by th deficient. This infor applicable lufe Safa	KS section any LSC Section section requirements that are ne provided K-tags, but are mation, along with the sty Code or NEPA standard netuded on Form CMS-2567.			
by NFPA 13, Standard Sprinkler Systems, Canopies, Porte-Co	RT is not met as evidenced if for the Installation of 2010 Edition, Extenor Roofs, schere, Balconies, Decks, or 8 15 7 1. Sprinklers shall be	:		
	ERVSUPPLIER REPRESENTATIVE'S SIGN	ATURE	W. TITLE	(X6) DATE

If continuation sheet Page 1 of 15



	TOF DEFICIENCIES OF CORRECT ON	(X1) PROVIDER/SUPPLIER/CLIA ICENTIFICATION NUMBER		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		056378	B Wing	Salah kang panggang	03	/10/2018
	PROVIDER ON SUPPLIED BY OAKS POST ACU			STREET ADDRESS, CITY, STATE ZIP COD 3850 E. ESTHER ST. LONG BEACH, CA 90804		
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K 300	Continued From p	age 1	К3	00		4-2-19
	porte-cocheres, ba	lerior roofs, canopies, alcomies, decks, or similar dirig 4 feet (1,2 m) in width.				
			:	K Tag identifier: K 30	<u>0</u>	
	failed to ensure a : under two canopie width. In the event	tion and interview, the facility sprinkler system was installed is that exceeding 4 feet (ft.) in of a fire, an exterior roof, or		Immediate corrective action those Residents affected by deficient practice:		
		not have a sprinkler system will recuation and protection for the juilding.		-No residents were affected b deficient practice	y this	
	Findings	8, betweer 8,05 a.m. to 10:30		-The blue canopies in front of building as well as the one in parking lot were removed on	the	
	a.m., the evaluator supervisor conduc- tour of the facility, following were obs	rand the maintenance todia Life Safety Code (LSC) During this LSC tour, the erved:		Plan Process to identify of residents potentially affects same deficient practice and corrective action(s) to be ta	ed by the	
	observed at the parentrance area was	here was a canopy cover irking lot entrance area. This also the facility's designated s canopy was a royal blue cloth		-All residents have the potent affected.	ial to be	•
	material that was cland appeared to his closer observation system attached to structure or the occ	firectly attached to the building ave a width over 4 feet (ft). A showed there was no sprinkler of this covering to protect the cupants, in the event of a fire. It		-Administrator and Maintenar Director assessed the outskir facility and no other areas of t building were affected.	ts of the	
	indicate if it was fin					- 1000
	with the maintenan canopy. The maint-	ief interview was conducted ice supervisor regarding this enance supervisor stated that ed to be 6 ft long and 6 ft wide				in the same of the
		ere was a canopy cover at the sanopy was made of the		i ,		Of Manager 1

	CF DEFICIENCIES	E & MEDICAID SERVICES EXT: PROVIDER/SUPPLIER/CL/A	/Y21 M = T	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER		IG 01 - MAIN BUILDING 01	COMPLETED		
		056378	B WING_	Bengrap, asken synapolic or sport (by 1 1991) asken by a collection of the collectio	03/10/2018		
NAME OF	PROJECT ON SUPPLA	(1	STREET ADDRESS, CITY STATE ZIP CO			
REGENO	CY OAKS POST ACU	TE CARE CENTER		3850 E. ESTHER ST.			
THE GETTE		TE GARE GENTER		LONG BEACH, CA 90804			
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K 300	Continued From p	ace 2	′ ′ K 30	0	4.2.		
	same (royal blue) attached to the bu width over 4 ft . A	cloth material that was directly inding and appeared to have a closer view revealed there was					
	protect the structulevent of a fire. It w	n attached to this covering to re or the occupants, in the ras also noted there was no tag indicate if it was fire resistant.		Facility measures and sys changes to ensure the def practice does not recur:			
	with the maintenar canopy. The maint	nef interview was conducted noe supervisor regarding this tenance supervisor stated that and to be 8 ft. long and 6 ft.		 If canopies are reconsidered company will have to provide information that they are fire or a sprinkler will need to be 	e retardant,		
	with the maintenar two canopies. The this canopy had be working at the facil added that he did it	ur, an interview was conducted the supervisor regarding these maintenance supervisor stated the in place since he started lity, 4 years ago. He further mot have any documentation to canopies were fire resistant or		Facility plan to monitor co- actions & sustain compliar Integrate QA Process: -Eindings from facility rounds quality assurance checks will brought forward to the month Assurance and Performance Improvement meetings and submitted, discussed and do	nce; s and if be nly Quality s will be scumented		
	was conducted wit maintenance supe. The administrator was informed that had a width which structure, must have	5. at 12:55 p.m., an interview in the administrator and the rivisor regarding this canopy, and maintenance supervisor any covering or roofing that extended beyond 4 ft. from the vera sprinkler system. During administrator stated that the these canopies.		for further recommendations Completion Date(s): 4/02/2			
	The deficient pract smoke compartme	ice affected two of three nts					
	acknowledged duri	B, the above findings wereing the survey process and ference, with the administrator					

OSS378 WINE OF PROVIDEN OR SUPPLET REGENCY CAKS POST ACUTE CARE CENTER 3850 ESTHER ST. LONG BEACH, CA 98804 PROVIDEN SHAP AND EXCEPTION OF BEACH CENTER X 10 BEACH CONSIDER SHAP OF CONNECTION OF THE PROVIDENS SHAP OF CONNECTION OF THE PROVIDENCE SHAP OF CONNECTION OF TH		TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
### STATE CARE CENTER AST			056378	B WING.	The state of the s	03	/10/2018
K 300 Continued From page 3 and the maintenance supervisor. K 321 Hazardous Areas - Enclosure SS-D CFR(s) NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8 1 or 10 or 9 3.5 9 When the approved automatic fire extinguishing system ortion 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-dosting 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 nazardous areas that are deficient in REMARKS 19.3.2.1. 19.3.5.9 Area Automatic Sprinkler Separation, NIA, a Boiler and Fuel-Fired Heater Rooms b Laundres (arger than 100 square feet) c Repair Maintenance and Paint Shops d Solied Linea Raoms (exceeding 64 galloss) f Combustiole Storage Rooms/Spaces (over 50 square feet) g Laborations (if classified as Severe Hazaro see K322) This REQUIREMENT is not met as evidenced by Based on observation and interview, the facility faired to emisure that hazardous areas were	REGENC (X4) IO FRCF(X	CY OAKS POST ACUT SHIMMARY SIZ (EACH DEFICILING	CEMENT OF BEFICENCIES CLICST BE PRECEDED BY FULL	PREEIX	3850 E. ESTHER ST. LONG BEACH, CA 90804 PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD	D B€	COMPLETION
Area Automatic Sprinkler Separation N/A Boller and Fusi-Fired Heater Rooms b Laundros (arger than 100 square feet) c Repair Maintenance (and Rooms) c Rooms b Laundros (arger than 100 square feet covers) c Rooms b Laundros (arger than 100 square feet) c Repair Maintenance (and Rooms) c Rooms (but a Rooms) c	IAU	NGG, DOGNO GNE	SO DENTI TIND HE ONARE DAY			MATE	
and the same rated	K 321	and the maintenant Hazardous Areas - CFR(s) NFPA 101 Hazardous Areas - Hazardous areas a having 1-hour fire in fire rated doors) or system in accordant When the approved system option is us separated from oth partitions and doors Doors shall be self-and permitted to hap protective plates the from the bottom of Describe the floor a hazardous areas the 19.3.2.1, 19.3.5.9 Area Separation NIA a. Boiler and Fuel-F b. Laundries (Targer c. Repair Maintena d. Soiled Linen Roole Trash Collection (exceeding 64 gallo f. Combustiole Stori (over 50 square fee g. Laborationes (if d. Hazard - see K322) This REQUIREMEN by: Based on observational storic for the same consuler that failed to ensure that	Enclosure Enclosure Enclosure The protected by a fire barrier esistance rating (with 3/4 hour an automatic fire extinguishing de with 8.7.1 or 19.3.5.9. If automatic fire extinguishing ed, the areas shall be er spaces by smoke resisting in accordance with 8.4. closing or automatic-closing we nonrated or field-applied at do not exceed 48 inches the door. Indicate the attention of particles are deficient in REMARKS. Automatic Sprinkler Auto		Immediate corrective action(s) those Residents affected by the deficient practice: -No residents were affected by the deficient practice: -Maintenance Supervisor installer 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 othe doors were affected by the deficient practice. Facility measures and systemic changes to ensure the deficient practice does not recur: -Maintenance Director and Adminimal make facility rounds weekly artest doors to assure that they latest doors to assure that they latest	e is y : e er ent : t . ister	4-2-18

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

STATEMENT OF DEFIG ENGILS XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION. IDENTIFICATION NUMBER A BUILDING 01 - MAIN BUILDING 01 056378 03/10/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3850 E. ESTHER ST. REGENCY OAKS POST ACUTE CARE CENTER LONG BEACH, CA 90804 SUMMARY STATEMENT OF DEFICENCIES (EACH JEHO FINCY MUDIT BE PRECEDED BY FULL X4) (C PREFIX PROVIDER'S PLAN OF CORRECTION IXS, CONFILETION PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULAL DRY OR LSC (SEA DEVING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY K 321 Continued From page 4 4-2-18 K 321 construction, regarding one door missing a self-closing device. In the event of a fire, the separation of the medical record office would not Facility plan to monitor corrective actions and sustain compliance; be achieved, which would allow smoke and/or fire Integrate QA Process: to travel from one area to another. -Any deficient practice will be Findings corrected immediately, and the findings of the facility rounds will be On March 10, 2018, between 8:05 a.m. to 10:30. documented and submitted at the a m., the evaluator and the maintenance Monthly Quality Assurance and supervisor conducted a Life Safety Code (LSC) Performance Improvement meeting. tour of the facility At 10:05 a.m., it was observed that there was a Date of Compliance: 4/02/18 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, 19/3/2/1/6, 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 naving jurisdiction, and shall have coors that are self-closing." During this LSC four, 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 las soon as

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER(SUPPLIER/CLA DENTIFICATION NUMBER	1 '	I PPLE CONSTRUCTION BING 01 - MAIN BUILDING 01		ATF SURVEY MPLETED
!		056378	B WING		0:	3/10/2018
REGENO	PROVIDEN OR SUPPLIFE CY OAKS POST ACU	TE CARE CENTER		STREET ADDRESS CITY, STATE, ZIP CO 3850 E. ESTHER ST. LONG BEACH, CA 90804	ÜE	
(X4) ID PREFIX TAG	/LAC/- DET/CIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	PREFI TAG		HOULD BE	COMPLETION DATE
K 321	smoke compartme On March 10, 2011 acknowledged dur curing the existion	lice affected one of three ents 5, the above findings were inc the survey process and ference, with the administrator	KS	321		1
SS=E	construction type, approved automatacordance with N Installation of Spirit Type I and It conmeasures are perinsprinkler protection or local regulations in hospitals, aprink closets of patient sof the closet does of sprinkler coverage required by NEPA. Sprinkler Systems. 19.3 5 1, 19.3 5 2, 19.4 2, 18.3.5 10, 3 This REQUIREMED by: Based on observational below the sprinkler are and below the sprinkler throughout the focial sprinkler throughout the sprinkler and below the sprinkler throughout the sprinkler and the sprinkler throughout thro	Installation Installation Installation Indinospitals where required by an expression of sprinkler system in FPA 13, Standard for the akler Systems. Instruction, alternative protection nitted to be substituted for vin specific areas where state prohibit sprinklers leaping rooms where the area not exceed 6 square feet and covers the closet footprint as 15, standard for Installation of 19,3,5,3, 19,3,5,4, 19,3,5,5.	К 3	Immediate corrective acti those Residents affected deficient practice: -The two heavy blankets were removed immediately on 3-Cardboard boxes were removed immediately on 3-Cardboard boxes were removed to the closet on 3-Cardboard boxes were removed immediately and the closet on 3-Cardboard boxes were removed immediately and the closet on 3-Cardboard boxes to identify or residents potentially affect the same deficient practic corrective action(s) to be -Maintenance Director facility rounds to assure that no oth were piaced within 18 inchedeflectors. No other areas waffected.	on(s) for by the ere 10-18 moved 13-10-18 ther ted by e and taken: atec er items s of	

	FEOF DEFICIENCIES OF DORRECTION	X11 PROVIDER/BUPPLIER/CLIA I DENTIFICATION NUMBER	N .	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY MPLETED
VAME OF	PROVIDER OR SUPPLIER	056378	8 WNG	STREET ADDRESS CITY, STATE, ZIP CODE	03/	10/2018
REGEN	CY OAKS POST ACUT	E CARE CENTER		3850 E. ESTHER ST. LONG BEACH, CA 90804		
(X4) ID PREFIX TAG	FACH DEFIDIENCY	JEMENT OF DEFICIENCIES CHART SEPRECEDED BY FULL SCENERYING INFORMATION)	ID PREFIX IAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD 8F	(X5) COMPLETE DATE
K 351	Continued From pa		K 35	51		4-2-1
	discharge in a horiz	sprinklers to provide water tortal plane and will function a of fire emergencies		Facility measures and system changes to ensure the deficit practice does not recur:		
	Findings:			-Maintenance Director and Adi		; ;
	a m , the evaluator supervisor conducte	batween 8:05 a.m. to 10:30 and the maintenance ed a Life Safety Code (LSC)	:	will make facility rounds weekl assure that object are within 18 inches from deflectors	•	
	following were obse			-Administrator and Maintenand Director educated staff on the importance of keeping objects		1
	two heavy blankets	as observed that there were stored on top of the resident 19 (One resident was inside 1		inches away from the deflector	S	
	this room.) These to from the defrector	plankets were 8 inches away		actions and sustain complia Integrate QA Process:		
	cardboard box (med	ss observed that there was a suring 24 inches by 24		-Any deficient practice will be corrected immediately, and the		
	closet, inside Room	stored on top of the resident 25 /Two residents were as sex was 12 inches away		findings of the facility rounds will documented and submitted at the Monthly Quality-Assurance and	he	
	from the deflector	box nee 12 manes andy		Performance Improvement med	eting.	
	plastic spray bottles shelf, inside the jani	vas observed that were four stored on a wall-mounted tor's dioset (across from the stottles were 10 inches		Date of Compliance: 4/02/18		
	away from the defie:	OSSIF.				
	was informed that the clearance between t	the maintenance supervisor : ere should be an 18-inch he deflectors and the nearest hance supervisor stated		!		
	these items would be	e removed, immediately.				
	The deficient practic smoke compartment	e affected two of three				

	RS FOR MEDICARS				Olylo Ide	<u>). 0938-039</u>
STATEMENT OF DEFICIENCIES (XI) PROVIDERISHIPULERICLIA // ND PLAN OF CORRECTION DENTIFICATION NUMBER		1 ' '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		056378	B WAG	The first state of the state of	03	3/10/2018
NAME OF	PROVIDER ON SUI PILER	* · · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CO		
RECENC	Y OAKS POST ACUT	E CADE CENTED		3850 E. ESTHER ST.		
**COCHC	OARS FOST ACL	I, GARE CENTER	[LONG BEACH, CA 90804		
7X4° ID PREF.X TAG	DARE DIRECTIONS.	GEMENT OF DEFICE NOVES FAULT HE PRECEDED BY FULL SCIDENT FYING INFORMATION)	PREFII TAG	PROVIDER'S PLAN OF CORR (FACH CORRECTIVE ACTION'S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	tas- COMPLETIO DATE
K 351	Continued From pa	ge 7	К 3	51		4-2-10
4.000	acknowledged during the exit confi and the maintenant	· · · · · · · · · · · · · · · · · · ·				
	Sprinkler System - CFR(s): NFPA 101	Maintenance and Testing	К3	53 <u>K Tag Identifier: K</u>	<u>353</u>	
	Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, oning of Water-based Fire. Records of system design, other and testing are		Immediate corrective action for those Residents affethe deficient practice: -No Residents were affect deficient practice.	cted by	
	maintained in a sec available. a) Date sprinkler s	well obation and readily vistem last checked		-All sprinkler heads were between October and Nov 2010 by Fire Fox Protection per Field Work Order date within to a wife head of the control	rember on Inc. ed 11/3/10	
	b) Who provided s	A 400-00001 - John Male (Mark Co. Mark Co. Markerson (Markerson)		which is within compliance 50- year time period.	e Or trie	
	Provide in REMARA any non-required or system 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by:	Simplemation on coverage for partial automatic sprinkler and NEPA 25 Total not met as evidenced		Plan/Process to identify residents potentially affithe same deficient pract corrective action(s) to b -All 319 sprinkler heads wireplaced in 2010.	ected by ice and e taken:	**************************************
	failed to provide doc sprinklers had been recognized testing li NFPA 25, Standard and Maintenance of Systems, Sprinklers	and record review, the facility - umentation that the facility's - replaced or tested by a absorptory, in accordance with or the Inspection, Testing Valter-Based Fire Protection that have been in service for epid be replaced or tested.		-The documented proof won file with the Maintenan Director		

Q 6., 14 1 just	42 LOK MEDICKE	E & MEDICAID SERVICES		OWR NO. 0938-03	
	TOF DEFICIENCIES OF CORRECTION	OLD EROY DER SUPPLIER/CUA CENT/FICATION NUMBER	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		056378	B. WING		03/10/2018
NAME OF	PROVIDER OR SUPPLIER	}		STREET ADDRESS, CITY, STATE, ZIP CODE	
REGENO	CY OAKS POST ACU	TE CARE CENTER		3850 E. ESTHER ST. LONG BEACH, CA 90804	
(X4) ID PREFIX TAG	(FACH OFFICIENC	A TEMENT OF DEFICIENCIES YEAR STREE PRECEDED BY FULL COLIDE VERYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP (DEFICIENCY)	OULD BE COMPLETIC
K 353	Continued From p	ace 8	К 3	53	4-2-1
	Findings		.,,		, i
	On March 10, 2018, at 12:30 p.m., review of the facility's fire inspection reports and documentation was penducted. During this review, it was notice 3 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 sprink ors were replaced or tested by a recognized testing laboratory. (According to NEPA 25, Standard for the Inspection, Testing and Maintenance of Wilter 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, 2016, 71,5 p.m., an interview was conducted with the administrator and the maintenance supervisor regording the 50-year sprinkler test. It was mentioned that facilities built over 50 years ago has recounted to test or replace their sprinklers and the resting must be conducted by a recognized testing laboratory. At the end of the intervalue the maintenance supervisor stated that the would contact an approved testing laboratory and have the sprinklers tested, as soon as possible. The maintenance supervisor and each that he would wait for the test results to see if the sprinklers need to be replaced.			Facility measures and sys changes to ensure the def practice does not recur: -Maintenance Director will controlled to rest the facility sprinkler symicinthly -Facility will continue to utiliz Fire Fox company to do qual assurance tests quarterly on sprinkler system Facility plan to monitor corrective actions and sus compliance; Integrate QA Process:	icient Intinue ystem e the ity the
	The deficient pract smoke company is	be affected three of three			
	On March 10, 200	s the acove findings were			

CENTE	49 FOR MEDICING	E,& MED'CAID SERVICES	+	DIVID	NO: 0938-039	
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/QUA DENT/EICATION NUMBER	1 1		DATE SURVEY COMPLETED	
		056378	a. wing		03/10/2018	
NAME OF F	PROVI <mark>DEA OR SUPPLIE</mark> A	and an exception are not as conservation and an exception and a second	1	STREET ADDRESS, CITY, STATE, Z.P.CODE		
REGENO	CY OAKS POST ACU	TE CARE CENTER		3850 E. ESTHER ST. LONG BEACH, CA 90804		
X4) ID PREFIX TAG	(EACH DEFICIENT	IACEDENT OF ELECTRONIES OF THE FREDYDED BY FULL LICEDDEN DRYING INFORMATION)	ID PREFO TAG	PHOVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(A5) - GOMPLETIO - DATE	
K 353		ring the survey process and recease with the administrator	К3	-	4-2-18	
	Portable Fire Extir CFR(s), NFPA 101		K 3	55 K Tag Identifier: K355	1	
	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, INFPA 10 This REQUIREMENT is not mot as evidenced			Immediate corrective action(s) for those Residents affected by the deficient practice:		
				No Residents were affected by the deficient practice		
	failed to maintain phealth care facilitie Standard for Porta	ation and interview, the facility portable fre extinguishers in all is a accordance with NFPA 10 able for elixtinguishers. The		-The ABC extinguisher was replaced with a Class A Fire extinguisher immediately on 3-10-18	; ;	
	designated smok which could harm in the event of a fit	puisher, located at facility's inglarea, was the improper type the residents, visitors and staff, inc.		Plan: Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:	1	
	a.m., the evaluator	8 between 6.05 a.m. to 10:30 rand the mointenance test a cife Safety Code (LSC)		-All other extinguishers were examined by the Maintenance Supervisor and no other extinguisher location was affected		
	designated smokir lot entrance. It was portable wall-mour smoking area. Clo- portable fire exting extinguisher (ar. ex-	as observed that there was a inglerea located at the parking is richided that there was one inted fire extinguisher at this ser doservation showed this justifier was a Class ABC fire xinglessner that disperses a dry him colores of wood, clothes,				

	OF DEFICIENCIES OF CORRECTION	SET PROVIDER/SUPPLIER/GUA GENT FICATION NUMBER		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		056378	B WING	recommendade (03/10/2018
	PROVIDER OR SUPPLIER BY OAKS POST AGUT	E CARE CENTER	38	REET ADDRESS, CITY, STATE, ZIP CODE 50 E. ESTHER ST. DNG BEACH, CA. 90804	
(X4) :D PREFIX TAG	(FACH DEFICIENC)	OF YEAR OF BEFORENDES CAUSTING PRECEDED BY BUCK SULTYN THY NO INFORMATION)	3D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
K 355	Continued From pages, oil, apphances		K 355	Facility measures and systemic changes to ensure the deficient practice does no recur:	ot 4-2-1
	the maintenance stextinguisher at this. The maintenance of the Class ABC fire type of fire extinguishment was mentioned that and/or visitor) got it ABC fire extinguish chemical and could smoker, possibly succerect fire extinguisher (an expressurized water, paper and clothes) stated he would remextinguisher aclosed. The deficient practismoke compartment.	approved water-based fire in deliposable of three sected one of three		-Maintenance Director will continue to monitor the extinguishers on a monthly bas to assure the correct ones are being used -Facility will continue to utrize the Fire Fox Inc. company to doquality 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.	
K 920	and the maintenant Electrical Equipme CFR(s): NFPA 101	t Flower Cords and Extens	K 920	Date of compliance: 4/02/18 K Tag Identifier: K 920 Immediate corrective action(s for those Residents affected by	i y .
	Extension Cards Power strips in a card used for component patient-care-related (PCREE) assemble	the mover Cords and be it dare vicinity are only if or individe e existing addigment of the have been assembled for and generate conditions of		the deficient practice: -Electric Fan and adding machin cords were removed on 3-10-18. -The domestic electrical extension cord was removed from the administrative office on 3-10-18.	

STATEMENT OF AND PLAN OF (FIDEFICIENCIES CORRECTION	(X), PROVIDENSUPPLER/CLIA ICENTE/CATION NUMBER	1	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
056378		056378	B WING		03/10/2018	
	OVIDER OR SCAPEES OAKS POST ACU	TE CARE CENTER		STREET ADDRESS CITY STATE, ZIP CODE 3850 E. ESTHER ST. LONG BEACH, CA 90804		
X4; :D PREFIX TAG	dEACH DEFICIENC	ATEMENT OF DEPICIENCES MALLOT BE PRECEDED BY FULL ACTORIZEN NO NEORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (IEACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	COMPLETIO DATE
1 n e e romania de la composition della composit	may not be used follectronics), exceptions that do not PCREE meet UL. It trips for non-PCR outside of vicinity) are rooms, power tandards. All power ecautions. Externosin cords ut mediately upon which it was install 0.2.4, 0.2.3.6 (NEPA 96 NEPA 70), 590.3(Inis REQUIREME yield to plug electrical adapters and mediately upon electrical adapters. In the evaluation, electrical ubstituted for fixed tructure.	trips in the patient care vicinity or non-PCREE (e.g., personal Authory term care resident user PCREE Power strips for 303 for UL 30501-1. Power EF in the patient care rooms impet UL 1363. In non-patient is trips meet other UL air strips meet of the purpose for colorable ion meets the conditions of the purpose for colorable ion and interview, the facility has equipment directly into a colorable ion of the use of domestic incomestic according domestic decreased colorable ion meets to air and colorable interview in and in possible fire. In a strips, in the possible fire in a strips, in the maintenance of air air strips of air strips of air air strips		-The unapproved power strip removed from room 6 and w replaced with an approved electrical power strip on 3-10. -The 6 prong domestic electrical power strip on 30. -The 3 prong domestic electrical adapter was removed from the beauty salon. Plan/Process to identify of residents potentially affect the same deficient practice corrective action(s) to be to domestic electrical power and domestic electrical power and domestic electrical wall outlied. -Maintenance Director and Administer will make facility weekly and assure that the condapters are used. -Administrator and Maintenar Director educated staff on the importance of using the corrective approved power strips.	ras 0-18 rical n room ical ical her ed by and aken: and all strips lers with ts.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A 8U-LDING 01 - MAIN BUILDING 01			re survey MPLETED
		056378	B WING			03	/10/2018
		TE CARE CENTER		3850	EET ADDRESS, CITY STATE ZIP CODE DELESTHER ST. NG BEACH, CA 90804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TAY DENT OF REPORNOIES OF DOUGH TO MIND THE ORMATION)	(D PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	fan and an adding domestic e-cetrical plugged into an el business office. 2. At 9:01 a.m., it conditioning unit velectrical extensionan electrical extensionan electrical extensionan electrical en electrical extensional extensional extensional electrical extensional electrical extensional extens	was observed that an electric of historical was plugged into a stransistic was learned was learned was observed that an air was plugged into a domestic at some which was plugged into pullet, at an administrative. Who case we inthat an electric attricts on electrical medical carried used to prevent was pagged into an electrical Relation of One resident was on oally it was intraced. What observed that two electric domestic was plugged into an according to the proposition of the propo	K 5		Facility plan to monitor corrective actions and susta compliance; Integrate QA Process: facility rounds will be documen submitted at the Monthly Quali Assurance and Performance Improvement meeting. Date of Compliance: 4/02/18	ted and	4-2-18

STATEMENT OF DEFICIENCIES PER RECORD AND PLAN OF CORRECTION CONTROL NUMBER		1	JETIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER BY OAKS POST ACU	UD56378 E CARE CENTER	B WING	STREET ADDRESS CITY, STATE, ZIP CO 3850 E. ESTHER ST. LONG BEACH, CA 90804		/10/2018
(X4) (D PREFIX TAG	(EACH DEFICIEN.	CHMENT OF DEFICIENCIES OF THE PROPERTY FULL OF DEFICIENTS SEGRMANONS	ID PREF TAG	FIX (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION DATE
K 923	mentioned that the electrical devices of nazards. At the end maintenance superproblems would be the Underwriters of independent Ameritechnologies to proceed the electrical devices of validates and certificates and the maintenant Gas Equipment - CFR(s)* NFPA 10** Gas Equipment - CGreater than or sensitive and the maintenant Storage locations of ventilated in according to the electricates within an enclosed within an enclosed limited-combustion gases are not storage separated from consprinklered) or enclosed	In power strip. It was also use of these unapproved out it can to possible fire (i.e., we interview, the series of that these electrical some strip in mitediately (Utilis). Long table which is an earliagency that analyzes new mote new safety standards for this agency tests, inspects, estimated two of three cities are electrical devices as the unacted two of three cities. The catove informage were eight actively process and earlies, with the administrator to separated Container Storage and the catove and Container Storage and the catove electric catovers of an enclosure or reconstruction, with door (or does be secured. Oxid zing with Lambrables, and are use the electric catovers. Since the container of catovers of a catovers. Since the container of the catovers of the catovers of the catovers of the catovers of the catovers. Since the container of the catovers of the		923 K Tag Identifier: K 9 Immediate corrective actithose Residents affected deficient practice: -No residents were affected deficient practice -"NO SMOKING" signs were outside of both medication immediately.	ion(s) for by the	4-2-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA DENT/FICATION NUMBER	1 1	CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	056378	B WING	no agrando francio MANTA II Magga agua ha gara da da da da AMA a francio (a a a ga.	03/10/2018
NAME OF PROVIDER OR SUPPLIER REGENCY OAKS POST ACUT	FICARE CENTER	385	REET ADDRESS, CITY, STATE, Z:P CODE 50 E. ESTHER ST. NG BEACH, CA 90804	
PRICES SEACH DEFICIENCY	EMERICON DUNCIES NECLEMPRECEDED BY FULL CODES OF YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-RÉFERENCED TO THE APPRI DEFICIENCY)	JUD BE COMPLETION
cylinders available if care areas with an acre agual to 303 curs stored in an enclored nandled with precox. A precautionary signeach door or gate of where the sign incluminimum "CAUTIC. STORED WITHING Storage is planned of which they are released to political pressure gardened empty acremarked to avoid in the open are product that it is a second to post "No 6 oxygen tanks are so NFPA 99, Heater Caused to post "No 6 oxygen tanks are so NFPA 99, Heater Caused to post "No 6 oxygen tanks are so NFPA 99, Heater Caused to post "No 6 oxygen tanks are so NFPA 99, Heater Caused to post "No 6 oxygen tanks are so NFPA 99, Heater Caused to post "No 6 oxygen tanks are so NFPA 99, Heater Caused to Supervisor conducts or supervisor conducts or supervisor conducts."	c 300 cubic feet ompartment, individual commartment, individual commartment, individual commartment aspragate volume of less than in fact are not required to be according to the additional feet is on fischinders must be according to storage room, des the wording as a second commart of a chinder storage room, des the wording as a second commart of the supplier. Second commart of the supplier of the	K 923	Plan/Process to identify other residents potentially affected the same deficient practice a corrective action(s) to be taken as where oxygen is stored assessed for NO SMOKI signs and no other areas were affected. Facility measures and system changes to ensure the deficipractice does not recur: - Administrator and DON educes staff on 3-23-18 regarding important of posting NO SMOKING sign outside of all areas where oxystored. -DON, her designee, DSD, Administrator and or Maintena Director will do facility rounds to assure that areas where ox stored will have NO SMOKING posted outside the door. Facility plan to monitor corrections and sustain compliantegrate QA Process: -Findings from facility rounds to collected for the month and with the oresented, discussed and documented at the monthly Qin Assurance and Performance Improvement meetings for furt review and recommendations.	d by and en: ed NG mic ent cated contance is gen is ance weekly yigen is 3 signs ective ance; will be all then contains the contance in

	TOF DEFICIENCIES OF CORRECTION	OBT FICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIES	056378	3 WING	,	EE ADDRESS CITY STATE ZIP CO		03/10/2018
	CY OAKS POST ACUI	TE CARE GENTER		3850	E ESTHER ST. IG BEACH, CA 90804		
(X4) -D PREFIX TAG	(EACH DEFICILISE)	TEM, N.T. OF DEPICIENCIES YOU SERVE PROSDED BY FULL DOES NOT MIND (INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CDR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 923	Continued From pa	ые 15	K	923			4-2-18
	cart (which was not (culift.) oxygen tar medication record. ("No Smoking" signathis medication rock." 2. At 9.30 a.m., it words to a medication rock. ("No Smoking" signathis medication rock." "No Smoking" signathis medication rock. ("No Smoking" signathis medication rock. ("The administration should be stated that "No Smoothe end of the interestated that a "No smouthle end of these medication rock. ("No Smoothe end of these medication rock.") The deficient plactic smoothe end of these medication rock. ("No Smoothe end of these medication rock.)	as observed that a "crash" con use), with a 25 cullft. forest inside Station 2's bloods abservation showed that it is were not posted outside of the nursing supervisor smaking" signs missing table a rooms, where the above. The nursing supervisor which signs should be posted and also expgen is stored. At least the nursing supervisor with a big oxygen is stored. At least the nursing supervisor to apply sign would be posted. The nursing supervisor to apply sign would be posted. The service of three the services of three the services that the services are supported to the services of the services and making with the administrator of the services with the administrator.					