STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. BUILDING 01 B. WING _____	05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAMERCY COURT	2200 GRAMERCY DRIVE SACRAMENTO, CA 95825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM K3 BUILDING: 01 K6 PLAN APPROVAL: 5/24/91 MAY 24 K7 SURVEY UNDER: 2000 Existing STRUCTURE TYPE: One Story, Type V (111), LIFE SAFETY CODE UNIT Fully Sprinklered SAN BERNARDINO The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 29753 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 112	K 000	K029 **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/3/16, The Soiled Linen room door across from Room 701, self-closing automatic door closer was adjusted; allowing the door to fully close and latch. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 5/3/16, Inspection of all self-closing doors, no others affected. **What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Maintenance Department personnel shall conduct daily testing/audits of all self-closing doors to ensure they latch when closed. Doors that fail to latch will be repaired. ▪ Audits shall be conducted daily for 6 months, then monthly to sustain compliance. ▪ Maintenance Director (MD) in-serviced (5/16/16 – 6/3/16) maintenance personnel on the facility Self Closing Doors P & P; specifically: self-closing doors must latch when closed.	6/3/16
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by:	K 029		

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

Administrator 5/23/16

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.

POC accepted 6/1/16 per Robert Compton

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K 029	Continued From page 1 Based on observation, the facility failed to maintain a hazardous area, as evidenced by a self-closing door that did not latch when tested. This could result in the spread of smoke in the event of a fire, and affected one of four smoke compartments in Canterbury Hall. Findings: During a tour of the facility with Maintenance Staff on 5/3/16, the hazardous areas were observed. CANTERBURY HALL At 1:27, the door to the Soiled Linen Room across from Room 701 failed to latch when tested.	K 029	**How the facility plans to monitor its performance to make sure solutions are sustained:** • Maintenance Director shall forward in-services to the facility monthly QA & PI meeting for a minimum of 6 months, then annually to sustain compliance. • Maintenance Director shall forward the daily Self-closing door audits to the facility monthly QA & PA meeting for 6 months, then monthly to sustain compliance. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM MAY 24 [illegible]	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in	K 051	LIFE SAFETY CODE UNIT SAN BERNARDINO K051 **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/17/16, Facility received OSHPD Construction Advisory Report – Final Construction: Project # S152037-34-00 Wellington BLDG # 8 Project 100% complete. Wellington BLDG 8 FACP & fire systems fully functional. ▪ 4/28/16, DPH Life Safety notified of request of an additional 6-month to 1 year of the current Waiver to complete the Canterbury BLDG 7 project to replace the FACP & Fire Systems. ▪ Canterbury BLDG 7 FACP is fully operational	6/3/16

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K 051	Continued From page 2 the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the facility failed to provide documentation regarding the final approval and project completion for the fire alarm system. This finding affected four of four smoke compartments in Wellington Hall (Building 8). The facility also failed to maintain the fire alarm system, as evidenced by the presence of an unapproved fire alarm control panel in one of four buildings. This finding affected four of four smoke compartments in Canterbury Hall (Building 7). Finding: During a tour of the facility and document review with Administrative and Maintenance Staff on 5/3/16, the Fire Alarm Control Panel (FACP) in Wellington Hall was observed, and a field visit report from the Office of Statewide Health Planning and Development (OSHPD), and activity reports from the monitoring company were reviewed. The panel was in a normal condition when observed, and the activity reports indicated that signals for all devices tested were received. A Waiver Extension Request Letter dated 5/3/16 to complete installation of the FACP in the Canterbury Building was reviewed on 5/6/16. 1. At 9:20 a.m., Administrative Staff 1 indicated that work would commence in Building 7 "this month, with a down time of about two to three days." Administrative Staff 1 further indicated that a fire watch would be implemented during the	K 051	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ All FACP's are at risk of becoming inoperable. ▪ Facility shall promptly implement Fire Watch P & P if a FACP becomes inoperable. ▪ Facility upon being notified that a FACP is inoperable shall promptly notify the Department, CMS Life Safety, & Sacramento Metro Fire. **What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ Canterbury BLDG 7, construction in process of the replacement of the Canterbury BLDG 7 FACP and fire systems. ▪ SimplexGrinnell contracted services to replace Canterbury BLDG 7 FACP and fire alarm systems. ▪ Facility shall implement Fire Watch's procedures during construction, when the Canterbury BLDG 7 FACP & Fire systems are non-operating during construction and maintain the Fire Watch's until FACP & Fire Systems construction/replacement approved by OSHPD FSLO and releases the facility from Fire Watch.	

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
LICENSING & CERTIFICATION PROGRAM

MAY 24

LIFE SAFETY CODE UNIT
SAN BERNARDINO

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K 051	Continued From page 3 installation of the panel, and that the facility would remain on fire watch for the duration of the project. At 1:39 p.m., the FACP at the Nurses Station in Canterbury Hall was observed in a normal condition. 2. At 5:02 p.m., a review of the OSHPD field visit report indicated that the project for the FACP installation was 95 percent complete in the Wellington Building. The report further indicated there were no issues noted during the visit, and that the system "is now in full service." The fire watch was removed at the time of the field visit. According to Administrative Staff 1, the facility awaits the final signoff, and indicated that there are "two paper steps left" before the project was deemed 100 percent complete. 3. At 4:07 p.m. on 5/6/16, a review of the Waiver Extension Request Letter dated 5/3/16, indicated a tentative date for the start of construction after OSHPD approvals was 5/9/16. The letter further indicated that the estimated project completion date for the installation of the FACP in the Canterbury Building was 6/1/16, and that once the project was completed, the OSHPD Fire Life Safety Officer would conduct an onsite field visit to approve and sign off on the project.	K 051	▪ Facility contracted Fire Systems monitoring company EMS shall conduct weekly testing of the Canterbury BLDG 7 FACP. ▪ Maintenance personnel shall conduct visual checks of the Canterbury BLDG 7 FACP. ▪ Facility shall implement Fire Watch's if the Canterbury BLDG 7 FACP or fire alarm system are not functioning and until the OSHPD FLSO releases the facility from Fire Watch's. ▪ Maintenance Director shall conduct weekly Fire Watch policy in-services at onset of Fire watch and weekly during fire watch. **How the facility plans to monitor its performance to make sure solutions are sustained:** • Life Safety, CA DPH /L & C & OSHPD shall be updated on the progress of the installation of the Canterbury FACP & unit fire alarm systems to ensure regulatory compliances. • Fire Watch logs shall be forwarded weekly to Life Safety & CA DPH/Department. • The Administrator & Maintenance Director shall forward analysis/update of the FACP installation process etc. to the facility monthly QA & A. • Fire Watch logs/schedules shall be reviewed weekly; forwarded to the monthly facility QA & A.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by:	K 064		

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K 064	Continued From page 4 Based on observation, the facility failed to maintain the portable fire extinguishers, as evidenced by a fire extinguisher that was not inspected within 30 days. This could result in the fire extinguisher malfunctioning in the event of a fire, and affected one of four smoke compartments in Ascot Hall (Building 6). NFPA 101, Life Safety Code, 2000 Edition 9.7.4 Manual Extinguishing Equipment: 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition 4-3.2 Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place.	K 064	• The Maintenance Director shall forward in-services to facility monthly QA & A until the IDT substantiates compliance. K064 **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/3/16, the maintenance director inspected the fire extinguisher located near the Social Services Office, certified the fire extinguisher complied with NFPA 10 Standards for Portable Fire Extinguishers **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 5/3/16 maintenance director inspected all facility fire extinguishers, no other affected.	6/3/16

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K 064	Continued From page 5 4-3.4 Inspection Recordkeeping. 4-3.4.1 Personnel making inspections shall keep records of all fire extinguishers inspected, including those found to require correcting action. 4-3.4.2 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. 4-3.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or in an electronic system (e.g., bar coding) that provides a permanent record. Findings: During a tour of the facility with Maintenance Staff on 5/3/16, the portable fire extinguishers were observed. ASCOT HALL At 3:27 p.m., the fire extinguisher near the Social Services Office was not inspected in April 2016.	K 064	**What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Maintenance Director shall conduct monthly inspections of all facility fire extinguishers to ensure all fire extinguishers meet NFPA 101 Life Safety codes or replace. **How the facility plans to monitor its performance to make sure solutions are sustained:** • The Maintenance Director shall forward monthly Fire Extinguisher audits to the facility monthly QA & A for a minimum of 6 months for review, and to sustain compliance.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	**K066** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/3/16, the plastic-lined trash-cans & discarded cigarette butts were removed from the designated smoking areas and non-combustible ashtrays placed back in the designated smoking areas.	6/3/16

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K 066	Continued From page 6 (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the designated smoking areas, as evidenced by the lack of ashtrays in the smoking areas, and by the presence of discarded cigarette butts and combustible materials inside a plastic-lined trash can. This could result in the increased risk of a fire, and affected two of four buildings. Findings: During a tour of the facility with Maintenance Staff on 5/3/16, the designated smoking areas were observed. CANTERBURY HALL 1. At 2:10 p.m., there were no non combustible ashtrays available in the Residents Smoking Area. Maintenance Staff 1 stated the ashtrays were removed from the area by the housekeeping staff to be cleaned during "outside cleaning" earlier in the morning. There were approximately two dozen discarded cigarette butts on the ground.	K 066	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Noncombustible ashtrays shall be maintained/present in all designated smoking locations at all times. ▪ Metal containers with self-closing covers shall be provided at all designed smoking areas. **What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Environmental Services Manager (ESM) in-serviced (5/16/16 – 6/3/16) environmental services staff on the facility Smoking Regulation P & P: specifically; noncombustible ashtrays are to be kept/cleaned in the designated smoking area at all times & plastic lined garbage cans are not allowed in designated smoking areas. ▪ The ESM shall conduct daily inspections/audits of the designated smoking areas: ensure noncombustible ashtrays & metal containers with self-closing covers are in designated smoking areas. & there are no plastic lined garbage cans in smoking areas. Reeducate staff who fail to follow Smoking Regulation P & P.	

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K 066	Continued From page 7 WELLINGTON HALL 2. At 3:03 p.m., discarded cigarette butts, cigarette packs, and cigarette pack wrappers were observed inside a small plastic-lined waste basket.	K 066	**How the facility plans to monitor its performance to make sure solutions are sustained:** • The ESM shall forward in-services to the facility monthly QA & A for a minimum of 6-months then annually to sustain compliance. • The (ESM) shall forward daily designated smoking areas audits to the facility monthly QA & A for a minimum of 6 months for review, and to sustain compliance.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain means of egress free of obstructions or impediments, as evidenced by the placement of items in close proximity to fire doors. This could result in delayed evacuation in the event of an emergency, and affected one of four smoke compartments in Wellington Hall (Building 8) and one of four smoke compartments in Ascot Hall (Building 6). Findings: During a tour of the facility with Maintenance Staff on 5/3/16, the corridors were observed. WELLINGTON HALL 1. At 2:31 p.m., a wheelchair was located at the fire door near the Nurses Station and Soiled Linen Room. When asked how long the chair was located near the fire door, Nursing Staff 1 stated the chair was placed there "a little bit after	K 072	K 072 **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/3/16, the wheelchair, nourishment cart & wound treatment cart were all removed from close proximity of the fire doors. ▪ The lift & wheelchair for resident 615 were relocated to allow continuous means of egress.	6/3/16

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K 072	Continued From page 8 2:00 o'clock." 2. At 3:09 p.m., a nourishment cart was located at the fire door near the Nurses Station and Soiled Linen Room. ASCOT HALL 3. At 3:34 p.m., a wound treatment cart was located approximately 10 inches from the fire door near Room 615. 4. At 3:38 p.m., a lift and a wheelchair for the resident in Room 615 were located across from each other on opposite sides of the hall. The placement of the lift and wheelchair reduced the egress path to 42 inches.	K 072	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 5/3/16 Maintenance Director conducted inspection of all fire doors; no others affected. ▪ Facility fire doors shall be kept clears of items. ▪ 5/3/16 Maintenance Director inspected all means of egress is continuously maintained, no other egress affected. ▪ Facility means of egress shall be continuously maintained free of obstructions or impediments.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the proper storage of oxygen cylinders, as evidenced by the storage of empty and full cylinders in the same rack. This could result in confusion and delay if a full cylinder is needed quickly in the event of an emergency, and affected the residents who receive oxygen	K 076	**What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Maintenance Director in-serviced (5/16/16 – 6/3/16) facility staff members on the facility Fire Door P & P; specifically; no items are allowed to be placed by and/or near a fire door. ▪ The Director of Maintenance in-serviced (5/16/16 – 6/3/16) facility staff members on the facility Means of Egress P & P: specifically, hallways means of egress must be continuously maintained; items cannot be placed in a hallway which blocks means of egress. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM	

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K 076	Continued From page 9 therapy in Ascot Hall (Building 6). NFPA 99, Standard for Health Care Facilities, 1999 Edition 4-5.5.2.2 Storage of Cylinders and Containers (b) Nonflammable Gases. 1. Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. Finding: During a tour of the facility with Maintenance Staff on 5/3/16, the Oxygen Storage Room was observed. ASCOT HALL At 3:47 p.m., one empty E-cylinder was stored with five full E-cylinders in the "Full Cylinder" rack. The empty cylinder was stored in the front of the rack.	K 076	▪ Maintenance Department personnel shall conduct daily inspections /audits of all fire doors to ensure items are not placed at or near fire doors. Reeducate staff who fail to follow Fire Door P & P. ▪ Maintenance Department personnel shall conduct daily inspections/audits of all hallways to ensure there are not items blocking means of egress. Reeducate staff who fail to follow Means of Egress P & P. **How the facility plans to monitor its performance to make sure solutions are sustained:** • The Maintenance Director shall forward in-services to the facility monthly QA & A for a minimum of 6-months then annually to sustain compliance. • The Maintenance Director shall forward daily means of egress and fire doors audits to the facility monthly QA & A for a minimum of 6 months for review, and to sustain compliance. **K 076** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/3/16, the one empty E-cylinder in the Ascot Hall was stored & labeled as empty in the designated empty cylinder rack.	6/3/16
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	K 144		

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	555459	A. BUILDING 01 B. WING _____	05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAMERCY COURT	2200 GRAMERCY DRIVE SACRAMENTO, CA 95825

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K 144	Continued From page 10 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the emergency and standby power system, as evidenced by weekly inspections that were not conducted on a consistent basis. This could result in failure of the generator in the event of an emergency, and affected four of four buildings. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition 6-3.4. A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. 6.4.1 Level 1 and level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly for a minimum of 30 minutes. Finding: During document review with Maintenance Staff on 5/3/16, the generator maintenance and testing records were requested. At 11:12 a.m., a review of the generator records indicated that the generator was not visually inspected for 19 days in October 2015. The dates of inspection were 10/3/15, 10/7/15, and 10/26/15. Maintenance Staff 1 acknowledged and confirmed this finding.	K 144	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 5/3/16 Maintenance Director conducted inspection of oxygen storage rooms to ensure all empty E-cylinders stored properly, no other affected. ▪ All empty E-cylinders shall be properly stored in designated empty cylinder racks; and marked to avoid confusion. **What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Maintenance Director in-serviced (5/16/16 – 6/3/16) facility staff members on the Oxygen Tanks Storage P & P; specifically; empty E-cylinders must be stored in the designated oxygen cylinder empty rack and marked as empty. ▪ Maintenance Department personnel shall conduct daily inspections /audits of all oxygen storage rooms to ensure empty E-cylinders are stored in designated racks and marked as empty. Reeducate staff who fail to follow facility Oxygen Storage P & P.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	K 147		

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K 147	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the electrical wiring and equipment, as evidenced by the use of surge protectors and extension cords, and by an obstructed electrical panel. The use of surge protectors and extension cords could result in the increased risk of fire. An obstructed electrical panel could result in delayed access or safe operation of the panel. These deficient practices affected seven smoke compartments in four of four buildings. NFPA 101, Life Safety Code, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. 400-8. Uses Not Permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	**How the facility plans to monitor its performance to make sure solutions are sustained:** • The Maintenance Director shall forward in-services to the facility monthly QA & A for a minimum of 6-months then annually to sustain compliance. • The Maintenance Director shall forward daily oxygen room audits to the facility monthly QA & A for a minimum of 6 months for review, and to sustain compliance. **K 144** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ The facility generator shall be inspected weekly. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ Maintenance Director and/or assigned designee shall conduct weekly inspections of the generator according to NFPA 99 & NFPA 110 regulations. ▪ Generator weekly inspections placed on the Administrative & Maintenance Director Outlook calendars.	6/3/16

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K 147	Continued From page 12 (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code Findings: During a tour of the facility with Maintenance Staff on 5/3/16, the electrical wiring and equipment were observed. HAMPTON COURT 1. At 12:29 p.m., a large recycle bin blocked clear access to Electrical Panel 5 D located across from the Telephone Room. This deficiency affected one of four smoke compartments in Hampton Hall. CANTERBURY HALL 2. At 1:21 p.m., a surge protector was observed in Room 708 near the head of the bed. A lamp and a breathing treatment machine were connected to the surge protector.	K 147	**What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Maintenance Director and/or assigned designee conducting the weekly generator inspection shall log the generator inspection on the facility Emergency Generator Weekly Inspection Test Log; then provide the Emergency Generator Weekly Inspection Test Log to the administrator upon completion of the generator inspection to ensure compliance. **How the facility plans to monitor its performance to make sure solutions are sustained:** • The Administrator shall forward the Emergency Generator Weekly Inspection Test Log to the facility monthly QA & A for a minimum of 6 months for review, and to sustain compliance. K 147 **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ▪ 5/3/16, the large recycle bin blocking access to the Electrical Panel 5 D was removed. ▪ 5/3/16, the surge protectors in room 713 near bed A, in the day room, Room 810 Bed B were removed.	6/3/16

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K 147	Continued From page 13 3. At 1:37 p.m., a surge protector in Room 713 was observed near Bed A. An electric toothbrush, a clock, and an electric shaver were connected to the surge protector. 4. At 1:55 p.m., two surge protectors in the Day Room were observed behind the TV. A cable box and a modem were plugged into Surge Protector #1. A router, a modem, the TV, and Surge Protector #1 were connected to Surge Protector #2. These deficiencies affected three of four smoke compartments in Canterbury Hall. WELLINGTON HALL 5. At 2:37 p.m., a surge protector was discovered in Room 810 near the head of Bed B. A cell phone charger, a lamp, and a radio were connected to the surge protector. This deficiency affected one of four smoke compartments in Wellington Hall. ASCOT HALL 6. At 3:20 p.m., a multi-outlet extension cord was discovered in Room 602 near Bed A. A nutrition machine, a transport scooter, and an IPad charger were connected to the extension cord. 7. At 3:43 p.m., a multi-outlet extension cord was discovered in Room 611 near Bed B. A small refrigerator was connected to the extension cord. These deficiencies affected two of four smoke compartments in Ascot Hall.	K 147	▪ 5/3/16, the multi-outlet extension cords were removed from room 602 Bed A, and room 611 near bed B. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** ▪ 5/3/16, Maintenance Director Personnel conducted inspection/audit of all Electrical Panels, others affected. ▪ Access to electrical panels shall not be blocked. ▪ 5/3/16, Maintenance personnel conducted inspection/search for surge protectors/extension cords, no other areas affected. **What measures will be put into place or what systemic changes made to ensure that the deficient practice does not recur;** ▪ The Maintenance Director in-serviced staff (5/16/16 – 6/3/16) on the facility Electrical Equipment P & P: specifically, access to electrical panels cannot be blocked. Extension cords & surge protectors are not allowed unless authorized by the Maintenance Director. ▪ Maintenance personnel shall conduct daily inspection/audits of all electrical panels access is not prohibited. Promptly in-service staff who fail to comply with facility Electrical Equipment P & P. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM	

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K 147	Continued From page 13 3. At 1:37 p.m., a surge protector in Room 713 was observed near Bed A. An electric toothbrush, a clock, and an electric shaver were connected to the surge protector. 4. At 1:55 p.m., two surge protectors in the Day Room were observed behind the TV. A cable box and a modem were plugged into Surge Protector #1. A router, a modem, the TV, and Surge Protector #1 were connected to Surge Protector #2. These deficiencies affected three of four smoke compartments in Canterbury Hall. WELLINGTON HALL 5. At 2:37 p.m., a surge protector was discovered in Room 810 near the head of Bed B. A cell phone charger, a lamp, and a radio were connected to the surge protector. This deficiency affected one of four smoke compartments in Wellington Hall. ASCOT HALL 6. At 3:20 p.m., a multi-outlet extension cord was discovered in Room 602 near Bed A. A nutrition machine, a transport scooter, and an IPad charger were connected to the extension cord. 7. At 3:43 p.m., a multi-outlet extension cord was discovered in Room 611 near Bed B. A small refrigerator was connected to the extension cord. These deficiencies affected two of four smoke compartments in Ascot Hall.	K 147	▪ Maintenance personnel shall conduct daily inspections of all facility rooms to ensure usage of electrical extension cords or surge protectors are complaint with regulations. Promptly in-service staff who fail to comply with the facility Electrical Equipment P & P. **How the facility plans to monitor its performance to make sure solutions are sustained:** • Maintenance Director shall forward in-services to the facility monthly QA & PI meeting for review/analysis, minimum of 6 months. Then annually to sustain compliance. • Maintenance Director shall forward the Electrical Equipment Daily Inspection/Audit Logs to the facility monthly QA & PI meeting for review analysis, minimum of 6 months. Then annually to sustain compliance. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH LICENSING & CERTIFICATION PROGRAM	

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