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

PRINTED: 12/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENN MAR HEALTHCARE CENTER	3938 COGSWELL ROAD EL MONTE, CA 91732

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1985 K7 SURVEY UNDER: 2012 EXSISTING STRUCTURE TYPE: ONE STORY, FULLY SPRINKLED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code; 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 45 Census: 45	K 000	**What corrective action will be accomplished for the residents found to have been affected by the deficient practice.** The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. The facility obtained a contract with a fire alarm monitoring company who will maintain, service and inspect the fire panel and smoke detectors annually and as needed. The monitoring company conducted a smoke sensitivity test on 12/18 and determined two smoke detectors are inoperative. The facility will replace them once approval is obtained from HCAI in writing. The fire alarm monitoring company will conduct an annual fire alarm inspection on 01/17/2024.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on an observation, interview and record review, the facility failed to: 1) provide	K 345		

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

Admin | 12/31/24

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

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K 345	Continued From page 1 documentation that the facility's fire alarm system was inspected, tested, and maintained annually (within the last 12 months) in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Sections 14.4.5, 14.6.2.1, and 14.6.3.2; and 2) provide documentation of a passing smoke detectors calibration and sensitivity testing (testing and adjustments done to the smoke detectors to ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range) conducted within the last five years in accordance with NFPA 72, 2010 Edition, Sections 14.6.2.1, 14.6.3.2, 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. These deficiencies have the potential to result in the failure of the fire alarm system which in case of a fire, would delay essential notification to building occupants and delay notification to emergency services, affecting the safety of 45 of 45 residents, staff, and visitors. Findings: During an interview on 12/5/2024 at 9:40 a.m. with the Administrator (ADM) and Maintenance Supervisor (MS), a written request for the annual sprinkler service and the smoke sensitivity calibration service report was made. 1) During a concurrent interview and record review on 12/5/2024 at 1:15 p.m. with the MS, the facility's "Fire Alarm Inspection Report", dated 9/21/2023, was reviewed. The report indicated that the facility's fire alarm system service was last serviced on 9/21/2023. The surveyor requested for documentation indicating that the facility's fire alarm system had been inspected and tested within the last 12 months. The MS was not able to provide evidence of the requested	K 345	**How will we identify other residents having the potential to be affected by the deficient practice and what corrective actions were taken** The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. **What measures will be put in place in a systematic change will be made to ensure that the deficient practice does not re-occur.** The maintenance supervisor will inspect all smoke detectors monthly and document his findings and report his findings at the QA monthly meeting. MS will report any irregularities to the administrator and monitoring company immediately.	

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K 345	Continued From page 2 documentation and stated that the vendor conducted the annual fire alarm service but did not issue a report to the facility. 2) During an observation on 12/5/2024 between 11 a.m. to 12:15 p.m. with the MS, the surveyor observed several smoke detectors throughout the facility. During a record review and interview on 12/10/2024 at 1:25 p.m. with the MS, the facility's "Smoke Detector Sensitivity Test Report", dated 1/26/2018, was reviewed. The report indicated that the facility's smoke detector sensitivity testing was conducted more than five years ago on 1/26/2018. The surveyor requested for documentation indicating that the facility's smoke detector sensitivity was conducted within the last five years. The MS stated that the vendor had not sent the smoke sensitivity report to the facility indicating if the smoke detectors sensitivity had passed or failed. During a review of the facility's policy and procedures titled, "Policies and procedures Maintenance Department", undated, indicated, "The Maintenance Supervisor shall be responsible for maintaining records of the Maintenance Department and submitting reports to the Administrator as required. Recordkeeping includes the following: a. Monthly inspection report of facility and equipment. b. Work order reports. c. Maintenance Repair Schedule, d. List of Repairman to make repairs on equipment, e. Warranties and Guarantees of supplies and equipment."	K 345	The MS and administrator will immediately after each smoke sensitivity test, request the report from the company and file those reports. If the reports are not generated properly, the MS and administrator will immediately inform the company. **How does the facility plan to monitor its performance to ensure that the solutions are sustained.** The VP of Clinical Services will review quarterly all reports to ensure compliance. Compliance Date: 12/30/2024	

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K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the facility's fire watch policy (a procedure in which a person or persons assigned to an area for the purpose of notifying the fire department, the building occupants, or both of an emergency; preventing a fire from occurring; extinguishing small fires; or protecting the occupants from fire or similar emergencies in the absence of an automatic sprinkler system and/or fire alarm system) by not notifying the authority having jurisdiction (AHJ, the local health facilities inspection division office) of the fire watch in accordance with NFPA 101, 2012 Edition, Section 9.6.1.6 and NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2. This failure resulted in the delay of onsite inspection by the AHJ (the local health facilities inspection division office), affecting the safety of 46 of 46 residents, staff, and visitors. Findings: During a review of the facility's "Fire Watch Log", dated from 10/18/2024 to 12/5/2024, the log indicated that the facility initiated their fire watch	K 346	**What corrective action will be accomplished for the residents found to have been affected by the deficient practice.** The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. The administrator notified the department on Dec 9th of the replacement taking place that day to ensure the fire panel will work. **How will we identify other residents having the potential to be affected by the deficient practice and what corrective actions were taken** The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice.	

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K 346	Continued From page 4 procedures on 10/18/2024. During an interview on 12/5/2024 at 10:45 a.m. with the ADM, the ADM stated that he had not notified the local health facilities inspection division office that the facility was on Fire Watch. The ADM stated that the fire panel was not working for a little over a month. During a review of the facility's policy and procedures titled, "Fire Watch," dated 10/1/2023, indicated, in the event of a fire watch, "The designated staff member will be responsible for: A. Notifying the local fire department, local health facilities inspection division office, and occupants of the Facility of the inoperable systems (s), the estimated time of repair, and an additional notification when the system (s) are repaired."	K 346	**What measures will be put in place in a systematic change will be made to ensure that the deficient practice does not re-occur.** The administrator and the MS received an Inservice by the VP of Clinical Services on 12/24/24 on the need to report to the department on unusual occurrences. The administrator reviewed the p&p for fore watch, and going forward, will inform the department when the fire alarm inoperative for more than 4 hours. **How does the facility plan to monitor its performance to ensure that the solutions are sustained.** The facility will review all incidents takin place in the fac facility during the monthly QA meetings to ensure that all incidents needing to be reported were reported and that the facility is in compliance. Compliance Date: 12/30/2024 David Slavin, Admin 12/30/2024	

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E 030	Continued From page 1 *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees.	E 030	How will we identify other residents having the potential to be effected by the deficient practice and what corrective actions were taken The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. What measures will be put in place in a systematic change will be made to ensure that the deficient practice does not re-occur. The administrator will review the list of department heads and replace as needed at our monthly QA meetings.	

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E 030	Continued From page 2 (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an up-to-date staff contact information within the facility's emergency preparedness communication plan. This deficient practice could delay facility's response and provision of care in the event of an emergency. This deficiency has the potential to negatively affect 45 out of 45 residents in the facility. Findings: During an interview on 12/5/2024 at 9:40 a.m. with the Administrator (ADM), the facility's written documentation indicating staff names and contact	E 030	**How does the facility plan to monitor its performance to ensure that the solutions are sustained.** The VP of Clinical Services will review and approve the EOP's list of staff quarterly. / Compliance date: 12/30/2024	

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E 030	Continued From page 3 information was requested. During a concurrent interview and record review on 12/5/2024 at 2 p.m. with the ADM, the Emergency Operations Program and Plan Manual (EOP), undated, was provided as the facility's most recently updated Emergency Preparedness Program record. The record did not include the current administration's staff names and phone numbers. The ADM stated that the list of current staff contact information will be updated on the EOP.	E 030	**What corrective action will be accomplished for the residents found to have been affected by the deficient practice.** The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. The facility will conducted full-scale earthquake exercise for all dept heads on 12/30/20205.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is	E 039	Please see attached full scale exercise scenario, sign in sheet and pictures. **How will we identify other residents having the potential to be affected by the deficient practice and what corrective actions were taken** The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. **What measures will be put in place in a systematic change will be made to ensure that the deficient practice does not re-occur.** The administrator will review all safety exercises conducted the previous month to ensure that the facility remains in compliance during our monthly QA meetings.	

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E 039	Continued From page 4 exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale	E 039	**How does the facility plan to monitor its performance to ensure that the solutions are sustained.** The VP of Clinical Services will quarterly review all of the facility's safety exercises conducted the previous quarter to ensure that the facility remines in compliance. Compliance date: 12/30/2024 David Slavin, Administrator Date: 12/31/2024	

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E 039	Continued From page 5 community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based: or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional	E 039		

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E 039	Continued From page 6 exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challange an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or	E 039		

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E 039	Continued From page 7 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A360	A. BUILDING _____ B. WING _____	12/05/2024

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E 039	Continued From page 8 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility. ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a	E 039		

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E 039	Continued From page 9 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and	E 039		

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E 039	Continued From page 10 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain	E 039		

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E 039	Continued From page 11 documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises,	E 039		

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E 039	Continued From page 12 and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to test its emergency plan by not conducting a full-scale exercise (a community-based exercise, facility-based functional exercise, or if the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan) within the last 12 months. This deficient practice has the potential for staff to not be prepared during an emergency that requires the activation of the emergency plan which could negatively affect the health and safety of 45 out of 45 residents residing in the facility. Findings: During an interview on 12/5/2024 at 9:40 a.m. with the ADM, a request for the facility's written documentation for emergency preparedness training requirements for both full scale exercise and secondary exercise was made. During a concurrent interview and record review on 12/5/2024 at 2:30 p.m. with the ADM, the Emergency Operations Program and Plan Manual (EOP), undated, was provided as the facility's most recently updated Emergency Preparedness Program record. The binder did not include records of written evidence of participation in a full-scale exercise or an after-action report from an incident that had occurred within the last 12 months. The MS stated that the facility had not conducted a full-scale exercise within the last 12 months.	E 039		