| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 056351 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CHATSWORTH PARK CARE CENTER | 10610 OWENSMOUTH<br>CHATSWORTH, CA 91311 |

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| K 000 | INITIAL COMMENTS<br><br>This facility was surveyed under 42 CFR Part 483.70 (a) Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes.<br><br>The following represents the findings of the Department of Public Health during a Life Safety Code Survey.<br><br>Representing the Department of Public Health:<br><br>Surveyor ID No. 05373, REHS, HFE<br><br>Highest S/S = E<br>Census = 111 | K 000 | _____<br><br>**Disclaimer Statement**<br><br>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. | |
| K 281 SS=E | Illumination of Means of Egress<br>CFR(s): NFPA 101<br><br>Illumination of Means of Egress<br>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.<br>18.2.8, 19.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Chapter 7 Means of Egress<br>Section 7.9 Emergency Lighting<br>7.9.1 General.<br>7.9.1.1 Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:<br><br>1) Buildings or structures where required in Chapters 11 through 43 | K 281 | **This plan of correction hereby constitutes the facility's Credible Allegation of Compliance**<br><br>**K281 NFPA 101 Illumination of Means of Egress**<br><br>Solar power illumination lights were installed in the front entrance, side and back exit doors on March 05, 2019. Solar power lights in the event of emergency evacuation will be used as means of egress that are illuminated to allow occupants to evacuate away from the building in a safe and immediate manner. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vmegat, RN | TITLE: DON | (X6) DATE: 3/28/2019

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 281 | Continued From page 1<br>2) Underground and limited access structures as addressed in Section 11.7<br><br>3) High-rise buildings as required by other sections of this code<br><br>4) Doors equipped with delayed-egress locks<br><br>5) Stair shaft and vestibule of smokeproof enclosures, for which the following also apply:<br><br>a) The stair shaft and vestibule shall be permitted to be include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment.<br><br>b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply.<br><br>A.7.9.1 Emergency lighting outside the building should provide illumination to either a public way or a distance away from the building that is considered safe, whichever is closest to the building being evacuated.<br><br>7.9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle, and not less than 0.1 foot candles, measured along the path of egress at floor level.<br><br>For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.<br><br>Based on observation and interview, the facility failed to provide emergency lighting to the path of | K 281 | The Administrator and Maintenance Supervisor made rounds upon notification to verify that there were no other means of egress in need of additional illumination on March 05, 2019.<br><br>Administrator provided in service training to maintenance supervisor and designee on March 05, 2019 regarding regulation on having emergency lighting outside the building to provide illumination to either a public way or a distance away from the building that is considered safe during emergency evacuation.<br><br>The Administrator and Maintenance Supervisor will continue to monitor by doing weekly rounds to ensure illumination lights are functioning properly and providing the necessary light to these exit corridors in case of emergency evacuation. Any identified concerns will be discussed during daily stand up meeting for follow up and corrective actions. | |

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| K 281 | Continued From page 2<br>egress from the front entrance, side, and back exit door. In the event of an emergency evacuation and interruption of normal power, areas used for means of egress that are illuminated may allow occupants to evacuate away from the building in a safe and immediate manner. The facility also failed to ensure there was a battery operated emergency light in the emergency generator area located at the Owensmouth street, behind the kitchen in the event of power outage and during interruption of normal power, as a means of illumination to check the generator.<br><br>The deficient practice affected the entire facility and one of the two generator areas.<br><br>Findings:<br><br>a. During a tour of the exterior area of the facility accompanied by the maintenance supervisor on March 04, 2019, all exit doors were noted going toward outside the facility. During an interview, the maintenance supervisor stated the exterior lightings were on regular power and not on emergency power system nor battery operated. The area on the south side of the facility had exterior emergency light on the path of evacuation.<br><br>b. During the tour of the facility on March 04, 2019, accompanied by the maintenance supervisor, the evaluator observed one of the two emergency generators was located on the west side of the facility in a shade. During an interview, the maintenance supervisor stated there was no emergency light that was either battery operated and /or operating with the generator in the area to be use in the event of power outage and during | K 281 | Administrator will monitor compliance and will report during monthly QAPI any identified trends for further reviews and recommendation.<br><br>Completion date: March 29, 2019. | |

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| K 281 | Continued From page 3<br>interruption of normal power, as a means of illumination to check the generator. | K 281 | | |
| K 364 SS=D | Corridor - Openings<br>CFR(s): NFPA 101<br><br>Corridor - Openings<br>Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut.<br>In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches.<br>Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.)<br>18.3.6.5.1, 19.3.6.5.2, 8.3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure that the corridor doors to the ice machine room did not have a transfer grilles/louver. A corridor door equipped with a transfer grille would not provide the required protection from fire and/or smoke during a fire emergency.<br><br>The deficient practice affected one out of five smoke compartments.<br><br>Findings: | K 364 | **K 364 Corridor – Openings**<br><br>The facility will ensure that the corridor doors to the ice machine room will not have a transfer grilles/louver.<br><br>Maintenance Supervisor have ordered the replacement door for the ice machine on 3/27/2019 and will be installed once available.<br><br>Administrator provided in-service training to maintenance supervisor/ and designee on March 5, 2019 regarding regulations on Corridor – Openings.<br><br>The Administrator and Maintenance Supervisor will continue to monitor compliance by doing weekly rounds to ensure that ice machine door is without transfer grilles/louver.<br><br>Completion date: March 29, 2019. | |

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| K 364 | Continued From page 4<br>On March 01, 2019, during a life safety code tour of the facility with the maintenance supervisor, it was noted that the corridor door to the ice-machine room located across from Room 314 had a transfer grilles/louver on the lower and top portion of the door.<br><br>During an interview with the maintenance supervisor at the time of the observation, he did not know they could not have transfer grille/louver on the door to the corridor. | K 364 | | |
| K 918 SS=C | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to | K 918 | **F 918 Electrical Systems – Essential Electric System**<br><br>The facility will ensure that there are two sets of instruction manuals kept in a secure area and convenient location near the equipment and the other set kept in a different secure location.<br><br>Maintenance Supervisor provided two separate instructional manuals for each generator to ensure the routine maintenance and operational testing programs of the EPSS is based on the manufacturer's recommendations and instruction manual. | |

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| K 918 | Continued From page 5<br>manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition<br>8.1 Generator Maintenance.<br>8.2.1 At least two sets of instruction manuals for all major components of the EPSS shall be supplied by the manufacturer(s) of the EPSS and shall contain the following:<br>(1) A detailed explanation of the operation of the system<br>(2) Instructions for routine maintenance<br>(3) Detailed instructions for repair of the EPS and other major components of the EPSS<br>(4) An illustrated parts list and part numbers<br>(5) Illustrated and schematic drawings of electrical wiring systems, including operating and safety devices, control panels, instrumentation, and annunciators.<br>8.2.2 For Level 1 systems, instruction manuals shall be kept in a secure, convenient location, one set near the equipment, and the other set in a separate location.<br>Based on observation and interview, the facility failed to ensure there were two sets of instruction manuals kept in a secure and convenient location near the equipment and the other set kept in a | K 918 | Administrator provided in-service training to maintenance supervisor/designee on March 05, 2019 regarding the regulations on having the instructional manuals available in a secure location during the maintenance and testing of the generators.<br><br>Administrator will monitor on going compliance thru weekly environmental rounds. Any identified issues will be addressed during daily stand up meeting and will be presented during monthly QA and A committee for further recommendation<br><br>Completion date: March 29, 2019 | |

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| K 918 | Continued From page 6<br>different secure location. The deficient practice had the potential to not ensure the routine maintenance and operational testing program of the EPSS is based on the manufacturer's recommendations and instruction manual.<br><br>This deficient practice affected the entire facility.<br><br>Findings:<br><br>On March 04, 2019, during observation of the generator and an interview with the maintenance supervisor he stated that he does not have any instruction manuals. He stated he did not he is require to have them available in the facility. There were two different emergency generators which were located in two separate area of the facility. During a concurrent interview, he stated that he will obtain a copy of the manual for each generator. | K 918 | | |
| K 923 SS=D | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. | K 923 | **F 923 Gas Equipment – Cylinder and Container Storage**<br><br>The facility will ensure that the full oxygen cylinder was separated from the empty cylinders. | |

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| K 923 | Continued From page 7<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>NFPA 99, Health Care Facilities Code, 2012 Edition<br><br>11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:<br><br>(1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device.<br>(2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them.<br>(3) Cylinders shall be protected from tampering by unauthorized individuals. | K 923 | Administrator and Central Supply manager made rounds to ensure full tank oxygen are separated from the empty tank in the Oxygen storage on March 5, 2019.<br><br>Director of Rehabilitation (DOR) provided in-service training to rehab staff March 15, 2019 regarding the Oxygen Tanks storage to ensure the full oxygen cylinders are stored separately from empty oxygen cylinder.<br><br>DSD provided in-service training to certified nursing assistants and restorative nursing assistants on March 26 to March 28, 2019 regarding the Oxygen Tanks Storage policy to ensure the full oxygen cylinders are stored separately from the empty oxygen cylinders.<br><br>Administrator, Central Supply Manager, Maintenance Supervisor and Assistant DSD will monitor compliance during routine rounds and any issues identified will be immediately corrected and discussed during daily stand up meeting. | |

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| K 923 | Continued From page 8<br>(4) Cylinders or cylinder valves shall not be repaired, painted, or altered.<br>(5) Safety relief devices in valves or cylinders shall not be tampered with.<br>(6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water.<br>(7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device.<br>(8) Sparks and flame shall be kept away from cylinders.<br>(9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them.<br>(10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1.<br>(11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.<br>(12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts.<br><br>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.<br><br>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.<br><br>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.<br><br>Based on observation and interview, the facility failed to ensure that the full oxygen cylinder was | K 923 | Administrator will monitor on going compliance random observation rounds. Any identified issues will be addressed and will be presented during monthly QA and A committee for further recommendation and plan of action.<br><br>Completion date: March 29, 2019 | |

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| K 923 | Continued From page 9<br>separated from empty cylinders; and the oxygen cylinder was properly chained or secured. The deficient practice could result in staff choosing an empty cylinder and may cause delay in a medical emergency.<br><br>The deficient practice affected one of five smoke compartments.<br><br>Findings:<br><br>On March 04, 2019, at 1:30 p.m., during a tour of the facility, the evaluator, in the presence of a maintenance supervisor, noted the following:<br><br>The small full oxygen (E) tank was stored in the empty oxygen storage closet across from the activity/kitchen. The sign on the door stated empty oxygen storage. The same oxygen tank was left loose in the closet and not secured.<br><br>During an interview with the maintenance supervisor at the time of the observation, he stated he could not explain why the staff was storing full and empty oxygen E- tanks together and why the oxygen tank was not secured. | K 923 | | |

POC accepted 05373 on 04/04/19

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

PRINTED: 03/15/2019
FORM APPROVED
OMB NO. 0938-0391

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| E 000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities.<br><br>Representing the Department of Public Health:<br><br>Surveyor ID No. 05373, REHS, HFE<br>Census 41111<br>Scope and Severity: C | E 000 | **Disclaimer Statement**<br><br>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. | |
| E 007 SS=C | EP Program Patient Population<br>CFR(s): 483.73(a)(3)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]<br><br>(3) Address patient/client population, including, but not limited to, persons at risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**<br><br>*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the emergency preparedness plan address resident population, including but | E 007 | **This plan of correction hereby constitutes the facility's Credible Allegation of Compliance**<br><br>**E007 EP PROGRAM PATIENT POPULATION**<br><br>The Administrator, Director of Nursing Services and IDT reviewed the emergency preparedness plan to address resident population to identify person and resident at risk to ensure resident receiving dialysis in the dialysis facilities receives adequate care and treatment is provided during emergency. Updated list was file in the Facility's emergency preparedness binder on 3/28/2019. | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 056351 | A. BUILDING _____ B. WING _____ | 03/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CHATSWORTH PARK CARE CENTER | 10610 OWENSMOUTH CHATSWORTH, CA 91311 |

| (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 |
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| E 007 | Continued From page 1<br>not limited to persons at risk, the type of services and the facility's ability to provide continuity of operations including delegations of authority and succession plans. The deficient practice has the potential for at risks residents not to be provided with adequate care and treatment.<br><br>Findings:<br><br>On March 04, 2019, at 11:30 a.m., during the documentation review with the administrator, it was determined that the facility failed to have an emergency preparedness plan that included resident population and at risk residents considering the type of services needed in an emergency such as residents who were receiving dialysis in the dialysis facilities. The administrator confirmed the findings and stated there were four residents residing in the facility who receive dialysis in a dialysis center and acknowledged the need for a plan for continuity of care for the residents who are in need of dialysis during emergency. | E 007 | The Administrator, Director of Nursing and IDT members, will to monitor compliance by reviewing and updating the resident at risk q monthly and as needed. Any identified issues will be discussed in the monthly QAPI meeting for further review and recommendation.<br><br>Compliance date: March 29, 2019. | |
| E 015 SS=C | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff | E 015 | **E015 EP – SUBSISTENCE NEEDS FOR STAF AND PATIENTS**<br><br>The Administrator, Director of Nursing, and Central Supply Coordinator have reviewed the policy and procedure for addressing the subsistence needs of the facility for medical and pharmaceutical supplies. The Emergency Preparedness program has been updated to include provisions, and "par level" inventories for current supplies on hand on March 28, 2019. | |

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| E 015 | Continued From page 2<br>and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br>[For Inpatient Hospice at §418.113(b)(6)(iii):]<br>Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only.<br>The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to have an emergency preparedness plan | E 015 | The Administrator, Director of Nursing, and Central Supply coordinator will monitor the subsistence needs for residents, facility staff, volunteers, and individuals from the community to address any immediate changes or adjustments needed to be aligned with the Emergency Preparedness Program.<br><br>The Administrator, Director of Nursing and IDT members, will continue to monitor compliance by updating the Emergency Preparedness Program annually and as needed to ensure facility's policy includes the subsistence needs of resident, staff, volunteers, individuals from the community. Any identified issues will be discussed in the monthly QAPI meeting for further review and recommendations.<br><br>Completion date: March 29, 2019. | |

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| E 015 | Continued From page 3<br>addressing the provision of subsistence needs (survival) for staff and residents whether they evacuate or shelter in place. The deficient practice has the potential for residents and staff not to receive subsistence needs in an emergency.<br><br>Findings:<br><br>On March 04, 2019, during a review of the documentation with the administrator, it was determined that the facility did not have a current written policy and procedure addressing the subsistence needs for residents, staff, volunteers, and individuals from the community. These subsistence needs include medical and pharmaceutical supplies.<br><br>The administrator confirmed the findings. | E 015 | | |