STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A340	A. BUILDING **02** B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR - 104	**1130 MONACO COURT** **STOCKTON, CA 95207**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 43380 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. Representing the California Department of Public Health: 43380 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 184	E 000		
K 000	INITIAL COMMENTS Surveyor: 43380 K3 BUILDING: 01 K6 PLAN APPROVAL: 3/1/1981 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. Resident Certified Beds: 184 Resident Census: 190 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The	K 000		

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

Electronically Signed | 06/07/2024

6/11/2024: POC accepted per Cynthia Luc, SSM-1

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K 000	Continued From page 1 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. Representing the California Department of Public Health: 43380 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		6/3/24

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K 321	Continued From page 2 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the hazardous area enclosures. This was evidenced by a corridor door that failed to latch. This affected 29 of 184 residents and one of eight smoke compartments and could result in the spread of smoke and fire. Findings: During a tour of the facility with the Maintenance Supervisor on 5/30/24, the hazardous enclosure areas were observed. At 11:23 a.m., the corridor door to the central supply closet near Nurse Station 3 failed to latch when tested. The door was equipped with a self-closing device and was tested three times. The room was approximately 64 square feet and stored central supplies for the facility. Upon interview, the Maintenance Supervisor stated that a fan in that room created pressure that prevented the door from latching.	K 321	K321 Hazardous Areas-Enclosure CFR(s) NFPA 101 HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility ensured hazardous areas were protected by repairing the corridor door to the Central Supply that failed to latch when tested during Life Safety Inspection tour. The self-closing mechanism was replaced on 6/03/24 by the Maintenance Supervisor and the door closed and latched properly when tested. The facility will maintain proper function of all doors to ensure they close and latch properly during routine rounds no less than quarterly. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents could be affected by a fire door failing to latch which would allow smoke and fire to spread to other areas in the event of a fire. The Maintenance Supervisor tested all fire doors in the facility on 6/3/24 and found no other doors that failed to close and	

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K 321	Continued From page 3	K 321	latch ensuring that smoke/and or fire would be contained to each compartment in the event of a fire. Staff will be reminded to report to Maintenance or Safety Officer any doors noted not to be closing and latching properly and the rationale for doing so at the refresher of Life Safety Inservice to be completed by 6/30/2024 and at the annual Emergency Operations Inservice training. WHAT MEASURES OR SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: During routine rounds by the Maintenance Supervisor and during fire drills by facility Safety Officer not less than quarterly fire doors will be checked to ensure that all close and latch to ensure that smoke/and or fire would be contained to each compartment in the event of a fire. Should any doors be found with a problem it will be adjusted/repaired as soon as possible. HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THIS PLAN MUST BE IMPLEMENTED, AND THE CORRECTIVE ACTION AVALUATED FOR IT□S EFFECTIVENESS. THE POC MUST BE INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM. The facility will monitor it□s performance through the routine door checks by the Maintenance Supervisor or designee and during the fire drills by the Safety Officer	

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K 321	Continued From page 4	K 321	not less than quarterly. Both Maintenance Supervisor and Safety Officer will remind staff to report to Maintenance any doors noted to be not closing and latching fully and the rationale of containing smoke/and or fire in each compartment in the event of a fire at least quarterly during fire drills and annually at the Emergency Operations Inservice. The Maintenance Director and Safety Officer(s)will report on the findings of routine inspections done not less than quarterly at the quarterly QAPI Committee Meeting x 1 year. See attached Fire Door Check log.	
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the smoke detectors. This was evidenced by an obstructed smoke detector. This affected 19 of 184 residents and one of eight smoke compartments and could result in a delay of notification to emergency forces in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6 Fire Detection, Alarm, and Communications	K 347	K347 Smoke Detector: HOWCORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: Tape on smoke detector near Station One Nursing station likely placed during a repair recently in the area. Tape (obstruction) was immediately removed by Maintenance Supervisor and a visual inspection noted it to be functioning on 5/30/24. All Smoke Detectors were also checked on 5/30/2024 and no other	5/30/24

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K 347	Continued From page 5 Systems. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 14.3.1 * Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1 Visual Inspection Frequencies 9. Initiating devices (h) Smoke detectors (excluding one- and two-family dwellings)- Semiannually 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance. Findings: During a tour of the facility and interview with the Maintenance supervisor on 5/30/24, the smoke detector were observed. At 10:15 a.m., a smoke detector on the ceiling in front of the cross-corridor doors near Nurse Station 1 was observed covered in masking tape. Upon interview, the Maintenance Director stated that they had recently updated Nurse Station 1, and the masking tape must have been left over from that project.	K 347	smoke detectors were found with any tape or other obstruction on them. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE DEFICIENT PRACTICE: All residents could be affected by an obstructed smoke detector that could result in delay of notification to emergency forces in the event of a fire in the facility. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The facility Maintenance Supervisor or designee will conduct routine visual checks of the smoke detectors no less than weekly during rounds. Smoke detectors that are covered for repair purposes will be returned to normal operation daily once repair work is completed for the day. The Facility Safety Officer/s will conduct routine building safety checks no less than quarterly including checking all smoke detectors for tape or debris obstructing it and immediately remove it and report to the Maintenance Supervisor or designee. All staff will be reminded of the importance of smoke detectors being free from obstruction at a refresher inservice completed by 6/30/2024 and at the mandatory annual Emergency Operations Inservice. HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT THE SOLUTIONS ARE SUSTAINED AND CORRECTIONS	

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K 347	Continued From page 6	K 347	ACHIEVED/SUSTAINED: The facility will monitor it□s performance through the facility Quality Assurance Performance Improvement Process (QAPI). The facility Maintenance Supervisor and Safety Officer/s will report findings from weekly and no less than quarterly inspections of smoke detectors during the Quarterly QAPI Committee Meetings. Should there be found a recurrence of tape or other debris on smoke detectors the QAPI Committee may initiate a Performance Improvement Project to study issues and adjust the plan as needed to ensure maintenance of facility smoke detectors at all times. QAPI Committee reviews will continue quarterly x 1 year. See attachment Cleared smoke detector.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		6/6/24

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K 353	Continued From page 7 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the fire sprinkler system. This was evidenced by missing signage on the control valve and foreign material on a sprinkler. This affected 61 of 184 residents and two of eight smoke compartments and could result in delay and confusion of identifying the fire sprinkler valve that serves the facility. NFPA 101 Life Safety Code, 2012 edition 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.1 Automatic Sprinklers. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.1 Automatic Sprinklers. 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems	K 353	K353 Sprinkler System: HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: A permanently marked weatherproof metal sign was placed and secured with corrosion- resistant wire on the sprinkler system to identify the portion of the building served by the control valve by 6/6/2024. The Maintenance Supervisor thoroughly cleaned the dust covered sprinkler head in the walk-in area of the kitchen noted on inspection of the facility on 5/3/2024 clearing any obstruction to the water flow from the sprinkler should a fire break out. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have potential to be affected by lack of maintenance of the fire sprinklers by an obstructed sprinkler and lack of sprinkler valve identification should a fire break out . Routine cleaning will be performed by Maintenance Supervisor or designee to prevent build-up of dust and debris on the sprinkler heads. The Maintenance Supervisor will ensure that this task is on the regular task list for Maintenance staff to complete. The Maintenance Supervisor or designee will visually inspect the sprinkler heads during	

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K 353	Continued From page 8 NFPA 13: Standard for the Installation of Sprinkler Systems, 2010 Edition 6.7.4 * Identification of Valves. 6.7.4.1 All control, drain, and test connection valves shall be provided with permanently marked weatherproof metal or rigid plastic identification signs. 6.7.4.2 The identification sign shall be secured with corrosion-resistant wire, chain, or other approved means. 6.7.4.3 The control valve sign shall identify the portion of the building served. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). Findings: During a tour of the facility and interview with the Maintenance Supervisor on 5/30/24, the automatic sprinkler system was observed. 1. At 9:33 a.m., the facility was observed with two fire sprinkler risers. The sprinkler control valve on the fire sprinkler riser near Nurse Station 1 was missing an identification sign. Upon interview, the Maintenance Supervisor acknowledged that the control valve was missing signage. 2. At 9:57 a.m., the single fire sprinkler in the ceiling of the walk-in refrigerator was observed. The sprinkler frame and sensing bulb was covered in dirt. Upon interview, the Maintenance	K 353	regular rounds no less than monthly to ensure no dust or other debris is obstructing the flow of water from the sprinkler in the even of a fire. The Maintenance Supervisor will ensure that the signage for the sprinkler valves is maintained, visible and meets the NFPA 13 standards for Identification of valves. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The facility Maintenance Supervisor or designee will document the regular monthly visual inspections in the Sprinkler System Maintenance Binder. The Maintenance Supervisor will ensure regular cleaning of sprinkler heads and placement/ condition of the valve signage continues to meet NFPA 13 standards during regular rounds in the facility. If obstruction/debris is found it will be cleaned/repaired as soon as possible to ensure proper functioning of the fire sprinkler system. Should signage be obstructed or nonreadable the Maintenance Supervisor or designee will promptly replace the sign within NFPA 13 standards. The Maintenance Supervisor or designee will report the status of routine monthly sprinkler checks and that Sprinkler valves have required signage to the Quality Assurance Performance Improvement (QAPI) committee in the monthly QAPI meetings. The Safety Officer/s will do spot checks during fire drills of sprinklers/signage as well as no less than quarterly Safety audits. All staff	

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K 353	Continued From page 9 Supervisor acknowledged that the sprinkler was covered in dirt.	K 353	will receive inservice education regarding importance of keeping sprinkler heads free of dirt/debris to maintain a fully functional sprinkler system to help put out a fire should one break out in the facility as well as the importance of signage on the sprinkler valves. Inservice education on keeping sprinkler heads free of dirt and sprinkler valves having required signage will also be included in the annual Emergency Operations Inservice mandatory for all staff. This will be completed by 6/30/2024 THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED AND CORRECTIONS ARE CONTINUED BY: The Facility will monitor it□s performance through the facility QAPI process. The Maintenance Supervisor and Safety Officer/s will report progress on routine rounds and monthly inspections of the sprinklers as well as the sprinkler valve signage to the QAPI Committee during the monthly meetings. Should there be problems identified by the Committee they may initiate a Performance Improvement Plan (PIP) to study the issues and strategize or adjust the plan as needed. Monthly review will continue for no less than 6 months (2 quarters) to ensure the effectiveness of the plan. See attached picture of clean sprinkler head	
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers	K 355		5/31/24

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K 355	Continued From page 10 Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the fire extinguishers. This was evidenced by missing inspection date and initials on the fire extinguisher tag. This affected the exterior generator area and could result in the failure of a fire extinguisher, in the event of a fire. NFPA 101: Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 * Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10: Standard for Portable Fire Extinguishers, 2010 Edition 7.2.4 Inspection Record Keeping. 7.2.4.3 Where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Findings: During a tour of the facility and interview with the Maintenance Supervisor on 5/30/24, the fire	K 355	K355 Portable Fire Extinguishers HOW CORRECTIVE ACTION WAS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The fire extinguisher that was missed for monthly inspection in the exterior generator area was inspected finding no issues and initialed by the Maintenance Supervisor by 5/31/24 and added to the monthly extinguisher inspection log. This was a recently added fire extinguisher recommended by the Stockton Fire Marshall and the newly added extinguisher was not added to the log contributing to Maintenance staff missing it□s monthly inspection. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE DEFICIENT PRACTICE: All residents have the potential to be affected by fire extinguishers not being maintained in the facility in the event of a fire if the extinguisher failed. The fire extinguisher near the generator was immediately inspected and noted no problems. The extinguisher was placed on the monthly extinguisher check log to ensure that the Maintenance Director or designee will be prompted to do a monthly	

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K 355	Continued From page 11 extinguishers were observed. At 9:57 a.m., the inspection tag on the fire extinguisher mounted in the generator enclosure was observed. The inspection tag was missing the record of monthly inspection dates and initials of the person performing the inspection for April 2024. The annual inspection and maintenance had been conducted on February 7, 2024. Upon interview, the Maintenance Supervisor acknowledged that the fire extinguisher was missing an inspection record for April.	K 355	inspection of the fire extinguisher, initial and date the extinguisher and check it off when complete in the fire extinguisher log in the Maintenance Department. The Maintenance Supervisor or designee will conduct no less than monthly checks of all fire extinguishers to ensure inspections were completed with a corresponding staff initials and date as well as checking the fire extinguisher inspection log to ensure it is logged. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Supervisor or designee will check no less than monthly all fire extinguishers to ensure monthly inspections including staff initials and date are placed on the fire extinguishers and that inspections are logged in the binder for all extinguishers. At any time that a new extinguisher is added the Maintenance Supervisor or designee will add the extinguisher and it□s designated location to the monthly extinguisher check binder and then check no less than quarterly to ensure no extinguishers are left out of the monthly inspections. Facility Safety Officers will do spot checks during fire drills and no less than quarterly building safety audits. Staff will be reminded of the importance of monthly inspections of facility fire extinguishers and the rationale for this in a refresher inservice by 6/30/2024, and at the mandatory annual Emergency Operations Inservice.	

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	05A340	A. BUILDING **02** B. WING _____	**05/30/2024**

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K 355	Continued From page 12	K 355	HOW THE FACILITY PLANS TO MONITOR IT S PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED AND CORRECTIONS ARE ACHIEVED: The facility plans to monitor it s performance through the facility QAPI process by reviewing reports from the Maintenance Supervisor or designee s monthly inspections of the fire extinguishers and extinguisher log along with reports from the Safety officer of the spot checks during fire drills and the no less than quarterly safety audit. Should the QAPI Committee determine that the plan is not effective and/or corrections not being achieved the committee may make adjustments to the plan, create a Performance Improvement Plan to study and strategize and ensure effectiveness of the plan. The plan will be reviewed by the QAPI committee x 6 months (2 quarters). see attached monthly check log	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		6/3/24

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K 372	Continued From page 13 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the smoke barrier walls. This was evidenced by penetrations in smoke barrier walls in the attic. This affected 43 of 184 residents and two of eight smoke compartments and could result in the spread of smoke between smoke compartments during a fire. NAPA 101, Life Safety Code, 2012 Edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(ac). (B) Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that	K 372	K372 Smoke Barriers Construction Completed by 6/3/2024 HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/3/2024 the penetrations in the smoke barrier wall on station One attic area found on inspection on 5/30/24 were fully sealed with 3M Fire Barrier IC-15WB Intumescent sealant. The penetrations were made during maintenance of the nursing station area. Upon completion the area was not sealed. On 6/3/24 the Maintenance Supervisor inspected all areas of the facility for penetrations and found no other penetrations in smoke barrier walls. HOW THE FACIITY WILL IDENTIFY OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by the deficient practice of penetrations in the barrier walls in the event of a fire in the facility. The Maintenance Supervisor examined on 6/3/24 all areas of the facility for penetrations and no others were found. Penetrations found during survey in	

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K 372	Continued From page 14 pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. Findings: During a tour of the facility and interview with the Maintenance Supervisor on 5/30/24, the smoke barrier walls were observed. At 10:11 a.m., a conduit was observed going through the smoke barrier wall above the cross-corridor doors near the station 1 Dining Room. The conduit had approximately six blue low voltage data cables running through it and was not sealed on the end with a material capable of restricting the transfer of smoke. Upon interview, the Maintenance Supervisor stated that they had a vendor complete work in the attic, and they did not seal the penetrations.	K 372	barrier walls were sealed with 3M Fire Barrier IC-15WB Intumescent sealant by 6/3/24. Maintenance Supervisor and Safety Officers will check facility for penetrations on routine rounds no less than quarterly and after maintenance is completed. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR: During routine rounds not less than quarterly made by the Maintenance Supervisor or designee the walls and ceilings of the facility will be checked for penetrations. If found the penetration will be sealed with fire sealant to ensure sealant of all smoke compartments to prevent spread of fire in the event of a fire. The Maintenance Director or designee will complete thorough inspections of the wall/ceilings checking for smoke barrier penetrations after repairs in the facility promptly sealing any penetrations found with 3M Fire Barrier IC-15WB Intumescent Sealant. Facility staff will be reminded of the need to report any penetrations noted in the facility walls/ceilings and to report immediately to Maintenance Department at refresher inservice to be given by 6/30/24 and during annual mandatory Emergency Operations Inservice. HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCETO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. EFFECTIVENESS. THE POC MUST BE INTEGRATED INTO THE	

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K 372	Continued From page 15	K 372	QUALITY ASSURANCE SYSTEM: The facility will monitor performance through the routine not less than quarterly rounds by the Maintenance Supervisor or designee and Safety Officers and after completion of any maintenance. The Maintenance Supervisor will report on the findings of his rounds at the Quarterly Quality Assurance Performance Improvement Committee meeting for 1 year. During the annual Emergency Operations Plan Inservice staff will be reminded to report any penetrations noted to the Maintenance Supervisor/Administrator. The QAPI committee will review the plan and may decide to complete a Performance Improvement Plan (PIP) for further study and revision of the plan to improve it□s effectiveness. The QAPI Committee will review quarterly x 1 year. see attached pics of smoke barriers sealed	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		6/30/24

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K 712	Continued From page 16 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on record review and interview, the facility failed to ensure that all staff on all shifts were familiar with the fire drill procedures. This was evidenced by the failure to conduct three of 12 fire drills in the past 12 months. This affected 184 of 184 residents, and eight of eight smoke compartments and could result in staff being untrained and unaware of their roles and responsibilities in the event of a fire. Findings: During record review and interview with the Assistant Director of Staff Development/Safety Officer on 5/30/24, the fire drill records were reviewed. At 12:59 p.m., the facility failed to provide documentation that fire drills were conducted on the second and third shifts, during the third quarter (July, August, September) and the first shift during the fourth quarter (October, November, December) of 2023. Upon interview, the Assistant Director of Staff Development/Safety Officer stated that the missing fire drill records was an oversight.	K 712	K712 Fire Drills HOW CORRECTIVE ACTION WAS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Safety Officer took over completing fire drills the third quarter 2023 when the vendor completing fire drills for the facility retired. Fire drills were completed with each shift for the quarter however some drill times were found to be at overlapping times between shifts. The Safety Officer reviewed the regulations with the Life Safety Surveyor on 5/30/2024 for complete understanding of how fire drills should be conducted to be in compliance with K712 and NFPA 101 for Nursing facilities with fire drills held at expected and unexpected times under varying conditions, at least quarterly on each shift. A calendar for drills following those guidelines for the remainder of the year was completed by 6/3/2024 and given to the Administrator. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED BY THE DEFICIENT PRACTICE: Since all residents have the potential to be affected by missed fire drills the Safety Officer will provide the schedule of fire drills for the next quarter to the Administrator and Safety officer will ensure that fire drills are conducted every shift every quarter at unexpected times without overlapping time between two shifts to be in compliance with the	

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K 712	Continued From page 17	K 712	regulations and maximize staff training for responsiveness in the event of a fire in the facility. WHAT MEASURES WILLL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Safety Officer will keep written drill evaluations with recorded times and signature sheets as proof of completion of fire drills and will log in the Fire Drill Binder. The Business Office will audit the Binder no less than quarterly to ensure fire drills are completed per regulation and logged. If noted missing fire drill/s this will be reported immediately to the Administrator and Safety Officers so corrective action can be taken. The facility Administrator will conduct spot-checks in completing routine rounds and checking in with the Safety Officers and Business Office staff. THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED AND ENSURE CORRECTIONS ARE ACHIEVED BY: Monitoring the fire drills through the facility QAPI process. The facility Safety Officers will report to the facility QAPI Committee monthly on the progress of fire drills and the times conducted. The Business Office Manager will report findings of Fire Drill Binder audits that are conducted no less than quarterly also to the QAPI Committee for 1 year. The QAPI Committee will examine the effectiveness of the interventions to ensure fire drills are	

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K 712	Continued From page 18	K 712	conducted every shift every quarter with separate unexpected times each time conducted and this will be monitored for at least one year and adjusted as needed. See attached Fire Drill Calendar	