STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056430	A. BUILDING **02** B. WING _____	**09/29/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHGATE POSTACUTE CARE	**40 PROFESSIONAL CENTER PARKWAY** **SAN RAFAEL, CA 94903**

(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: Federal ID Number 43380 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 42	E 000		
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local	E 031		10/29/21

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

Electronically Signed | 10/14/2021

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.

10/14/21 Accepted by Janine Smith-Farmer

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E 031	Continued From page 1 emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on document review and interview, the facility failed to maintain the emergency communication plan. This was evidenced by the failure to include contact information for the Office of the State Ombudsman. This affected 42 of 42 residents and could result in a delayed response to an emergency situation. Findings: During document review and interview with the Administrator on 9/29/21, the emergency communication plan was reviewed. At 10:59 a.m., the emergency preparedness plan did not include contact information for the Office of the State Long-Term Care Ombudsman. When	E 031	What corrective action/s will be accomplished for those fire safety requirements found to have been deficient: On 9/29/2021, the Administrator wrote and included in the list of emergency contacts the telephone number and address of the Office of the State Long-Term Care Ombudsman. Complete Date: 9/29/2021 How to identify related fire safety features that may have the potential to be affected by deficient practice and what corrective action will be taken. The Administrator reviewed the facility□s list of emergency contact to ensure that	

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E 031	Continued From page 2 interviewed, the Administrator confirmed the finding.	E 031	the facility list has the contact information of federal, state, tribal, regional, and local emergency preparedness staff. Complete Date: 9/29/2021 What measure will be put in place or what systemic change will be made to ensure that the deficiency found will not recur: The Administrator will review monthly with the Department Heads, the internal and external emergency contact list included in the facility□s Emergency Operation Plan to ensure that the contact information for the federal, state, tribal, regional, and local emergency preparedness staff are correct and current. Complete Date: 10/29/2021 How will the corrective actions be monitored to ensure that the deficient practice will not recur: The Administrator will present to the Quality Assessment and Assurance Committee the Status of compliance for review and immediate action and inclusion to the QAPI Program as needed. This Plan of Correction will be completed by 10/29/2021	
E 032 SS=D	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3),	E 032		10/29/21

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E 032	Continued From page 3 §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to provide a communication plan that included accurate information for primary and alternate means of communication. This could result in the lack of notification to staff, federal and state officials, tribal, regional and local emergency management agencies in the event of an emergency, and affected 42 of 42 residents. Findings: During document review and interview with Maintenance Staff on 9/29/21, the EPP was requested and reviewed.	E 032	What corrective action/s will be accomplished for those fire safety requirements found to have been deficient: The Department Heads and the Administrator planned and decided that the following will be used as the facility EOP□s Primary Communication: land lines and cell phone with texting, and for alternate communication the following will be used; hand- held radios, internet, and alert networks. Complete Date: 10/11/2021 How to identify related fire safety features that may have the potential to be affected	

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E 032	Continued From page 4 At 11 a.m., a satellite phone and HAM radio were included as alternate means of communication in the EPP's communication plan. When interviewed, Maintenance Staff confirmed the finding that the facility did not utilize these forms of alternate communication in emergency situations.	E 032	by deficient practice and what corrective action will be taken. On 10/11/2021, the Department Heads and the Administrator determined that hand-held radio (walkie-Talkie), internet, and alerts networks are the readily available modes of alternate communication for the staff. Complete Date: 10/112021 What measure will be put in place or what systemic change will be made to ensure that the deficiency found will not recur: The DSD will provide in-service to the staff on the use of the alternate communication such as hand-held radio (walkie-talkie), internet, and alerts networks. Complete Date: 10/112021 The DSD will conduct a monthly exercise on the use of the alternate communication available to the staff. Complete Date: 10/29/2021 How will the corrective actions be monitored to ensure that the deficient practice will not recur: The Administrator will report to the Quality Assessment and Assurance Committee the Status of compliance during its monthly meeting for review and immediate action and inclusion to the QAPI Program as needed. This Plan of Correction will be completed	

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E 032	Continued From page 5	E 032	by 10/29/2021.	
K 000	INITIAL COMMENTS	K 000		
	Surveyor: 43380 K3 BUILDING: 02 K6 PLAN APPROVAL: 3/22/1974 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, W/ PARTIAL BASEMENT, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. 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. 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. Census = 42			
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		10/29/21

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K 161	Continued From page 6 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by a penetration in the ceiling. This could result in the	K 161	What corrective action/s will be accomplished for those fire safety requirements found to have been deficient:	

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K 161	Continued From page 7 spread of smoke in the event of a fire and affected one of two smoke compartments. Finding: During a tour of the facility and interview with Maintenance Staff on 9/29/21, the walls and ceilings were observed. At 11:46 a.m., a thirteen inch by two and a half inch penetration was observed in the ceiling around a wooden panel in the Oxygen Storage Room. When interviewed, Maintenance Staff confirmed the finding.	K 161	On 9/29/2021, the Maintenance Staff patched the thirteen inches by two and a half inches penetration found on the ceiling around a wooden panel in the Oxygen Storage Room with a piece of particle board to maintain integrity of the ceiling. Complete Date: 9/29/2021 How to identify related fire safety features that may have the potential to be affected by deficient practice and what corrective action will be taken: On 9/29/2021, the Maintenance Staff conducted an inspection of the walls and ceiling in the building for possible penetrations. No other penetration was found during the inspection. Complete Date: 9/29/2021 What measure will be put in place or what systemic change will be made to ensure that the deficiency found will not recur. On 10/11/2021, the Administrator provided in-service to maintenance staff regarding K161, Building Construction Type and Height □ NFPA 101 that focused on the integrity of the building. Complete Date: 10/11/2021 The Maintenance Staff will conduct a monthly inspection of the ceilings and walls in the building to ensure that potential holes or gaps in the ceilings or walls will be patched in a timely manner to maintain the integrity of the building. Complete Date: 10/29/2021	

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K 161	Continued From page 8	K 161	On 10/11/2021, the Administrator created a log that documents the monthly inspection of ceilings and walls by the maintenance staff. Complete Date: 10/11/2021 The Administrator provided in-service housekeeping staff to report any sightings of holes and gaps on the ceilings and on the walls for immediate repairs. Complete Date: 10/11/2021 The Administrator and the Maintenance Supervisor will review the log to ensure that the monthly inspection of walls, ceilings, and holes is sustained and followed up. Complete Date: 10/29/2021 How will the corrective actions be monitored to ensure that the deficient practice will not recur: The Maintenance Supervisor will report status of compliance to the Quality Assessment and Assurance Committee during its monthly meeting for review and immediate action and inclusion to the QAPI Program as needed. Plan of Correction will be completed by 10/21/2021	
K 344 SS=E	Fire Alarm - Control Functions CFR(s): NFPA 101 Fire Alarm - Control Functions	K 344		10/29/21

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K 344	Continued From page 9 The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the fire safety function of the fire alarm system. This was evidenced by the fire doors not closing when the fire alarm was activated. This affected 42 of 42 Residents and could result in the spread of smoke in the event of a fire. NFPA 101: Life Safety Code, 2012 Edition 19.3.4.4 Fire Safety Functions. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5.) 9.6.5 Fire Safety Functions. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Unlocking of doors (5) Elevator recall and shutdown (6) HVAC shutdown Findings: During a tour of the facility and interview with Maintenance Staff on 9/29/21, the fire alarm system was tested.	K 344	What corrective action/s will be accomplished for those fire safety requirements found to have been deficient: On 9/29/2021, the Maintenance Supervisor called the Fire Alarm System and Signaling Company contracted by the facility to diagnosed and to fix the cause of the failure of the fire door to be release from their magnetic hold-open devices when the manual fire alarm pull station was initiated. Complete Date: 9/29/2021 On 9/30/2021, the Fire Alarm System and Signaling Technician diagnosed and repaired the cause of the failure of the fire doors to close, all the other components of the fire alarm system were observed to have functioned properly. Complete Date: 9/30/2021 On 9/30/2021, after the repair, the technician and the Maintenance Supervisor tested the fire alarm system by pulling the manual fire alarm pull station and as required the fire doors were released from their magnetic hold-open devices. Complete Date: 9/30/2021	

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K 344	Continued From page 10 1. At 12:45 p.m., the manual fire alarm pull station next to the Nurses Station was initiated. The audible and visual alarms were activated, but the fire doors did not release from their magnetic hold-open devices. The doors did release when the "silence alarm" button was pushed on the Fire Alarm Control Panel. When interviewed, Maintenance Staff confirmed that the fire doors failed to close when the manual fire alarm pull station was initiated. 2. At 12:50 p.m. the Inspectors Test Valve (ITV) was initiated on the exterior of the building. The audible and visual alarms were activated at 42 seconds after the ITV was initiated, but the smoke compartment doors did not release from their magnetic hold-open devices. The doors did release when the "silence alarm" button was pushed on the Fire Alarm Control Panel. When interviewed, Maintenance Staff confirmed that the fire doors failed to close when the ITV was initiated.	K 344	How to identify related fire safety features that may have the potential to be affected by deficient practice and what corrective action will be taken. On 9/30/2021, after Fire Alarm System and Signaling Technician diagnosed and repaired the cause of the failure of the fire doors to close, all the other components of the fire alarm system were observed to have functioned properly. Complete Date: 9/30/2021 What measure will be put in place or what systemic change will be made to ensure that the deficiency found will not recur. The Administrator and the Maintenance Supervisor will review the Fire Alarm System Monthly Testing Log to ensure that the required testing is done and that issues arising from the monthly testing are addressed immediately. Complete Date: 10/29/2021 How will the corrective actions be monitored to ensure that the deficient practice will not recur: The Maintenance Supervisor will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of compliance for review and immediate action and inclusion to the QAPI Program as needed. This Plan of Correction will be completed by 10/21/2021	

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K 363	Continued From page 11	K 363		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		10/29/21

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K 363	Continued From page 12 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by corridor doors that did not latch when tested or were obstructed from closing. This affected two of two smoke compartments and could result in the spread of fire or smoke in the event of a fire. Findings: During a tour of the facility and interview with Maintenance Staff on 9/29/21, the corridor doors were observed. 1. At 11:55 a.m., the corridor door to Resident Room 7 was obstructed from closing by the bedside curtain of Bed A. When interviewed, Maintenance Staff confirmed that the door was obstructed from closing by the bedside curtain. 2. At 12:07 p.m., the corridor door to Resident Room 25 was obstructed from closing by a small garbage can that was stationed directly in front of the door. When interviewed, Maintenance Staff confirmed that the door was obstructed from closing by the placement of the small garbage can. 3. At 12:16 p.m., the corridor door to the Kitchen Dry Storage/Refrigerator Room did not latch. The latch bolt was missing from the door, which prevented the door from securely latching to the door frame. When interviewed, Maintenance Staff confirmed the finding and stated that the door had	K 363	What corrective action/s will be accomplished for those fire safety requirements found to have been deficient: On 9/29/2021, the Maintenance Staff pulled the bedside curtain away from Room 7□s corridor door to ensure that it will not impede the closing of the door. Complete Date: 9/29/2021 On 9/29/2021, the Maintenance Staff immediately removed the small garbage can that was found directly in front of Room 25□s door to keep the door free to be closed during emergency. Complete Date: 9/29/2021 On 9/29/2021, the Maintenance Staff replaced the missing latch bolt from the kitchen dry storage/refrigerator room door frame to ensure that the door will latched completely when close. Complete Date: 9/29/2021 How to identify related fire safety features that may have the potential to be affected by deficient practice and what corrective action will be taken. On 9/29/2021,the Director of Staff Development (DSD) instructed CNAs to inspect doors of rooms assigned to them and to remove any obstruction that can prevent doors from closing properly.	

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	056430	A. BUILDING **02** B. WING _____	**09/29/2021**

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K 363	Continued From page 13 been previously forced open and the latch bolt was not replaced.	K 363	Complete Date: 9/29/2021 On 9/29/2021, the Maintenance Staff inspected and tested all door latches to ensure that the doors will securely latch when close. Complete Date: 9/29/2021 What measure will be put in place or what systemic change will be made to ensure that the deficiency found will not recur. On 10/11/2021, the DSD provided in-service to staff regarding keeping corridors and doors free from any obstructions and to report doors that do not latch properly when close. Complete Date:10/11/2021 The Maintenance Staff will conduct daily visual inspection of the corridors and doors and remove or remind other staff of keeping the doors from any obstructions. Complete Date:10/29/2021 The Maintenance Staff will conduct monthly inspection of the doors and door latches to ensure that doors securely latch when close. Complete Date: 9/29/2021 The Administrator will review at random the door latches inspection log of the maintenance staff to ensure that inspection is done and that issues arising from the inspection are addressed on a timely manner. Complete Date: 10/29/2021	

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K 363	Continued From page 14	K 363	How will the corrective actions be monitored to ensure that the deficient practice will not recur: The Maintenance Staff will report the status of compliance to the Quality Assessment and Assurance Committee during its monthly meeting for review and immediate action and inclusion to the QAPI Program as needed. This Plan of Correction will be completed by 10/29/2021.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		10/29/21

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K 920	Continued From page 15 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by the use of extension cords to permanently power appliances, and by the use of non secured powers strips. This affected one of two smoke compartments and could result in causing a fire. NFPA 101 Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70 National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as	K 920	What corrective action/s will be accomplished for those fire safety requirements found to have been deficient: On 9/29/2021 the Maintenance Staff removed the extension cords and the electric fan installed on the wall of the DSD/Business Office/Medical Records Office. Complete Date: 9/29/2021 On 9/29/2021, the Maintenance staff secured the power strip powering the computer by mounting power strip on the wall. Complete Date: 9/29/2021 On 9/29/2021, the Maintenance Staff pulled the plug of the industrial refrigerator from the yellow extension that was plugged on the wall and directly plugged the refrigerator on the wall outlet. Complete Date: 9/29/2021 On 9/29/2021, the Maintenance Staff pulled the plug of the wall mounted air conditioner in the kitchen from the yellow extension cord plugged on the wall and plugged the refrigerator directly to the wall outlet. Complete Date: 9/29/2021 How to identify related fire safety features	

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K 920	Continued From page 16 otherwise permitted in this Code (7) Where subject to physical damage 400.10 Pull at Joints and Terminals. Flexible cords and cables shall be connected to devices and to fittings so that tension is not transmitted to joints or terminals. Exception: Listed portable single-pole devices that are intended to accommodate such tension at their terminals shall be permitted to be used with single-conductor flexible cable. Findings: During a tour of the facility and interview with the Maintenance Staff on 9/29/21, the electrical equipment was observed. 1. At 11:40 a.m., a white extension cord was observed powering a wall-mounted fan in the Director of Staff Development/Business Service/Medical Records Office. When interviewed, Maintenance Staff confirmed the finding. 2. At 11:41 a.m., a white power strip was observed cable-tied to the power cord of a wall-mounted fan and hanging approximately three inches above the ground. The power strip powered computer equipment and the wall-mounted fan. When interviewed, Maintenance Staff confirmed the finding. 3. At 12:22 p.m., an industrial refrigerator in the Kitchen was observed plugged into a yellow extension cord that was plugged into a wall outlet. When interviewed, Maintenance Staff confirmed the finding.	K 920	that may have the potential to be affected by deficient practice and what corrective action will be taken: On 9/29/2021, the Maintenance Staff inspected all employees offices and resident rooms and other areas where extension cords may be in use. No other extension cords were found in use. Complete Date: 9/29/2021 What measure will be put in place or what systemic change will be made to ensure that the deficiency found will not recur: On 10/11/2021, the Director of Staff Development provided in-service to the staff as regards not to use extension cords to power appliances or any medical equipment. In case of need for additional power source, the staff should report such need to the Maintenance Staff for appropriate solution. Complete Date: 10/11/2021 The Maintenance Supervisor will conduct weekly rounds and inspection of offices, common rooms, kitchen, and resident rooms to ensure that extension cords are not being used in the building to power any electrical equipment. Complete Date: 10/29/2021 The Administrator will conduct random rounds and inspection of department offices and resident rooms to determine if extension cords are being used in the building and to address this issue immediately. Complete Date: 10/29/2021	

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K 920	Continued From page 17 4. At 12:23 p.m., a wall-mounted air conditioner in the kitchen was observed plugged into a yellow extension cord that was plugged into a wall outlet. When interviewed, Maintenance Staff confirmed the finding.	K 920	The Administrator will review inspection log of the Maintenance Staff to determine implementation of the plan of correction compliance regarding extension cords. Complete Date: 10/29/2021 How will the corrective actions be monitored to ensure that the deficient practice will not recur: The Maintenance Staff will report status of compliance to the Quality Assessment and Assurance Committee during its monthly meeting for review and immediate action and inclusion to the QAPI Program as necessary. This Plan of Correction will be completed by 10/29/2021. Preparation and/or execution of this Plan of Correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	