STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. BUILDING **02** B. WING _____	**04/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREEK CARE CENTER	**1139 CIRBY WAY** **ROSEVILLE, CA 95661**

(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: 48731 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: 48731 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000	This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attched documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery. This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations. RECEIVED By LSC at 8:10 am, May 14, 2024	
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), §485.542(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 emergency preparedness staff. (ii) Other sources of assistance.	E 031	E 031 The Administrator updated the emergency preparedness communication plan to include the current contact information for the assigned Long-Term Care Ombudsman. This updated information has been placed in all relevant EOP binders throughout the facility. The communication plan within the EOP will be reviewed at least annually and revised as needed to ensure the plan is relevant and up to date with any changes the Emergency Operations Committee deem necessary.	5/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Truhar | TITLE: Administrator | (X6) DATE: 5/13/24

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

5/30/24 POC approved by Cynthia Luc, SSM-I

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E 031	Continued From page 1 *[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: 48731 Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan. This was evidenced by the failure to include the emergency contact information. This affected 91 of 91 residents and could result in not having the planning and preparation to protect the health and safety of the clients. Findings: During record review and interview with the Maintenance Director on 4/24/24, the facility's emergency preparedness plan was reviewed. At 3:12 p.m., the facility failed to provide the contact information of the Office of the State Long-Term Care Ombudsman. Upon interview,	E 031		

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E 031	Continued From page 2 the Maintenance Director stated that the contact information was likely forgotten.	E 031		
K 000	INITIAL COMMENTS Surveyor: 48731 K3 BUILDING: 02 K6 PLAN APPROVAL: 04/09/1987 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, 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: 48731 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 91 Licensed Beds: 99	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height	K 161		

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K 161	Continued From page 3 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 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.	K 161	K 161 The Environmental Services Supervisor (ESS) repaired the identified penetration around the sprinkler head in the named office by securely installing an escutcheon. All other sprinkler heads in the facility were observed and deemed to be in compliance The facility maintenance staff will continue to observe and monitor sprinkler heads to ensure they are in good working order and determine if any repairs are needed in the future. The ESS will report any concerns identified during these rounds to the QA Committee to determine the level of effectiveness.	5/20/24

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K 161	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 48731 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 affected 42 of 91 residents and one of four smoke compartments. This could result in the spread of smoke in the event of a fire. Findings: During a tour of the facility and interview with the Maintenance Director on 4/24/24, the building construction was observed. At 10:46 a.m., a ceiling penetration approximately one and a half inches in diameter was observed around the sprinkler head in the Capital Medical Extended Care Doctor's Office near Nursing Station II. The sprinkler pipe was exposed by the penetration. Upon interview, the Maintenance Director stated that the penetration was likely missed on inspections.	K 161		
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.	K 321	K 321 The ESS scheduled the door repair vendor to come out and repair the failed latch. The repair was completed on 5/1/24.	5/20/24

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K 321	Continued From page 5 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 (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: 48731 Based on observation and interview, the facility failed to maintain the hazardous areas. This was evidenced by a door to hazardous area with a self-closing device that failed to latch. This affected 18 of 91 residents and one of four smoke compartments. This could result in the passage of smoke and fire in a hazardous area. Findings: During a tour of the facility and interview with the Maintenance Director on 4/24/24, the hazardous areas were observed. At 9:58 a.m., the door to the Mechanical Room	K 321	All other self-closing doors were inspected and found to be working properly and latched as designed. The ESS and maintenance staff will routinely inspect all self-closing doors to ensure that they are functioning properly. The ESS will report any concerns identified during these rounds to the QA Committee.	

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K 321	Continued From page 6 near the back walkway on the north side of the building was equipped with a self-closing device and failed to latch when tested. The room was approximately eight feet by eight feet and contained two water heaters, two holding tanks, two televisions, a boiler, and a roll of insulation. Upon interview, the Maintenance Director stated that he had not checked the door recently.	K 321		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324	K 324 The ESS has arranged for our vendor, "Blazin Repair," to commence annual inspections of our kitchen cooking equipment. The first inspection is scheduled for 5/15/24. The ESS obtained records to show that our vendor had cleaned the kitchen hood exhaust as required on 10/18/23 and most recently on 2/21/24. Records from the same vendor were obtained to show that the semi-annual inspection of the kitchen hood fire suppression system were also completed. The Administrator or designee will audit the facility's TELS (maintenance record keeping) system to ensure scheduled tasks are completed timely and that appropriate documenation is provided to show these tasks have been completed for 4 months. Results of these audits will be brought to the QA Committee meeting and additional education will be provided to staff as deemed necessary.	5/20/24

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K 324	Continued From page 7 by: Surveyor: 48731 Based on record review and interview, the facility failed to maintain the kitchen cooking equipment and kitchen hood fire suppression system. This was evidenced by the failure to provide kitchen inspections and test reports. This affected 10 of 91 residents and one of four smoke compartments. This could result in the increased risk of a kitchen fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1 * Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months. 11.5 Inspection, Testing, and Maintenance of	K 324		

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K 324	Continued From page 8 Listed Hoods Containing Mechanical, Water Spray, or Ultraviolet Devices. Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected and tested by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. 11.7 Cooking Equipment Maintenance. 11.7.1 Inspection and servicing of the cooking equipment shall be made at least annually by properly trained and qualified persons. Findings: During record review and interview with Maintenance Director on 4/24/24, the records for the kitchen maintenance were requested and reviewed. 1. At 3:04 p.m., the facility failed to provide records of the annual kitchen cooking equipment inspection. The kitchen contained six gas burners, two ovens, two convection ovens, and a flat griddle. Upon interview, the Maintenance Director stated that the record was with the vendor. 2. At 3:05 p.m., the facility failed to provide two of two records of the semi-annual kitchen hood fire suppression system inspection. No prior kitchen hood fire suppression system inspections were provided for review. Upon interview, the Maintenance Director stated that the record was with the vendor. 3. At 3:06 p.m., the facility failed to provide two of two semi-annual kitchen hood exhaust cleanings.	K 324		

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K 324	Continued From page 9 The most recent hood exhaust cleaning provided for review was dated for 1/28/23. Upon interview, the Maintenance Director stated that the record was with the vendor.	K 324		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on observation and interview, the facility failed to maintain the fire alarm system components. This was evidenced by circuit disconnecting means for the fire alarm system that was not identified with red marking. This affected 91 of 91 residents and four of four smoke compartments. This could result in staff inability to identify the circuit breaker in an emergency.	K 341	K 341 Upon identification, the ESS marked the fire alarm circuit disconnecting means with a red marking to clearly identify it as per the regulation. There were no other electrical panels within the facility with a similar concern. The ESS or designee will routinely check this panel to ensure that the appropriate circuit is always identifiable by this red marking.	5/20/24

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K 341	Continued From page 10 NFPA 101, Life Safety Code, 2012 Edition 19.3.4 Detection, Alarm, and Communications Systems. 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 Systems. 9.6.1 * General. 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 10.5.5.2 Circuit Identification and Accessibility. 10.5.5.2.1 The location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. 10.5.5.2.2 For fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." 10.5.5.2.3 For fire alarm systems the circuit disconnecting means shall have a red marking. 10.5.5.2.4 The circuit disconnecting means shall be accessible only to authorized personnel. Findings: During a tour of the facility and interview with the Maintenance Director on 4/24/24, the fire alarm systems circuit disconnecting means was observed.	K 341		

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K 341	Continued From page 11 At 11:05 a.m., the electrical panel labeled as "P-EI" that housed the fire alarm circuit disconnecting means did not have red marking that identified them as connected to the fire alarm system. The breaker was labeled as 25 and the panel was located in the corridor between Resident Rooms 105 and 107. Upon interview, the Maintenance Director stated that he had not been talked to about the fire alarm circuit disconnecting means before.	K 341		
K 353 SS=F	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 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: 48731 Based on observation, record review, and	K 353	K 353 The ESS and the Maintenance Assistant adequately cleaned the identified sprinkler heads to ensure that there was no accumulation of foreign material. Routine inspections/cleanings will be added to the TELS system to ensure build-up does not occur again. The Administrator, ESS or designee will randomly inspect sprinkler heads througout the facility, weekly for 4 weeks to confirm compliance. The package of diapers in the clean linen room near Resident Room 219 was removed and stored elsewhere to allow for the required 18-inch clearance from the sprinkler head. The ESS or designee will routinely check that room and all other sprinkler heads that have the potential to be affected to ensure there is proper clearance. The ESS will schedule monthly gauge and valve inspections and ensure proper documentation is kept regarding these inspections. The contracted vendor did perform the quarterly sprinkler inspection for the fourth quarter of 2023 and the ESS reached out to them to obtain the record.	5/20/24

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K 353	Continued From page 12 interview, the facility failed to maintain the automatic fire sprinkler system. This was evidenced by the failure to maintain the sprinkler system components and the failure to conduct the required sprinkler inspections and test. This affected 91 of 91 residents and four of four smoke compartments. This could result in the failure of the sprinkler system to operate. NFPA 101, Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements. 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. 9.7.1.1 * 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 (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height 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. NFPA 25, Standard for the Inspection, Testing,	K 353	The Administrator or designee will audit these quarterly reports for the next 4 quarters to ensure they are completed and appropriate paperwork is received. Results of these inspections and audits will be brought to the QA Committee for review and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. BUILDING **02** B. WING _____	**04/24/2024**

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K 353	Continued From page 13 and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 5.2.1 Sprinklers. 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). 5.2.4 Gauges. 5.2.4.1 * Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 13.1.1.2 Table 13.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 13.1.1.2 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Control Valves Locked -Monthly Tamper switches-Monthly Alarm Valves Exterior-Monthly Gauges-Weekly/monthly Fire Department Connections-Quarterly Testing Main Drains-Annually/quarterly Waterflow Alarms-Quarterly/semiannually 13.4 System Valves. 13.4.1 Inspection of Alarm Valves. Alarm valves shall be inspected as described in 13.4.1.1 and 13.4.1.2. 13.4.1.1 * Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 14 pressure is being maintained. (2) The valve is free of physical damage. (3) All valves are in the appropriate open or closed position. (4)The retarding chamber or alarm drains are not leaking. 13.6 Backflow Prevention Assemblies. 13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. Findings: During a tour of the facility, record review, and interview with the Maintenance Director on 4/24/24, the sprinkler heads were observed and inspection records were requested and reviewed. 1. At 10:01 a.m., the sprinkler head on the overhang of the exit near the Director of Nursing's Office was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the sprinkler head quickly developed a buildup of foreign material due to it being outside. 2. At 10:18 a.m., the sprinkler head in the corridor between Rehabilitation Services and the Rehabilitation Office was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 3. At 10:27 a.m., one of two sprinkler heads in Resident Room 202 near Resident Room 200 was covered by an accumulation of foreign material. Upon interview, the Maintenance	K 353		

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K 353	Continued From page 15 Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 4. At 10:30 a.m., one of two sprinkler heads in Resident Room 216 near Resident Room 218 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 5. At 10:35 a.m., two of five sprinkler heads in the Laundry Room near Resident Room 225 were covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 6. At 10:37 a.m., the sprinkler in the Soiled Linen Room near the Laundry Room was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 7. At 10:38 a.m., one of two sprinkler heads in Resident Room 223 near Resident Room 221 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 8. At 10:40 a.m., one of two sprinkler heads in Resident Room 216 near the Clean Linen Closet was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 9. At 10:43 a.m., the sprinkler head in the Clean	K 353		

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K 353	Continued From page 16 Linen Room near Resident Room 219 did not have an eighteen inch clearance from the top of the storage to the deflector. A package of diapers was stored approximately nine inches directly under the deflector of the sprinkler head. Upon interview, the Maintenance Director stated that the staff likely left the diapers in the room. 10. At 10:44 a.m., one of two sprinkler heads in Resident Room 217 near Resident Room 219 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 11. At 10:52 a.m., the sprinkler head in the corridor between Resident Rooms 118 and 117 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 12. At 10:57 a.m., two of two sprinkler heads in Resident Room 123 near the Medical Records Office were covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 13. At 10:58 a.m., two of two sprinkler heads in Resident Room 119 near Resident Room 121 were covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 14. At 11:07 a.m., the sprinkler head in the corridor between the Emergency Food & Water Supply Room and the Staff Lounge was covered	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 17 by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the duster the facility had was not sufficient to clean the sprinkler heads. 15. At 3:10 a.m., the facility failed to provide nine of twelve monthly gauge and valve visual inspections of the sprinkler system. The facility provided the annual inspection dated for 9/6/23, the five-year inspection dated for 6/1/23, and a quarterly inspection dated for 1/29/24. Upon interview, the Maintenance Director stated that the inspections had not been asked for previously. 16. At 3:11 a.m., the facility failed to provide the records of the quarterly sprinkler inspection for the fourth quarter (October, November, December) of 2023. The facility provided the annual inspection dated for 9/6/23, the five-year inspection dated for 6/1/23, and a quarterly inspection dated for 1/29/24. Upon interview, the Maintenance Director stated that the record was with the vendor.	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers 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: 48731 Based on observation and interview, the facility	K 355	K 355 All of the identified fire extinguishers were inspected to ensure they are in proper working order. This montly task has been added to the TELS system in order to better track and ensure monthly compliance. The 2 spare fire extinguishers unde the desk in the Maintenance office were removed and secured.	5/20/24

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K 355	Continued From page 18 failed to maintain the portable fire extinguishers. This was evidenced by missing monthly fire extinguisher inspections and unsecured fire extinguishers. This affected 91 of 91 residents and four of four smoke compartments. This could result in the malfunctioning of the portable fire extinguishers. 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 Manual Extinguishing Equipment. 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 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm) 7.1.2 Personnel. 7.1.2.1 * Persons performing maintenance and recharging of extinguishers shall be certified. 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1 * Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2 * Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. 7.2.4.3 Where at least monthly manual	K 355	The Administrator or designee will visually inspect the fire extinguishers and their inspection tags for 4 months to ensure compliance with monthly inspections. Results of these inspections will be brought to the QA Committee for review.	

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K 355	Continued From page 19 inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. 7.2.4.4 Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Findings: During a tour of the facility and interview with the Maintenance Director on 4/24/24, the portable fire extinguishers were observed. 1. At 10:00 a.m., the inspection tag for the fire extinguisher near the Storage Rooms of the back walkway on the north side of the building was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 2. At 10:12 a.m., the inspection tag for the fire extinguisher in the kitchen near the Kitchen Manager's Office was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 3. At 10:15 a.m., the inspection tag for the	K 355		

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K 355	Continued From page 20 K-Class fire extinguisher in the kitchen near the dishwashing station was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 4. At 10:21 a.m., the inspection tag for the fire extinguisher in the Electrical Room near the Dietician Office was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 5. At 10:34 a.m., two portable fire extinguishers were observed freestanding and unsecured on the ground under the desk of the Maintenance Office near the Janitor's Closet. Upon interview, the Maintenance Director stated that the fire extinguishers were spares. 6. At 10:36 a.m., the inspection tag for the fire extinguisher in the Laundry Room near Resident Room 225 was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags.	K 355		

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K 355	Continued From page 21 7. At 10:41 a.m., the inspection tag for the fire extinguisher in the corridor between Resident Room 221 and the Clean Linen Room was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 8. At 10:50 a.m., the inspection tag for the fire extinguisher in the courtyard near Resident Room 211 was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 9. At 10:53 a.m., the inspection tag for the fire extinguisher in the corridor between Resident Room 126 and the Patient Bath was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags. 10. At 10:59 a.m., the inspection tag for the fire extinguisher in the corridor between Resident Rooms 119 and 117 was missing the monthly inspection for December of 2023. The annual service and inspection for the fire extinguisher was dated for 11/15/23. Upon interview, the	K 355		

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K 355	Continued From page 22 Maintenance Director stated that he remembers the vendor doing the inspection in December of 2023 and that the vendor potentially mislabeled the inspection tags.	K 355		
K 363 SS=D	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.	K 363	K 363 The door stop to the Patient Bath was removed and discarded so that the door could close and latch. The self-closing mechanism on the door to the Sierra Lounge was adjusted/repaired and is working properly. The ESS or designeee will perform routine inspections of all self-closing doors to ensure there are no obstructions blocking them from operating properly and to ensure they are in good working order. Any repair concerns beyond the scope of the ESS or mainteance staff will be referred to the preferred vendor for such repairs and tracked for completion.	5/20/24

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K 363	Continued From page 23 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a corridor door that was obstructed from latching and a corridor door with a self closing device that failed to latch. This affected 31 of 91 residents and two of four smoke compartments. This 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 the Maintenance Director on 4/24/24, the corridor doors were observed. 1. At 10:54 a.m., the corridor door to the Patient Bath near the Janitor's Closet and the Director of Nursing's Office was equipped with a self-closing device and was obstructed from latching by a door stop. The door remained open approximately five feet wide. Upon interview, the Maintenance Director stated that the door stop was likely in use because the door was not equipped with a magnetic hold-open device. 2. At 11:08 a.m., the corridor door to the Sierra Lounge near the Printing Area was equipped with a self-closing device and failed to latch when tested. Upon interview, the Maintenance Director	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 24 stated that the corridor door was likely missed on inspections.	K 363		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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. 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 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918	K 918 The 30-minute load test and battery conductance tests for the generator to be completed monthly have been added to the TELS system for tracking purposes. The Administrator or designee will conduct monthly audits of the load and conductance testing for 6 months to ensure compliance. The required 4-hour load test was conducted by the contracted provider and the record of this test is included in the evidence of correction. Results of the monthly audits will be brought to the QA Committee for review.	5/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 25 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on record review and interview, the facility failed to maintain the essential electrical system. This was evidenced by the failure to conduct the required inspections and tests. This affected 91 of 91 residents and four of four smoke compartments. This could result in the malfunction of the diesel generator. NFPA 101 Life Safety Code, 2012 edition 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1 Utilities. 9.1.3 Emergency Generators and Standby Power Systems. Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition. 8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.7 Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. BUILDING **02** B. WING _____	**04/24/2024**

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K 918	Continued From page 26 maintained in full compliance with manufacturer's specifications. 8.4 Operational Inspection and Testing. 8.4.1 * EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSs, or initiated by opening all switches or breakers supplying normal power to all ATSs that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. BUILDING **02** B. WING _____	**04/24/2024**

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K 918	Continued From page 27 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. Findings: During record review and interview with the Maintenance Director on 4/24/24, generator records were requested and reviewed. 1. At 3:08 p.m., the facility failed to provide the records of the monthly 30-minute load tests for 11 of 12 months for the 45 kilowatt propane generator. The facility provided a two-hour load test dated for 3/26/24. Upon interview, the Maintenance Director stated that the load tests were conducted but not recorded. 2. At 3:09 p.m., the facility failed to provide the records of the monthly battery conductance tests of the sealed acid battery for 11 of 12 months for the 45 kilowatt propane generator. The facility provided a two-hour load test dated for 3/26/24 that included conductance testing. Upon interview, the Maintenance Director stated that the tests were conducted but not recorded. 3. At 3:31 p.m., the facility failed to provide a record of the four-hour load test for the 45 kilowatt propane generator. There were no previous records provided for review to when the last four-hour load bank test was conducted. Upon interview, the Maintenance Director stated that the test had not been requested in previous surveys.	K 918		