STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING 02 B. WING	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	676 THIRD STREET WOODLAND, CA 95695

(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: 32973 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: 32973 Census: 84	E 000	*The preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it.*	6/8/18
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical	E 013	**E 013** **This facility has a plan of emergency preparedness that has been updated in January of 2017.** **This facility will reference to Waiver 1135 should the president of the USA or the secretary of state declare a state of emergency.** **Please see attached the index of the Emergency preparedness plans Binder which include various**	

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
2018 MAY 30 PM 3:15
LICENSING & CERTIFICATION PROGRAM

[redacted] NATURE TITLE (X6) DATE 5/30/18

...ich the institution may be excused from correcting providing it is determined that ...e.) Except for nursing homes, the findings stated above are disclosable 90 days ...or nursing homes, the above findings and plans of correction are disclosable 14 ... deficiencies are cited, an approved plan of correction is requisite to continued ...

5/30/18 — Approved by Cynthia Lc

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E 013	Continued From page 1 emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on record review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide policy and procedure indicating the facility's role and awareness in providing treatment and care under an 1135 waiver in the event of an emergency. This affected residents and staff, and could result in the facility being inadequately prepared to provide care at an alternate location during an emergency. (b) Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E 013	**emergencies scenarios which delineate how residents will be taken care of/ care would be provided at an alternate location should they be relocated in case of evacuation due to an emergency.**	6/8/18

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E 013	Continued From page 2 section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain: (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal. (2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location. (3) Safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. (4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility.	E 013		

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E 013	Continued From page 3 (5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. (7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents. (8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings: During record review and interview with administrative staff on 5/8/18, the EP policies and procedures were requested and reviewed. At 4:30 p.m., there was no policy and procedure outlining the facility's plan in providing care and treatment at an alternate location under an 1135 waiver, in the event of an emergency. Upon interview, Administrative Staff 2 confirmed the finding.	E 013		
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c)	E 029	See next Page please	

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	056109	A. BUILDING 02 B. WING	05/03/2018

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E 029	Continued From page 4 (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 annually. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide policies and procedures for a method to share information from the emergency plan with residents and their families or representatives. This affected residents and staff, and could potentially result in ineffective emergency planning and evacuation. (c) Communication plan. The LTC 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 annually. The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Residents' physicians. (iv) Other LTC facilities. (v) Volunteers. (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency.	E 029	E029 6/8/18 Every Emergency Preparedness Plan includes information a method and clear instruction on how to share information from the residents and their families and representatives. This very action was demonstrated when this facility assisted in the evacuation/receiving of evacuated residents from Yuba Skilled nursing care facility during the Oroville dam crisis with the Sacramento CDPH arrived the very next morning and inspected our process with unsubstantiated deficient practice. All other items alleged to be missing in Tag E029 are present in the binder. This author, the administrator of this facility offered to send a whole binder of the Emergency Preparedness Plan to the supervisor who indicated it was necessary.	

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E 029	Continued From page 5 (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff. (ii) Federal, State, tribal, regional, or local emergency management agencies. (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii). (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). (7) A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. (8) A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Findings: During document review and interview with Administrative Staff on 5/8/18, the EP was	E 029		

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E 029	Continued From page 6 reviewed. At 4:35 p.m., the EP plan failed to provide policy and procedure for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families or representatives. Upon interview, Administrative Staff 2 confirmed the finding.	E 029		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must	E 03	**E 036** **The first community drill available to us is dated July 21st. there were no drills conducted in Yolo county to our knowledge prior to survey.** **The administrator will communicate with the Yolo county emergency preparedness center and obtain any possible dates or plans on the July 21st meeting.**	6/8/18

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E 036	Continued From page 7 develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on document review and interview, the facility failed to complete an emergency preparedness (EP) drill. This was evidenced by the failure to complete a community-based full-scale exercise. This affected residents and staff, and had the potential to have an ineffective Emergency Preparedness (EP) plan. (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. (1) Training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 036		

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E 036	Continued From page 8 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility- based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed. Findings:	E 036		

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E 036	Continued From page 9 During record review and interview with Administrative Staff on 5/8/18, the EP drills were requested and reviewed. At 4:10 p.m., the drills provided failed to include a community-based full-scale exercise. Upon interview, Administrative Staff 2 confirmed the finding stating that the facility had not completed or documented efforts to complete a community-based full-scale exercise.	E 036		
K 000	INITIAL COMMENTS Surveyor: 32973 K3 BUILDING: 01 K6 PLAN APPROVAL: 09/23/69 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: THREE STORY W/PARTIAL BASEMENT, CONSTRUCTION TYPE 1 (332), 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: 32973 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 84	K 000		

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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 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	K 161	K 161 The ceiling minute penetration by computer wires (cited as one inch) in a locked internet equipment closet in the lobby away from resident residential area was fixed the same evening identified by the surveyor. All other areas where computer wires are threaded through the building structure are confirmed to be sealed. The maintenance director will insure any new additions of wires will be secured/sealed moving forward. If this continues to be an issue it will be brought to the attention QA. 6/8/18	

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K 161	Continued From page 11 approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, the facility failed to maintain the integrity of the building construction. This was evidenced by a ceiling penetration. This affected 1 of 13 smoke compartments, and could result in the passage of smoke to other areas in the event of a fire. Findings: During a tour of the facility with staff on 5/8/18, the walls and ceiling were observed. At 2:30 p.m., the walls and ceiling in the Telephone Equipment Room, were observed. There was an approximately one inch diameter penetration with cables traveling through it, located in the ceiling.	K 161	K211 Annual testing and inspection of the smoke in the 13 compartments was NOT completed per 2567. An annual inspection of the fire department was conducted on May 17/18 and a letter of no violation of the fire code was awarded to the facility. The letter in form of email will be scanned with the new POC.	6/8/18
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, document review, and interview, the facility failed to maintain the fire	K 211	Additionally, our corporate environmental consultant is certified to inspect and rate fire doors and he is in agreement that doors of this facility are appropriately rated. Last inspection and declaration of safety was 4/23/18	

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K 211	Continued From page 12 rated door assemblies. This was evidenced by the absence of an annual inspection and testing certification. This affected 13 of 13 smoke compartments, and could result in the malfunction of the doors to contain fire to a compartment. NFPA 101. Life Safety Code, 2012 Edition 19.1.1.4.1.1 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) 8.3.3 Fire Doors and Windows. 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protective's, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protective's, 2010 edition. Chapter 5 Care and Maintenance 5.1* General. 5.1.1 Application. 5.1.1.1 This chapter shall cover the care and maintenance of fire doors and fire windows. 5.2.14 Maintenance of Closing Mechanisms	K 211		

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K 211	Continued From page 13 5.2.14.1 Self-closing devices shall be kept in working condition at all times. 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. Findings: During a facility tour, document review, and interview with staff on 5/8/18, the annual inspection and testing for fire/exit doors was requested. At 1:30 p.m., the facility was observed with 3 hour fire rated cross-corridor doors in all smoke compartments. No certification for annual testing and inspection was available for review. Upon interview, Staff 2 confirmed the finding, stating that no annual testing/inspection was performed on the doors.	K 211		
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: 32973 Based on observation, document review, and interview, the facility failed to maintain the smoke detectors. This was evidenced by the failure to provide a current smoke detector sensitivity	K 347	K 347 **Smoke detectors sensitivity testing contract has been secured and testing will be performed next week at the earliest** **The maintenance director will insure record keeping of each and every testing** **If issues occur, it will be brought to QA.**	6/8/18

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	056109	A. BUILDING 02 B. WING	05/08/2018

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K 347	Continued From page 14 testing. This affected 13 of 13 smoke compartments, and could result in delayed notification or false alarm of a fire due to a malfunctioning smoke detector. 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 9.6.1.3 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 Code, 2010 Edition 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. 14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained. 14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test	K 347		

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K 347	Continued From page 15 Instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction. 14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. 14.4.5.3.6 Smoke detectors or smoke alarms listed as field adjustable shall be permitted to either be adjusted within the listed and marked sensitivity range, cleaned, and recalibrated, or be replaced. 14.4.5.3.7 The detector or smoke alarm sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector or smoke alarm. Findings: During a facility tour, document review, and interview with staff on 5/8/18, the smoke detector sensitivity report was requested. At 12:55 p.m., the facility was observed with hard wired smoke detectors located in corridors and rooms. The current smoke detector sensitivity report was requested for review. No current or previous reports were available for review. Documentation titled "Annual Fire Alarm Inspection/Test" dated 5/4/18, indicated that 25	K 347		

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K 347	Continued From page 16 smoke detectors had functional testing performed, but not sensitivity. Upon interview, Staff 2 confirmed the finding.	K 347		
K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, record review, and interview, the facility failed to maintain the elevator. This was evidenced by the failure to provide monthly testing for an elevator equipped with fire fighters' emergency services. This affected 13 of 13 smoke compartments, and could potentially result in an elevator malfunction and harm to staff and residents.	K 531	K531 The elevator was tested by the elevator twice for emergency services this year and 12 times last year. This author. administrator, is in communication with the elevator contractor maintenance company to locate the rest of the records. The facility is considering changing vendors with better track of documentations. Regardless, the facility will insure we have a monthly emergency testing for the elevator documented clearly, the maintenance director will responsible to maintain logs and if any issues arise it will be brought to QA.	6/8/18

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K 531	Continued From page 17 NFPA 101, Life Safety Code, 2012 Edition. 19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4. 9.4.6 Elevator Testing. 9.4.6.2 All elevators equipped with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASMEA17.1/CSA B44, Safety Code for Elevators and Escalators. Findings: During a facility tour, document review, and interview with staff on 5/8/18, the elevator was observed and records were requested. At 11:42 a.m., the facility was observed with one elevator equipped with fire fighters' emergency recall. No documentation was provided to show that the fire fighters' emergency services on the elevator had been tested on a monthly basis for the past 12 months. Upon interview, Staff 2 confirmed the finding.	K 531		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712	See next Page please	

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K 712	Continued From page 18 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 This REQUIREMENT is not met as evidenced by: Surveyor: 32873 Based on document review and interview, the facility failed to conduct fire drills one per shift per quarter. This was evidenced by no documentation for the performance of two of twelve fire drills. This affected 13 of 13 smoke compartments, and could result in staff being untrained and unaware of shift-specific roles and responsibilities during an emergency. 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1. 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.6 Drills shall be conducted quarterly on	K 712	K712 The facility has at least 2 drills one per shift from January –May of this year. Those were faxed to the surveyor before 10 am the following morning. This aouther will be happy to resend or scan/email if better suited to your liking. The facility will continue to have a at least a drill per quarter per shift.	6/8/18

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K 712	Continued From page 19 each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following: (1) Use of alarms (2) Transmission of alarms to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire 19.7.2.3 Staff Response. 19.7.2.3.1 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. 19.7.2.3.2 All health care occupancy personnel shall be instructed in the use of the code phrase to ensure transmission of an alarm under any of the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system	K 712		

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K 712	Continued From page 20 19.7.2.3.3 Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Findings: During document review and interview with Staff on 5/8/18, the fire drill records were requested and reviewed. At 11:30 a.m., no documentation was available for PM and Night Shift fire drills, first quarter (January, February, March) 2018. Upon interview, Staff 2 confirmed the findings. The facility was given the opportunity to submit documentation by 5/9/18, 10:00 a.m. Documentation was submitted for PM and Night Shift drills performed in the first quarter 2017, not 2018.	K 712	**K918** **The facility has a portable generator with a waiver letter that was sent to CMS and awaiting response. A new letter was sent to CMS following the completion of this POC. Should the waiver not be granted, the facility will immediately take the necessary steps to permanently mount the generator.** 6/8/18	
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.	K 918	**The facility's maintenance director will be responsible to follow up with bids to anchor the generator permanently.** **The administrator will follow on the maintenance director progress periodically till the project complete.** **If this issue continues, it will be brought to QA.**	

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K 918	Continued From page 21 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 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation, record review, and interview, the facility failed to maintain the emergency power supply system (EPSS). This was evidenced by the failure to provide a permanently installed EPSS and maintain a temporary installed EPSS and incomplete documentations. This affected 13 of 13 smoke compartments, and could potentially result in a generator failure during an emergency power outage. NFPA 101 Life Safety Code, 2012 edition 19.5 Building Services.	K 918		

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K 918	Continued From page 22 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 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 4.4* Level. This standard recognizes two levels of equipment installation, performance, and maintenance. 4.4.1* Level 1 systems shall be installed where failure of the equipment to perform could result in loss of human life or serious injuries. 4.4.2* Level 2 systems shall be installed where failure of the EPSS to perform is less critical to human life and safety. 4.4.3 All equipment shall be permanently installed. 7.4 Mounting. 7.4.1 Rotating energy converters shall be installed on solid foundations to prohibit sagging of fuel, exhaust, or lubricating oil piping and damage to parts resulting in leakage at joints. 7.4.1.1 Such foundations or structural bases shall raise the engine at least 150 mm (6 in.) above the floor or grade level and be of sufficient elevation to facilitate	K 918		

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K 918	Continued From page 23 lubricating-oil drainage and ease of maintenance. 7.4.2 Foundations shall be of the size (mass) and type recommended by the energy converter manufacturer. 7.4.3 Where required to prevent transmission of vibration during operation, the foundation shall be isolated from the surrounding floor or other foundations, or both, in accordance with the manufacturer ' s recommendations and accepted structural engineering practices. 7.4.4 The EPS shall be mounted on a fabricated metal skid base of the type that shall resist damage during shipping and handling. After installation, the base shall maintain alignment of the unit during operation. 7.5* Vibration. Vibration isolators, as recommended by the manufacturer of the EPS, shall be installed either between the rotating equipment and its skid base or between the skid base and the foundation or inertia base. Chapter 8 Routine Maintenance and Operational Testing 8.1* General. 8.1.1 The routine maintenance and operational testing program shall be based on all of the following: (1) Manufacturer's recommendations (2) Instruction manuals (3) Minimum requirements of this chapter (4) The authority having jurisdiction	K 918		

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K 918	Continued From page 24 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. 8.3.4.1 The permanent record shall include the following: (1)The date of the maintenance report (2)Identification of the servicing personnel (3)Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4)Testing of any repair for the time as recommended by the manufacturer 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. 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. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations. 8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of	K 918		

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K 918	Continued From page 25 failure of the primary source. 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. Findings: During a facility tour, document review, and interview with staff on 5/8/18, the EPSS was observed and records were requested. 1. At 11:00 a.m., the facility was observed with a temporary 60 kilowatt (KW) diesel generator. The generator was located in the back parking lot on the west side of the building, at approximately 7 feet distance from the building. It was stationed on a wheeled platform without observable seismic bracing. The facility was noted to have a Centers for Medicare & Medicaid Services (CMS) temporary waiver in-place, with a final extension for the waiver until 1/17/18. At 12:10 p.m., documentation titled "Proposal-Remove Existing Portable Generator and Install a Permanent Diesel Powered Generator" dated 1/23/17, indicated a price quote to install a permanent generator, and that the	K 918		

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K 918	Continued From page 26 proposal was valid only for 30 days after the proposal date of 1/23/17. No other proposals, plans, or permit to install a permanent generator were available for review. Upon interview, Staff 2 confirmed the finding stating only the price-proposal was obtained. During Life Safety Code surveys on 6/29/17, 5/17/16, 4/21/15, 4/25/14, and 5/9/13, the facility was cited for operating a temporary generator without approval. 2. At 12:00 p.m., the facility was not able to provide a current annual fuel quality testing record for the temporary generator stored diesel fuel supply (200 gallon tank) at the time of survey. Upon interview, Staff 2 confirmed the finding stating that the testing was not performed. 3. At 12:02 p.m., monthly load documentation for the temporary generator did not indicate minimal exhaust temperature, or that 30 percent of the name plate kilowatt rating was achieved. No annual 90 minute supplemental load bank testing was available for review. Upon interview, Staff 2 confirmed the finding. The facility was given until 5/9/18, at 10 a.m. to fax or email the Annual Load Bank Test results if available. No report was received by the facility at the given time. 4. At 1:25 p.m., no documentation was available for an initial acceptance testing and approval for the temporary generator. Staff 2 confirmed the finding stating an acceptance test and permit were not available.	K 918		