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

PRINTED: 08/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING 01 B. WING	08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAIN WEST POSTACUTE CARE	812 WEST MAIN STREET TURLOCK, CA 95380

(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 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE V CONSTRUCTION, 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 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101 Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 27994 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 94	K 000	Main West Post Acute Care - SNF makes its best effort to operate in substantial compliance with both Federal and State Law. Nothing in this Plan of Correction is an admission otherwise. The facility has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. The facility is submitting this plan of correction as required by law as its written credible allegation of compliance for the alleged deficiencies. K012 (SS=D) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. All penetrations in Rooms 1, Nurse Station and Fax Copier Room near Room 43 will be filled by Maintenance Supervisor and qualified designee with fire rated caulks. 2. Also, when vendors work on cables, Maintenance supervisor or qualified designee will visually inspect work done and ensure that no penetrations are left uncovered. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.**	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of the building construction. This was evidenced by unsealed penetrations in the walls and ceilings. This affected two of seven smoke compartments and could result in the faster spread of fire and smoke to other areas of the facility.	K 012		

[redacted] S SIGNATURE TITLE (X6) DATE

Acting Admin. 8-26-16

cy which the institution may be exceused 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.

POC accepted 9/16/16 per Jared Okimoto

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K 012	Continued From page 1 Findings: During a tour of the facility with Maintenance Staff on 8/3/16, the walls and ceilings were observed. 1. At 9:46 a.m., there was an approximately 1/4 inch penetration around a phone line in the wall of Room 1. 2. At 9:56 a.m., there was an approximately 1/4 inch penetration in the wall, above a dry erase board, at Nurse Station 1 Utility/FACP Room. 3. At 10:35 a.m., there were two approximately 1/4 inch penetrations around a cord in the ceiling in the Fax/Copier Room near Room 43.	K 012	1. Assistant Administrator and Maintenance Supervisor made a visual inspection of all rooms in the facility to ensure that no other non covered penetrations were present. 2. Discussed the findings in the morning Stand up meeting and notified leadership team to report any penetrations on walls, floors and ceilings if they find any when they do the facility rounds and to put in the Maintenance TO DO log, **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Quarterly walk around of rooms to visually inspect penetrations if any in the walls, floors and ceilings by Administrator and Maintenance Supervisor or qualified designees. 2. Quarterly log monitor for wall, floors and ceiling penetrations and ensure to plug and caulk immediately. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Administrator and MS or qualified designees will report their inspection and findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9//01/2016	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by:	K 018		

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K 018	Continued From page 2 Based on observation, the facility failed to maintain the corridor doors. This was evidenced by four doors that were obstructed from closing and latching. This affected three of seven smoke compartments and could result in the inability to contain smoke or fire to a room. Findings: During a tour of the facility with Maintenance Staff on 8/3/16, the corridor doors were observed. 1. At 9:48 a.m., the door to Room 2 was obstructed from closing by a wheelchair. 2. At 10:02 a.m., the self closing door to the Housekeeping Closet was obstructed from closing by a brush holder. 3. At 10:27 a.m., the door to Room 28 was obstructed from closing by a bedside table. 4. At 10:29 a.m., the door to Room 31 was obstructed from closing by a bedside table.	K 018	**K018 (SS=E)** **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. Immediately, the obstruction (wheel chair) was removed from the door in Room 2. The Brush holder was also removed from the House Keeping Closet door. The bedside table was relocated as not to obstruct the door of Room 28. The bedside table in Room 31 was also relocated to ensure that the door will close without obstruction. 2. Staff were reminded that doors should not be obstructed for free ingress and egress and so that doors can be closed or opened completely in an emergency situation. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.**	
K 048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a complete emergency preparedness plan. This was evidenced by the fire and disaster manual that failed to list the types and uses of fire extinguishers available in the facility and by the failure to update the Fire and Disaster Manual. This affected seven of seven smoke compartments and could result in a	K 048	1. The Administrator and Maintenance Supervisor checked all rooms and made sure that no other doors were obstructed and will be able to close and open completely in an emergency situation. 2. Reminded Staff during the visual inspection process that no doors should be obstructed to ensure free and easy ingress and egress in an emergency situation.	

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K 048	Continued From page 3 delayed staff response to fire or disaster emergencies. NFPA 101 Life Safety Code, 2000 Edition 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (8) Extinguishment of fire 19.7.1.3 Employees of health care occupancies shall be instructed in life safety proceduros and devices. 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers, 1998 Edition 1-4.2 The classification and rating system described in this standard is that of Underwriters Laboratories Inc. and Underwriters Laboratories of Canada, and is based on extinguishing preplanned fires of determined size and description as follows: (a) Class A Rating. Wood and excelsior (b) Class B Rating. Two-in. (5.1-cm) depth n-heptane fires in square pans (c) Class C Rating. No fire test. Agent must be a nonconductor of electricity (d) Class D Rating. Special tests on specific combustible metal fires (e) Class K Rating. Special tests on cooking appliances using combustible cooking media (vegetable or animal oils and fats) 2-3.2 Fire extinguishers provided for the protection of cooking appliances that use	K 048	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Daily walk around by Administrator or Maintenance Supervisor or qualified designees of the facility to ensure that no obstruction will prevent the doors from completely opening and closing. 2. Document/Log in Daily Walk rounds findings. 3. Emphasize on Monthly Fire and Internal disaster drills the importance of keeping doors free of obstruction. 4. Include "Unobstructed Doors" as a priority topic in the Monthly Safety Committee Meeting **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Administrator and MS (or qualified designees) will report their inspection and in-service activities, findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 048	Continued From page 4 combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. Findings: During record review and interview with Staff on 8/3/16, the emergency preparedness plan were reviewed. 1. At 11:55 a.m., the Fire and Disaster Manual provided at the time survey failed to indicate when the manual was last reviewed. A review of the fire safety procedure failed to list or describe the Class K type fire extinguisher that was observed in the Kitchen. Upon interview, three kitchen staff were asked what they would do when there was a grease fire? Two of three staff indicated that they would utilized a fire extinguisher depending on the size of the grease fire. When asked what type of fire extinguisher they would use, two staff pointed toward the ABC fire extinguisher in the Kitchen instead of the Class K fire extinguisher. 2. At 1:30 p.m., the facility provided two Fire and Disaster Manuals at the time of survey. The Fire and Disaster manual from Nurse Station 4 had not been updated and included a prior Administrator's contact information instead of the current Administrator's contact information. The Fire and Disaster manual from Nurse Station 1 and 2 provided no Administrator information. Upon interview, Maintenance Staff stated that the previous Administrator left a year ago.	K 048	**K 048 (SS=E)** **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. Reviewed Manual and will update the review date. Will include in the policy the description and use of the Class K Type fire extinguisher that was observed in the Kitchen. 2. Maintenance Supervisor and Dietary Manager will conduct an In Service to Kitchen Staff on the use of the ABC fire extinguisher vs the Class K fire extinguisher. 3. Will update the information provided with the New Administrator in the Fire and Disaster Manuals. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. All copies of the Fire and Disaster Manuals in all Nurse Stations and Administrator's office will be updated with the New Administrator Name and contact information. 2. There is only one Dietary Service/Kitchen and thus the deficiency will not have the	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 048	Continued From page 4 combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. Findings: During record review and interview with Staff on 8/3/16, the emergency preparedness plan were reviewed. 1. At 11:55 a.m., the Fire and Disaster Manual provided at the time survey failed to indicate when the manual was last reviewed. A review of the fire safety procedure failed to list or describe the Class K type fire extinguisher that was observed in the Kitchen. Upon interview, three kitchen staff were asked what they would do when there was a grease fire? Two of three staff indicated that they would utilized a fire extinguisher depending on the size of the grease fire. When asked what type of fire extinguisher they would use, two staff pointed toward the ABC fire extinguisher in the Kitchen instead of the Class K fire extinguisher. 2. At 1:30 p.m., the facility provided two Fire and Disaster Manuals at the time of survey. The Fire and Disaster manual from Nurse Station 4 had not been updated and included a prior Administrator's contact information instead of the current Administrator's contact information. The Fire and Disaster manual from Nurse Station 1 and 2 provided no Administrator information. Upon interview, Maintenance Staff stated that the previous Administrator left a year ago.	K 048	potential of affecting other residents once the Dietary Staff were properly Inserviced and knowledgeable on the use of the ABC fire extinguisher and Class K Fire Extinguisher. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Monthly In Services by the Maintenance Supervisor or Dietary Services Supervisor or qualified designees on the proper use of ABC fire extinguishers vs K type fire extinguisher in the Kitchen. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The MS and Dietary Services Supervisor (or qualified designees) will report their inspection and in-service activities, findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	
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K 052	Continued From page 5 A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire alarm system. This was evidenced by incomplete test and inspection records for the fire alarm system. This affected seven of seven smoke compartments and could result in a malfunctioning fire alarm system in the event of a fire emergency. NFPA 101 Life Safety Code, 2000 edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1.4 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 Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. 19.7.6 Maintenance and Testing (see 4.6.12) 4.6.12.2 Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. NFPA 72 National Fire Alarm Code, 1999 edition 1-6.3 Records. A complete, unalterable record of the tests and operations of each system shall be kept until the next test and for 1 year thereafter. The record shall be available for examination	K 052	K052 (55=F) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** The vendor was duly notified to schedule before September 1 another fire alarm inspection that will cover all 9 pull stations , 26 smoke detectors, one water flow, one supervisory switch, 16 horns, and one bell including all heat detectors. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. The Annual Inspection of the Fire Alarms will cover all the 9 pull stations , 26 smoke detectors, one water flow, one supervisory switch, 16 horns, and one bell including all heat detectors. 2. Maintenance Supervisor or qualified designee will review Annual Inspection report and ensure that it is complete and that fire safety related items were inspected by the vendor.	

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K 052	Continued From page 6 and, if required, reported to the authority having jurisdiction. Archiving of records by any means shall be permitted if hard copies of the records can be provided promptly when requested. Exception: If off-premises monitoring is provided, records of all signals, tests, and operations recorded at the supervising station shall be maintained for not less than 1 year. 7-1.2.2 Service personnel shall be qualified and experienced in the inspection, testing, and maintenance of fire alarm systems. Examples of qualified personnel shall be permitted to include, but shall not be limited to, individuals with the following qualifications: (1) Factory trained and certified (2) National Institute for Certification in Engineering Technologies fire alarm certified (3) International Municipal Signal Association fire alarm certified (4) Certified by a state or local authority (5) Trained and qualified personnel employed by an organization listed by a national testing laboratory for the servicing of fire alarm systems Table 7-3.1 Visual Inspection Frequencies 9. Initiating Devices e. Fire Alarm Boxes-semi-annually F. heat detectors-semi-annually h. Smoke Detectors-semi-annually 7-3.2* Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted	K 052	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Ensure that a Complete Annual Fire Alarm Inspection Schedules are calendared and that reports are duly reviewed and filed in the Fire and Internal Disaster Folder. 2. Maintenance Supervisor to review report and discuss results with Administrator and Safety Committee. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Administrator and MS (or designees) will report their inspection and in-service activities, findings and action plan to ensure compliance to the facility's Safety Committee Monthly meeting and the Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 052	Continued From page 7 to be extended to annual. Table 7-3.2 shall apply. Exception: Devices or equipment that are inaccessible for safety considerations (for example, continuous process operations, energized electrical equipment, radiation, and excessive height) shall be tested during scheduled shutdowns if approved by the authority having jurisdiction but shall not be tested more than every 18 months. Table 7-3.2 Testing Frequencies 15. Initiating Devices d. Fire - Gas and other Detectors - tested annually e. Heat Detectors (The requirement of 7-3.2.2 shall apply)-annually 7-3.2.3 for restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. f. Fire Alarm Boxes-annually h. All Smoke Detectors - Functional-annually 19. Alarm Notification Appliances a. audible device-annually b. audible textual notification appliances-annually c. visible device-annually 7-5.2.2 A permanent record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 7-5.2.2. (1) Date (2) Test frequency (3) Name of property (4) Address	K 052		

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K 052	Continued From page 8 (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(s) tested, for example, " Tests performed in accordance with Section _____. " (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturers (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative (15) Disposition of problems identified during test (for example, owner notified, problem corrected/successfully retested, device abandoned in place) 7-5.3 Supervising station fire alarm systems, records, pertaining to signal received at the supervising station that result from maintenance, inspection, and testing shall be maintained for not less than 12 months. Upon request, a hard copy record shall be provided to the authority having jurisdiction. Paper or electronic media shall be permitted. Findings: During record review and interview with Maintenance Staff on 8/3/16, the annual fire alarm system test and inspection reports were	K 052		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAIN WEST POSTACUTE CARE	812 WEST MAIN STREET TURLOCK, CA 95380

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K 052	Continued From page 9 requested. 1. At 12:05 p.m., the facility provided a partial one page, with no title, annual fire alarm inspection report dated 6/16/16. The report indicated that the facility had nine pull stations, 26 smoke detectors, one waterflow, one supervisory switch, 16 horns, and one bell. Under comments, it indicated, "Annual fire test passed. No heat detector tested, most of them are not hooked up or are out of date." The report failed to indicate how many devices were tested, the outcome of each device test, and the locations. Upon interview, Maintenance Staff stated he would contact the vendor for the full detailed report. The facility was given the opportunity to send via e-mail the completed annual fire alarm inspection report by 8/4/16 at 9 a.m. On 8/4/16 at 7:45 a.m., the facility e-mailed the monitoring company activity reports instead of a completed annual fire alarm inspection report. A review of the customer activity report indicated that five pull stations (1, 6, 7, 8, and 9) were tested. The activity reports further indicated that a tamper alarm, a waterflow, six smoke detectors, and a heat detector were tested. The monitoring company activity report did not confirm all fire alarm devices and components were tested. There were no documents that confirmed all fire alarm devices and components had been tested and inspected during the past 12 months.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054		

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K 054	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the smoke detectors. This was evidenced by a battery operated smoke detector that failed to alarm when tested, by the failure to test the battery operated smoke detector weekly, and by the failure to complete a smoke detector sensitivity test for all smoke detectors. This affected seven of seven smoke compartments and could result in a delayed notification of smoke, in the event of a fire. NFPA 101, Life Safety Code, 2000 edition 19.3.4.5.1 Detection systems, where required, shall be in accordance with Section 9.6 9.6.1.3 The provisions of the Section 9.6 cover the basic functions of the a complete fire alarm system, including fire detection, alarm, and communications. These systems are primary intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 9.6.1.4 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 Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code.	K 054		

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K 054	Continued From page 11 NFPA 72, National Fire Alarm Code, 1999 edition 2-3.3* Sensitivity. 2-3.3.1 Smoke detectors shall be marked with their nominal production sensitivity (percent per foot obscuration), as required by the listing. The production tolerance around the nominal sensitivity also shall be indicated. 2-3.3.2 Smoke detectors that have provision for field adjustment of sensitivity shall have an adjustment range of not less than 0.6 percent per foot obscuration. If the means of adjustment is on the detector, a method shall be provided to restore the detector to its factory calibration. Detectors that have provision for program-controlled adjustment of sensitivity shall be permitted to be marked with their programmable sensitivity range only. 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system. 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. 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. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be	K 054	**K054 (SS=F)** **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. Battery operated smoke detector in Social Service office will be replaced with a brand new unit and will be tested weekly by maintenance with corresponding Monitor Log Report. 2. Contact vendor and schedule a complete Smoke Sensitivity Test on all Smoke detectors in the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.**	

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K 054	Continued From page 12 tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. Findings: During a tour of the facility, record review, and interview with Maintenance Staff on 8/3/16, the battery operated smoke detectors were observed and records for the battery operated smoke detectors and smoke sensitivity test reports were requested. 1. At 10:42 a.m., the facility was observed with a battery operated smoke detector in the Social	K 054	1. All smoke detectors will be scheduled for a Complete Smoke Sensitivity Test to be compliant with this requirement. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. The maintenance supervisor or qualified designees will re-inspect the battery operated smoke detectors once a week and perform a battery test. 2. Contracted vendor will do a Smoke Detector Sensitivity test for the 26 Smoke Detectors in the facility before September 1, 2016. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Supervisor or qualified designees will report their inspection and the Vendors Smoke Sensitivity Test findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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	055475	A. BUILDING 01 B. WING:	03/03/2016

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K 054	Continued From page 13 Service Office. When the test button was pressed, the smoke detector failed to emit an audible sound. 2. At 12:29 p.m., the facility was not able to provide any weekly testing records for the battery operated smoke detector located in the Social Service Office. The direction on the cover of the smoke detector indicated "test weekly." Upon interview, Maintenance Staff stated the facility did not have a log for the battery operated smoke detector. 3. At 12:30 p.m., there were no records that indicated the facility had completed a smoke detector sensitivity test on all smoke detectors within the past two years.	K 054	K062 (5S=E) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. Third quarter sprinkler system inspection completed on //15/15 did not indicate that a water flow alarm was tested thus we have contacted vendor to schedule another inspection before 9/01/16 that will document a water flow test compliance. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. All quarterly Sprinkler Inspection by the vendor must include a water flow alarm test. 2. Quarterly Sprinkler Inspection Report by Vendor should be immediately reviewed with Administrator by Maintenance Supervisor or qualified designee.	
K 062 5S=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain the automatic sprinkler system and components. This was evidenced by the failure to complete one of four quarterly sprinkler system waterflow alarm tests. This affected seven of seven smoke compartments and could result in a delayed notification of a malfunctioning automatic sprinkler system alarm valve. NFPA 101, 2000 edition 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained	K 062		

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K 062	Continued From page 14 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, and Maintenance of Water-Based Fire Protection Systems 1998 edition Chapter 2 Sprinkler Systems, 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determined the minimum required frequencies for inspections, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. 1-8*. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and pre-action valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. 2-3.3* Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. Findings: During record review with Maintenance Staff on	K 062	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Quarterly inspection report of vendor for water flow alarm test should be calendared for a full year. Confirm visit date a week before via phone call to ensure that tests are done as scheduled. 2. Exit review with vendor by Maintenance supervisor or qualified designee of findings for each quarterly visit and verify if 100% testing was done for the water flow alarm tests. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Supervisor or qualified designees will report their inspection and the Vendors Water flow Alarm Test findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 062	Continued From page 15 8/3/16, the quarterly sprinkler reports were reviewed. 1. At 12:03 p.m., the third quarter sprinkler system inspection, completed on 7/15/15, did not indicate that a waterflow alarm test was completed	K 062	K064 (SS=D)	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire extinguishers. This was evidenced by a fire extinguisher that had tamper indicators and safety seals dislodged. This affected one of seven smoke compartments and could result in a malfunctioning fire extinguisher in the event of a emergency. NFPA 101 Life Safety Code, 2000 edition 19.3.5.6 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 provision of another section of this code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguisher. NFPA 10 Standard for Portable Fire Extinguisher, 1998 Edition 4-3.2 Procedures. Periodic inspection of fire extinguishers shall include a check of at least the	K 064	**How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. ABC fire extinguisher in the kitchen will be replaced with a brand new one before September 1, 2016. 2. Ensure that during monthly checks of the Fire Extinguishers that tamper indicators and safety seal are intact and compliant with regulations. Include in the Fire Extinguisher Monitor Monthly Monitor Log. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. A 100% check of all ABC fire extinguishers were done by Maintenance Supervisor and qualified designee to ensure that all Fire extinguishers have intact tamper indicators and safety seals. No other broken or noncompliant tamper indicators and safety seals were found.	

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K 064	Continued From page 16 following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or " hefting " (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place Findings: During a tour of the facility with Maintenance Staff on 8/3/16, the fire extinguishers were observed. 1. At 2:00 p.m., an ABC fire extinguisher in the Kitchen was observed with the tamper indicator hanging out and the safety seal missing.	K 064	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. A Monthly Inspection by Maintenance Supervisor or qualified designee of 100% of the fire extinguishers in the building. 2. Document through a Monthly Fire Extinguisher Monitor Log. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Supervisor or qualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under	K 066	**Include dates when corrective action will be completed.** 9/01/2016	

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K 066	Continued From page 17 direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the designated smoking areas. This was evidenced by cigarette butts disposed of in containers with combustible trash. This affected one of seven smoke compartments and could result in a cigarette ignited fire emergency. Findings: During a tour of the facility with Maintenance Staff on 8/3/16, the designated smoking areas were observed. 1. At 10:50 a.m., the Resident's designated smoking area was observed. A red receptacle that was for disposal of ashes only was observed containing trash inside.	K 066	K066 (SS=D) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. The Maintenance Supervisor worked with the Housekeeping Supervisor and the Red Receptacle was immediately emptied of trash. 2. The Housekeeping Supervisor or qualified designee will do a daily check and emptying of the red receptacle and ensure that no combustible materials are inside. Housekeeping supervisor notified Housekeeping Staff assigned to the area of the daily check and emptying of the red receptacles. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. No other red receptacle was found in the facility. Only one in the Designated Smoking area.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the kitchen hood exhaust system. This was evidenced by the facility's failure to complete one of two semiannual kitchen hood exhaust cleanings. This affected one of	K 069	**hat measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.**	

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K 069	Continued From page 18 seven smoke compartments and could result in a kitchen grease fire. NFPA 101 Life Safety Code, 2000 edition 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3 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 Operation, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation, 1998 edition 8-2.3 If required, certificates of inspection and maintenance shall be forwarded to the authority having jurisdiction. Table 8-3.1 Exhaust System Inspection Schedule Systems serving moderate-volume cooking operations - Semiannually 8-3.1.2 When a vent cleaning service is used, a certificate showing date of inspection or cleaning shall be maintained on the premises. After cleaning is completed, the vent cleaning shall place or display within the kitchen area a label indicating the date cleaned and the name of the servicing company. It shall also indicate areas not cleaned. Findings: During record review and interview with Maintenance Staff on 8/3/16, the kitchen hood	K 069	1. A Daily check and emptying of the red receptacle by the Housekeeping Supervisor or qualified designees. 2. If noncompliance is found on the daily check and emptying of the red receptacle , the Housekeeping supervisor will document findings and report to the Administrator or qualified designee during the Daily Stand up Meeting or afternoon Stand Down meeting. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Housekeeping Supervisor or qualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 069	Continued From page 19 exhaust system cleaning records were requested. 1. At 12:07 p.m., the facility was not able to provide one of two semiannual kitchen hood exhaust system cleaning records at the time of survey. The last kitchen hood cleaning was performed on 5/25/16. Upon interview, Maintenance Staff stated that the facility did not get it done.	K 069	K069 (SS=D) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. The Maintenance Supervisor contacted vendor and scheduled a Kitchen Hood Exhaust System Cleaning on or before November 24, 2016. 2. The Kitchen Hood Exhaust System Cleaning Schedule was communicated to the Dietary Services Supervisor. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. There is no other Kitchen Hood in the facility. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Calendar the semiannual schedules for the next 18 months to ensure that no semiannual schedules are missed.	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to comply with the regulations regarding portable space heating devices. This was evidenced by failure to follow manufacturer's specifications and by the failure to confirm portable space heaters would not exceed 212 degrees Fahrenheit. This affected one of seven smoke compartments and could result in a portable space heater ignited fire emergency. NFPA 101 Life Safety Code, 2000 edition 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the	K 070		

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K 070	Continued From page 20 authority having jurisdiction. 19.7.6 Maintenance and Testing (see 4.6.12) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212·<F (100·<C). 4.6.12 Maintenance and Testing. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 70 National Electrical Code, 1999 edition 110-3 Examination, Identification, Installation and use of Equipment (b) Installation and use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. NFPA 99 Health Care Facilities, 1999 edition 2-1 Labeled. Equipment or materials to which has been attached a label, symbol, or other identifying mark of an organization that is acceptable to the authority having jurisdiction and concerned with product evaluation, that maintains periodic inspection of production of labeled equipment or materials, and by whose labeling the	K 070	2. Document the Semi Annual Schedule in the Kitchen Hood C **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Housekeeping Supervisor or qualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 070	Continued From page 21 manufacturer indicates compliance with appropriate standards or performance in a specified manner. 9-2.1.8.1 Manuals. The manufacturer of the appliance shall furnish operator's maintenance, and repair manuals with all units. These manuals shall include operating instructions, maintenance details, and testing procedures. The manuals shall include the following where applicable: (d) Step-by-step procedures for proper use of the appliance (e) Safety considerations in application and in servicing. Findings: During a tour of the facility, record review, and interview with Maintenance Staff on 8/3/16, the portable space heaters were observed and records were requested. 1. At 10:42 a.m., a portable space heater was observed in the Social Service Office. The space heater was stationed within one inch of plastic bags and a carpeted partition wall. The label on the space heater indicated, "High temperature, keep electrical cords, drapery, and other furnishing at least 3 feet (0.9m) from the front of the heater and away from the side and rear." There was no documentation that was provided to show any inspection or testing of the portable space heater to ensure that it did not exceed the maximum temperature requirement of 212 degrees Fahrenheit. Upon interview, Maintenance Staff confirmed the findings.	K 070	K070 SS=D) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. The portable space heater was immediately removed from the Social Service Office. 2. No Portable Space heater shall be used in the facility unless in an emergency situation and before they are deployed will be checked and will be duly documented with an Emergency Use Portable Heater Log. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. There is no other Portable heater in use in the facility. A 100% check of all rooms were done by the Maintenance Supervisor and Housekeeping Supervisor. **What measures will be put into place or what systemic changes the facility will make to ensure that**	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076	Continued From page 22 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the oxygen storage locations. This was evidenced by the failure to secure oxygen storage rooms from unauthorized entry, by unsecured cylinders, and by the mixed storage of empty and full cylinders that were not clearly segregated. This affected one of seven smoke compartments and could result in an increased safety risk due to the unauthorized access to oxygen cylinders, damage to cylinders, or a delay in locating a full oxygen cylinder. NFPA 101 Life Safety Code, 2000 edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99 Standard for Health Care Facilities, 1999 edition 1-2 Application . Chapters 12-18 specify the conditions under which the requirement of Chapters 3 though 11 shall apply in Chapters 12 through 18 Chapter 16-Nursing Home Requirement 16-3.8.1 Patient. Equipment shall conform to requirement for patients equipment in Chapter 8	K 076	**the deficient practice does not recur.** 1. To ensure compliance the facility will define an Emergency Portable Heater use Policy. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Housekeeping Supervisor or qualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 076	Continued From page 23 Chapter 8-Gas equipment 8-3.1.11.1 storage requirement 8-3.1.11 Storage for nonflammable gases greater than 3000 ft.3 shall comply with 4-3.1.1.2 and 4-3.5.2.2 8-3.1.11.2 storage of nonflammable gases less than 3000 ft.3 (85 m3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors or (gates outdoors) that can be secured against unauthorized entry 4-3.5.2.2 (2) If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. (3) 4-3.1.1.2 Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. (11-C) Enclosure for supply systems shall be provided with a door or gates that can be locked. Findings: During a tour of the facility with Maintenance Staff on 8/3/16, the oxygen storage rooms were observed. 1. At 9:50 a.m., the door to the Oxygen Storage Room near Room 5 was observed unsecured from unauthorized entry. There were three oxygen H tanks and 13 oxygen E cylinders inside the room. 2. At 9:51 a.m., the Oxygen Storage Room near Room 5 was observed. There were two oxygen E cylinders in the room that were freestanding and unsecured on the floor.	K 076	**K076 (SS=D)** **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. The door lock to the Oxygen storage room was changed to the Hotel type door lock with Key by the Maintenance Supervisor to ensure security from unauthorized entry. 2. Secured the two oxygen cylinders with shelving and chain and checked that there are no other free standing cylinders. Notified DSD to conduct Inservices for Nurses that there should be no Free Standing Oxygen Cylinders. 3. Labelled and Segregated Empty versus full oxygen Cylinders. Notified DSD to conduct InServices to Nurses that empty and full oxygen cylinders should be segregated and labelled all the time. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.**	

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K 076	Continued From page 24 3. At 9:51 a.m., the Oxygen Storage Room near Room 5 was observed. One of three storage racks had two full oxygen E cylinders mixed with one empty oxygen E cylinder. The full and empty cylinders were not segregated.	K 076	1. There is only one Oxygen Storage Room in the facility. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. Daily check by Maintenance Supervisor or qualified designees and Charge Nurse to ensure compliance for Oxygen Cylinder storage. 2. Document in Oxygen Storage Monitor Log Daily by the Charge Nurse. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The DON and Maintenance Supervisor or qualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and.8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain the emergency power supply system (EPSS). This was evidenced by the facility's failure to complete six of 12 monthly generator load tests for a duration of not less than 30 minutes. This affected seven of seven smoke compartments and could result in the potential failure of the generator in the event of a power outage. NFPA 101 Life Safety Code, 2000 edition 19.5.1 Utilities, Utilities shall comply with the provisions of section 9.1 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power System. NFPA 110 Standard for Emergency and Standby Power System, 1999 Edition 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer ' s recommendations, instruction	K 144		

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K 144	Continued From page 25 manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly 6-4.2 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate	K 144	**K144 (SS=E)** **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. The Maintenance Supervisor duly noted the compliance requirements of 12 monthly 30minutes load test for emergency generators. 2. This will be documented and logged in the Emergency Generator Monthly Load Test Monitor/Log. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 2. There is only one Emergency Generator for the facility and the Maintenance supervisor or qualified designee will ensure and document the 12 monthly 30 minute load test is done correctly. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.**	

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K 144	Continued From page 26 rating for 60 minutes, for a total of 2 continuous hours. Findings: During record review with Maintenance Staff on 8/3/16, the diesel generator test and inspection records were reviewed. 1. At 11:40 a.m., the monthly generator load test records were reviewed. Six of 12 monthly generator load tests, conducted on 8/13/15, 9/18/15, 10/30/15, 11/27/15, 12/24/15, and 1/15/16, indicated that the load test was ran for 18 minutes. The facility failed to complete six of 12 monthly 30 minute generator load tests during the past year.	K 144	1. Calendar the scheduled monthly 30 minute load test for the emergency generator. 2. Document each monthly 30 minute load test for emergency generator in the Emergency Generator Monthly Load Test Monitor/Log. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Supervisor or qualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the electrical devices and wiring connections. This was evidenced by the use of extension cords, use of adaptors, medical equipment plugged into power strips, power strips suspended off the floor, missing cover plates, and electrical panels circuit that were not labeled or had gaps. This affected seven of seven smoke compartments and could result in an increased risk of an electrical fire. NFPA 101 Life Safety Code, 2000 edition 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1 9.1.2 Electric. Electrical wiring and equipment	K 147		

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K 147	Continued From page 27 shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70 National Electrical Code, 1999 edition 110-12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (c) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 110-22 Identification of Disconnecting Means. Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate it purposes unless located and arranged so the purpose is evident. The marking shall be sufficient durability to withstand the environment involved. 240-83 Marking (a) Durability and Visible. Circuit breakers shall be marked with their ampere rating in a manner that will be durable and visible after installation. Such marking shall be permitted to be made visible by removal of a trim or cover. 384-13 General. All panelboards shall have a rating not less than the minimum feeder capacity required for the load computed in accordance	K 147	**K147 (SS=E)** **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1.The Power Strip was removed form Room 1 and ensured that oxygen concentrator and the bed are plugged in the wall outlet without the use of Power Strips. 2. The alarm unit in Room 1 was replaced with a unit with a cover plate by the Maintenance Supervisor. 3. In Room 2 near Bed B, the electric bed was unplugged from the overhead light outlet and was plugged into the correct wall outlet. 4. In Room 3 near Bed B, an electric bed was unplugged from the overhead light outlet and plugged into the correct wall outlet. 5. In Room 3, the missing vent will be replaced by new exhaust motors with vent covers by the Maintenance Supervisor or qualified designee before September 1, 2016. 6. In Room 7, the three plug adapter were removed and and the two cable boxes were plugged to the correct wall outlet by the Maintenance Supervisor.	

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K 147	Continued From page 28 with Article 220. Panelboards shall be durably marked by the manufactured with the voltage and the current rating and the number of phases for which they are designed and with the manufacturer name or trademark in such a manner so as to visible after installation, without disturbing the interior parts of wiring. All panelboard circuits and circuit modification shall be legibly identified as to purpose or use on a circuit directory located on the face or inside of the panel doors. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. 400-10. Flexible cords and cables shall be connected to devices and to fittings so that tension will not be transmitted to joints or terminals. 406.6 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface.	K 147	7. Maintenance supervisor contacted vendor to schedule and fix the electrical panel near Nurse Station 1 & 2 that had approximately ¼ inch gap above circuit breaker Switch one. Fix should be in compliance before September1, 2016. 8. In the Nurse Station 1 and 2 Utility/FACP room the transformer metal flex conduit that was running out of a junction box without a cover plate was corrected by installing a cover plate. This was done by the Maintenance Supervisor. The ceiling vent will be replaced with a new unit with cover plate before September 1, 2016. 9. In Nurse Station 1 and 2, the electrical panel had a circuit breaker switch 15 that was not labelled that was in the ON position but was not labelled for anything. The Maintenance Supervisor or qualified designee will relabel all the switch circuit breakers before September 1, 2016 10. In the Medical Records Office, a power strip was suspended off the floor. The power strip with surge protector was relocated flat and upright on the floor by the Maintenance Supervisor. 11. In Room 14, a clock was plugged into a black extension cord. The Maintenance Supervisor and Social Service removed the black extension cord and unplugged the electrical clock. The clock was plugged into the wall outlet. 12. Electrical panel located A located in Kitchen had circuit breaker 3 switch that was on the ON position but was not labelled for anything. The Maintenance Supervisor or qualified designee will label and	

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K 147	Continued From page 29 Findings: During a tour of the facility with Maintenance Staff on 8/3/16, the electrical devices and wiring connections were observed. 1. At 9:45 a.m., an electric bed and a oxygen concentrator were plugged into a power strip in Room 1. 2. At 9:47 a.m., an alarm unit in the ceiling was missing a cover plate in Room 1. 3. At 9:48 a.m., an electric bed was plugged into a overhead light outlet near Bed B in Room 2. 4. At 9:49 a.m., an electric bed was plugged into a overhead light outlet near Bed B in Room 3. 5. At 9:50 a.m., a ceiling vent was missing a 12 inch by 12 inch cover in the Soiled Linen Room near Room 3. 6. At 9:51 a.m., two cable boxes were plugged into a three plug adapter in Room 7. 7. At 9:55 a.m., a corridor electrical panel near Nurse Station 1 and 2 had an approximately 1/4 inch gap above circuit breaker switch 1. 8. At 9:56 a.m., the Nurse Station 1 and 2 Utility Room/FACP room was observed. A transformer metal flex conduit was running out of a junction box without a cover plate. A ceiling vent was missing a 12 inch by 12 inch cover. 9. At 9:57 a.m., an electrical panel located at Nurse Station 1 and 2 had circuit breaker switch 15 that was in the on position but was not labeled	K 147	determine what the Circuit Breaker is for. If it is not dedicated to a specific unit to supply power, will label and put to OFF position before September 1, 2016. 13. At 10:30 am, a corridor electrical panel EM located near the Dining Room had Circuit Breaker Switch 5 that was on the ON position but was not labelled for anything. Between circuit breaker switches 21 and 23, there was an approximately 1/8 inch gap. The maintenance Supervisor or qualified designee will determine what this Switch is specifically for and will label appropriately. If not powering any specific unit will turn to OFF position and label appropriately, the Maintenance Supervisor corrected the 1/8 inch gap by adjusting the switch position and ensuring that no gap is present between circuit breaker switches 21 and 23. 14. In Room 43 a cellphone charger was plugged into a white extension cord near Bed A. The extension cord near Bed A was unplugged and removed by the Maintenance Supervisor. 15. A suspended power strip/surge protector was suspended off the floor in the Business Office. The Maintenance person relocated the power strip and was laid flat and on the floor. 16. In Room 22, Bed B and oxygen concentrator was plugged into the overhead light outlet. The Maintenance Supervisor and Charge Nurse plugged the concentrator to the correct wall outlet.	

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	055475	A. BUILDING 01 B. WING	08/03/2016

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MAIN WEST POSTACUTE CARE	812 WEST MAIN STREET TURLOCK, CA 95380

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K 147	Continued From page 30 for anything. 10. At 9:58 a.m., a power strip was suspended off the floor in the Medical Record Office. 11. At 10:01 a.m., a clock was plugged into a black extension cord near Bed B in Room 14. 12. At 10:11 a.m., electrical panel A located in the Kitchen had circuit breaker switch 3 that was in the on position but was not labeled for anything. 13. At 10:13 a.m., a corridor electrical panel EM located near the Dining Room had circuit breaker switch 5 that was in the on position but was not labeled for anything. Between circuit breaker switches 21 and 23, there was an approximately 1/8 inch gap. 14. At 10:14 a.m., a cell phone charger was plugged into a white extension cord near Bed A in Room 43. 15. At 10:15 a.m., a power strip was suspended off the floor in the Business Office. 16. At 10:23 a.m., an oxygen concentrator was plugged into a overhead light outlet near Bed B in Room 22. 17. At 10:28 a.m., nebulizer equipment was plugged into a overhead light outlet near Bed B in Room 29. 18. At 10:31 a.m., a radio was plugged into a white extension cord that was connected to a overhead light outlet near Bed A in Room 17. 19. At 10:40 a.m., a corridor electrical panel C by	K 147	18. In Room 17, Bed A a radio was plugged into a white extension cord connected to an overhead light outlet. The Maintenance Supervisor and Social Service removed the white extension cord and explained to resident and family that white extension cords are not compliant with State safety requirements. 19. In the Fax/Copier Room there is an approximately ¼ inch gap between Circuit Breaker Switches 24 and 26. The Maintenance Supervisor fixed the gap between the 2 cited switches. 20. In the Business Office Telephone Equipment Room a power strip was suspended off the floor. The Maintenance person relocated the power strip and laid it flat on the floor. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. The Maintenance Supervisor and Qualified Designee conducted a 100% visual check of all the rooms in the facility to ensure that there are no existing gaps in the electrical panels and between circuit breaker switches. 2. The Maintenance Supervisor and Qualified Designee implemented a 100% visual check of all rooms for use of extension cords and no	

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K 147	Continued From page 31 the Fax/Copier Room had an approximately 1/4 inch gap between circuit breaker switches 24 and 26. 20. At 10:45 a.m., a power strip was suspended off the floor with items plugged into it, in the Business Office Telephone Equipment Room.	K 147	additional noncompliance were found. 3. The Maintenance Supervisor and Qualified Designee conducted a 100% visual check of suspended power strips and no additional noncompliance were found. 4. The Maintenance Supervisor and Qualified Designee conducted a 100% visual check of all rooms for any noncompliant plug ins of O2 concentrators and nebulizer equipments. There were no additional non compliant plug ins to overhead light outlets.	
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a written protocol to ensure that if the automatic sprinkler system was out of service for four or more hours in a 24 hour period that the authority having jurisdiction (AHJ) would be notified. This was evidenced by incomplete documentation. This affected seven of seven smoke compartments and could result in the AHJ being unable to exercise oversight in the event of a sprinkler system shut down. Findings: During record review and interview with Maintenance Staff on 8/3/16, the automatic sprinkler system fire watch policy was reviewed. 1. At 12:00 p.m., the documentation provided for an approved fire watch for the automatic sprinkler system did not include guidance for the notification of the California Department of Public	K 154	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 1. In Service Nurses and CNAs and staff to notify Maintenance Supervisor or official Designee via the Maintenance Daily Log of any use of extension cords in the facility. Educate them that it is not in compliance with safety requirements. 2. Monthly visual checks of all electrical panels and Circuit breaker switches and ensure that labels are complete and that there is no significant gaps in the panel and the circuit breaker switches. Document/ log in the Monthly Electrical Panel and Circuit Breaker Log. 3. Monthly 100% visual checks for all rooms and ensure that there is no extension cords in	

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K 154	Continued From page 32 Health (CDPH) if the sprinkler system was out of service for four or more hours in a 24 hour period. Upon interview, Maintenance Staff confirmed the findings.	K 154	use. Document Findings in the Monthly Log for Noncompliant use of extension cords. 4. Monthly 100% visual check of use of power strips and ensure that there are no suspended power strips and that they are flat on the floor or secured to a stable location. Document any noncompliance or findings in the Monthly Maintenance Log. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Supervisor orqualified designees will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a written protocol to ensure that if the fire alarm system was out of service for four or more hours in a 24 hour period that the authority having jurisdiction (AHJ) would be notified. This was evidenced by incomplete documentation. This affected seven of seven smoke compartments and could result in the AHJ being unable to exercise oversight in the event of a fire alarm system shut down. Findings: During record review and interview with Maintenance Staff on 8/3/16, the fire alarm system fire watch policy was reviewed. 1. At 12:00 p.m., the documentation provided for an approved fire watch for the fire alarm system did not include guidance for the notification of the California Department of Public Health (CDPH) if the fire alarm system was out of service for four or more hours in a 24 hour period. Upon interview, Maintenance Staff confirmed the	K 155		

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K 155	Continued From page 33 findings.	K 155	**K154** (SS=C) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. The documentation for the Fire Watch for the Automatic Sprinkler system did not include the guidance for the Notification of the California Department of Public Health if the Sprinkler system was out for four hours or more in a 24 - hour period. The Manual will be updated to include the Guidance for CDPH notification. Update will be made before September 1, 2016. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 1. All Facility Fire and Disaster Manuals in Nurses Stations and Administrator Office will be updated with the guidance for Notification of the CDPH if the Sprinkler system was out for four hours or more in a 24 hour period. Update of the Manual will be made before September 1, 2016.	

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K 155	Continued From page 33 findings.	K 155	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 3. Annual review of Fire and Disaster Manual to ensure that all Policy Information and guidance are in compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Administrator or qualified designee will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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K 155	Continued From page 33 findings.	K 155	K155 (SS=C) **How correction (s) will be accomplished for those residents found to have been affected by the deficient practice.** 1. the documentation for the Fire Watch for the Fire Alarm Systmem did not include the guidance for the Notification of the California Department of Public Health if the Fire Alarm system was out for four hours or more in a 24 hour period. the Manual will be updated to include the Guidance for CDPH notification. Update will be made before September 1, 2016. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.** 2. All Facility Fire and Disaster Manuals in Nurses Stations and Administrator Office will be updated with the guidance for Notification of the CDPH if the Fire Alarm system was out for four hours or more in a 24 hour period. Update of the Manual will be made before September 1, 2016. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** 2. Annual review of Fire and Disaster Manual to ensure that	

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K 155	Continued From page 33 findings.	K 155	all Policy Information and guidance are in compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Administrator or qualified designee will report their inspection and their findings and action plan to ensure compliance to the facility's Quality Assessment and Assurance (QAA) committee on a quarterly basis. **Include dates when corrective action will be completed.** 9/01/2016	

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