STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555025	A. BUILDING **02** B. WING _____	**01/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	**2278 NICE STREET** **MENTONE, CA 92359**

(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: 40597 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: 40597 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 42 Abbreviations: Administrator Designee: AD	E 000		
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:	E 031		2/4/22

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

Electronically Signed | 02/04/2022

2/10/22 Accepted by Jose Gonzalez

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E 031	Continued From page 1 (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on document review and interview, the facility failed to maintain the emergency preparedness (EP) communication plan. This was evidenced by missing contact information for federal, regional, state, and ombudsman emergency preparedness staff. This could result in a delayed response to coordinate care during an emergency, and 42 of 42 residents could have been affected. Findings: During document review and interview with the	E 031	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken	

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E 031	Continued From page 2 AD on 1/25/22, the EP plan was reviewed, and the emergency official contact information was requested. At 3:45 p.m., the emergency operations program manual provided by the AD did not include the contact information or where to locate the information for Federal Emergency Management Agency (FEMA), California Governor's Office of Emergency Services (Cal-OES), Inland Counties Emergency Medical Agency (ICEMA), and Ombudsman. At 4:31 p.m., upon interview, the AD stated that the contact information was located in a separate binders.	E 031	The facility Administrator/Designee and Director of Nursing(DON) updated the Emergency Operations Plan to include contact information for all required local, State, and Federal emergency preparedness staff on 2/3/22. Staff in-service on the updated contact information was initiated by the Administrator or designee on 2/4/22. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The Administrator/ Designee will monitor agency changes monthly so that the necessary update and revision of the contact list can be completed as necessary. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system A special Quality Assurance Performance Improvement Meeting (QAPI) was convened by the Administrator /Designee	

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E 031	Continued From page 3	E 031	and Director of Nursing on 2/4/22 to present the results of the standard Recertification survey and the Plan of Correction(POC). The Administrator /Designee will monitor ongoing compliance with the updated contact information for federal, regional, state and local agencies through monthly QAPI committee review x 3 months, then through established quarterly QAPI meetings thereafter. Corrective Action Completion Date: 2/4/2022	
K 000	INITIAL COMMENTS Surveyor: 40597 K3 BUILDING: 01 K6 PLAN APPROVAL: 9/1/1976 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public	K 000		

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K 000	Continued From page 4 Health: 40597 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census = 42 Abbreviations: Administrator Designee: AD Maintenance Director: MD Maintenance Supervisor: MS Building and Facility Director: BFD	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on observation and interview, the facility failed to maintain the doors equipped with a self-closing device. This was evidenced by the failure to repair or replace a broken self-closer on	K 223	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the	2/4/22

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K 223	Continued From page 5 a door to a hazardous area. This could result in the spread of smoke or fire to other areas in the facility during a fire, and affected one of three smoke compartments. Findings: During a facility tour with the MD on 1/25/22, the self-closing doors were observed, and the AD was interviewed. At 11:36 a.m., the door to the Director of Nursing office had a broken self-closing device. The office was greater than 50 square feet and observed having combustible materials. The door was also equipped with a release device that automatically closes upon activiation of the fire alarm. During a concurrent interview, the AD confirmed the finding and stated that the door closer broke last week.	K 223	deficient finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Repair of the Director of Nursing's door with a broken self-closing device was completed 1/27/22. The Maintenance Staff was inserviced of the regulation and the finding on 1/25/22 by the Administrator/Designee. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The Maintenance Facility Inspection Log was modified by the Administrator Designee to include weekly inspection of self-closing doors x4 weeks and then monthly moving forward. The revision was reviewed with the MD. The results of these weekly Inspection will be reported by the Maintenance Director (MD) to the Administrator/ Designee weekly for further actions or recommendations.	

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K 223	Continued From page 6	K 223	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system A special QAPI meeting was convened by the Administrator/Designee and DON on 2/4/22 to present the results of the standard Recertification survey and the Plan of Correction (POC). The MD will present the findings of the weekly Inspection rounds of self-closing doors to the QAPI monthly meeting x3 then quarterly moving forward. Corrective Action Completion Date: 2/4/2022	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		2/4/22

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K 321	Continued From page 7 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on observation, the facility failed to maintain the hazardous areas. This was evidenced by a hazardous area that did not have a self-closing or a release device that automatically closes upon activation of the fire alarm. This affected one of three smoke compartments and could result in the inability to contain smoke and fire within a hazardous area. NFPA 101 Life Safety Code, 2012 Edition 19.3.2 Protection from Hazards 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms	K 321	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Repair of the self-closing device in the Boiler Room door was completed on 1/27/22.	

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K 321	Continued From page 8 Findings: During a facility tour with the MD on 1/25/22, the hazardous areas were observed. At 11:31 a.m., the door to a boiler room was not equipped with a self closing device. The boiler room opened into the Director of Nurses office.	K 321	The Maintenance Staff was educated on the regulation and deficient finding by the Administrator/Designee on 1/25/22. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The Maintenance Facility Inspection Log was modified by the Administrator Designee to include weekly inspection of self-closing doors x4 weeks and then monthly moving forward. The revision was reviewed with the MD. The results of these weekly Inspection will be reported by the MD to the Administrator/ Designee weekly for further actions or recommendations. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system A special QAPI Meeting was convened by the Administrator/Designee and Director of Nursing on 2/4/22 to present the results of the standard Recertification survey and	

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K 321	Continued From page 9	K 321	the POC. The MD will present the results of the weekly inspection of self-closing doors in the monthly QAPI meeting x3 then quarterly moving forward. Corrective Action Completion Date: 2/4/2022	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on observation, document review, and interview, the facility failed to maintain the	K 353	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	2/4/22

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K 353	Continued From page 10 components of the wet-pipe sprinkler system. This was evidenced by the failure to repair a leak on an alarm valve. This affected three of three smoke compartments and could results in the fire protection system not functioning in a fire event. NFPA 101, Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 13.4.1 Inspection of Alarm Valves. Alarm vales shall be inspected as described in 13.4.1.1 and 13.4.1.2. 13.4.1.1* Alarm valves and stem risers check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained. (2) The valve is free of physical damage. (3) All valves are in the appropriate open or closed position. (4) The retarding chamber or alarm drains are not leaking. Findings:	K 353	No residents were affected by the deficient finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The Cluster Building and Facilities Director contacted Quick Response Fire Protection Inc. on 1/26/22 to repair the inspector test valve leak next to the kitchen and evaluate the entire Fire Sprinkler System in the facility to ensure facility safety and regulatory compliance. Quick Response Fire Protection Inc. has scheduled to repair the test valve leak to the kitchen and evaluate the entire Fire Sprinkler System in the facility on 2/9/22. The Cluster Building and Facilities Director provided education to the Maintenance Director/Designee as regards to Proper Sprinkler Maintenance on 1/25/22. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The Maintenance Director/Designee will conduct weekly inspection of sprinkler	

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K 353	Continued From page 11 During a facility tour with the MD on 1/25/22, the wet-pipe sprinkler system was observed, and the BFD was interviewed. At 1:53 p.m., the inspector test valve located next to the kitchen was observed with a continuous leak. During a concurrent interview, the BFD confirmed the finding and stated that he was not aware the valve was leaking. At 2 p.m., during document review, the monthly sprinkler system inspection log was provided by the BFD. The log indicated that the sprinkler system valve's last inspection was completed on 1/21/22 and the log did not identify any problems.	K 353	valves to ensure a leak-free system x4 weeks and then monthly moving forward. Results of the Weekly Inspection will be submitted by the MD to the Administrator/Designee weekly for further action or recommendations How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system The Administrator/Designee and DON convened a special QAPI meeting on 2/4/22 to present the results of the standard Recertification survey and the POC. Weekly audits of the sprinkler valves to ensure a leak free system will be presented by the MD to the QAPI monthly meeting x3 then quarterly moving forward. Corrective Action Completion Date: 2/9/22	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		2/4/22

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K 355	Continued From page 12 inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 40597 Based on observation, document review, and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by the failure to remove a fire extinguisher from service for recharging. This could result in improper discharge during a fire event, and one of three smoke compartments were affected. NFPA 101, Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 7.1.3 Replacement while Servicing. Fire extinguishers removed from service for maintenance or recharging shall be replaced by a fire extinguisher suitable for the type of hazard being protected and shall be of at least equal rating. 7.2.2 Procedures. Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items:	K 355	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The Cluster Building and Facilities Director requested replacement extinguisher from Quick Response Fire Protection along with 2 back up extinguishers for emergency replacement purposes on 1/25/22. These were delivered to the facility on 1/26/22. A full house inspection of all other fire extinguishers conducted by the MD and Administrator/ Designee on 1/26/22 and did not identify a similar finding. Inservice education on the importance of ensuring fire extinguishers are up to date with inspections was completed on 1/25/22 by the Cluster Building and Facilities Director.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	**2278 NICE STREET** **MENTONE, CA 92359**

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K 355	Continued From page 13 (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators 7.2.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. 7.2.3.1 Rechargeable Fire Extinguishers. When an inspection of any rechargeable fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. 8.5.2.6 A drop in pressure of the test gauge, which is an indication of a leak, shall be cause for rejection or retest. Findings: During a facility tour with the MD on 1/25/22, the portable fire extinguishers were observed, and staff was interviewed. At 11:30 a.m., there was an ABC fire extinguisher stored in the Director of Nursing office that was outside its normal range and indicated recharge status. The extinguisher was certified in January 2022. The inspection tag did not have an initial and date showing that it was inspected by staff. During a concurrent interview, the MD confirmed the finding.	K 355	What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The MD created a log of each fire extinguisher and their location on 1/26/22 to ensure none is missed during monthly inspections. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system A special QAPI meeting was convened by the Administrator/Designee and the DON on 2/4/22 to present the results of the standard Recertification survey and the POC. The MD will present the results of the monthly fire extinguisher inspection to the monthly QAPI committee meeting x 3 and quarterly thereafter Corrective Action Completion Date: 2/4/2022	

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K 355	Continued From page 14 At 2:18 p.m., documentation title, "Quick Response Fire Protection" dated 1/18/22 indicated that 11 fire extinguishers were maintained and certified by the vendor. Upon interview, the MD acknowledged the findings.	K 355		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		2/4/22

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K 918	Continued From page 15 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: 40597 Based on observation, document review, and interview, the facility failed to maintain the emergency power supply (EPS). This was evidenced by the failure to test the lead acid storage battery at least once a month, by the failure to complete the load bank test of the spark-ignited generator at least once within every 36 months, and by the absence of the operational test record after repair. This could result in a disruption of critical care services to the facility during an emergency, and this affected three of three smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition 6.4.4.1.1.3 Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition-Chapter 8, Routine Maintenance and Operational Testing. 8.3 Maintenance and Operational Testing. 8.3.2 A routine maintenance and operational testing program shall be initiated immediately after the EPSS has passed acceptance tests or after completion of repairs that impact the operational reliability of the system. 8.3.2.1 The operational test shall be initiated at an	K 918	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient finding. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The Building and Facilities Director contacted the Vendor Power Plus on 1/26/22, to perform the annual generator maintenance and 36-month load bank test and issue a report. Vendor Power Plus is scheduled to be in the facility on 2/21/22 to perform a generator maintenance and load bank test. A report will be submitted to the facility after service. The Building and Facilities Director provided education to Maintenance Director as regards Monthly Generator Battery Testing and Annual Generator Maintenance on 1/25.	

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K 918	Continued From page 16 ATS and shall include testing of each EPSS component on which maintenance or repair has been performed, including the transfer of each automatic and manual transfer switch to the alternate power source, for a period of not less than 30 minutes under operating temperature. 8.3.4 A permanent record of the EPSS inspections, test, 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 8.3.5 * Transfer switches shall be subjected to a maintenance and testing program that includes all of the following operations: (1)Checking of connections (2)Inspection or testing for evidence of overheating and excessive contact erosion (3)Removal of dust and dirt (4)Replacement of contacts when required 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.4.9 * Level 1 EPSS shall be tested at least once within every 36 months. Findings: During a facility tour and interview with the MD and BFD on 1/25/22, the EPS was observed, and document was requested.	K 918	What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur The Maintenance Director will update the existing maintenance log and add/schedule both the monthly generator battery testing inspection and schedule of the annual maintenance. The Administrator/Designee and MD will conduct the scheduled monthly generator testing and annual maintenance. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system A special QAPI meeting was convened by the Administrator/Designee and DON on 2/4/22 to present the results of the standard Recertification survey and the POC. The Administrator/ Designee and MD will present results of the monthly generator battery testing and the annual	

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K 918	Continued From page 17 1. At 12:20 p.m., the generator was equipped with one lead acid storage battery. The surveyor asked the MD if the battery was tested monthly. During a concurrent interview, the MD confirmed it was not tested. At 2:39 p.m., the BFD provide the monthly test record of the 5 kilowatt propane generator. Documentation did not include any battery testing from January 2020 to January 2021. During a concurrent interview, the BFD confirmed the finding and stated that he was not able to locate it. 2. At 3:04 p.m., the 36 month load bank test was not completed. During a concurrent interview, the BFD confirmed the finding and stated that they are working on a service agreement with the vendor. 3. At 3:07 p.m., the annual maintenance of the generator was not completed. The surveyor requested the operational test of the generator after the generator was rebuilt and bearings replaced. During a concurrent interview, the BFD stated that the rebuild was done by the previous owner and the new owner did not have documentation available.	K 918	maintenance compliance to the QAPI monthly committee meeting for monitoring and recommendations. Corrective Action Compliance Date: 2/21/22	