Approved POC on 12/30/24 by 49577

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

PRINTED: 12/19/2024
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
	056234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLORA POST ACUTE REHAB HOSP	3801 E ANAHEIM ST LONG BEACH, CA 90804

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K 000	INITIAL COMMENTS K3 BUILDING: 1 K6 PLAN APPROVAL:8/20/1970 K7 SURVEY UNDER: 2012 Existing STRUCTURE TYPE: ONE STORY,UNPROTECTED WOOD FRAME TYPE: 1, FULLY SPRINKLED 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. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 99 Census: 91	K 000	Marlora Post Acute Rehabilitation Hospital submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner averse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis.	12/28/2024
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress	K 211	**Corrective Action:** We moved the items blocking the hallway so that there was enough space available in the event of an emergency.	12/28/2024

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

Peter Getz | Administrator | 12/28/2024

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

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K 211	Continued From page 1 continuously free of all obstructions to full instant use in case of emergency. In the event of smoke and/or fire, an unobstructed means of egress is essential in prompt evacuation of residents and staff as well as facilitating easy access into the facility by the fire department in response to an emergency. This deficiency affected one of three smoke compartments. Findings: During a concurrent observation and interview on 12/05/2024 at 2:28 p.m. with the Maintenance Supervisor (MS) in the corridor next to room (rm) 36, an unattended laundry cart, cleaning supplies cart and resident manual lift were stored on one side of the corridor resulting in the corridor measuring 3 feet across. This was verified by the MS. The MS acknowledged the findings.	K 211	**Identification of Others at Risk:** All residents have the potential to be affected in the event of an emergency evacuation. Inserviced staff on not blocking the hallway. **Measures/Systemic Changes:** Inservice staff on not blocking the hallway, making sure there is always enough space available. Spot checks and rounds by Administrator/Maintenance Supervisor/DSD or Designee to ensure staff is following proper protocol. **Monitoring Performance:** Maintenance Supervisor or Designee will monitor the hallway daily to make sure the hallway is clear. He will keep a log to track and show that the hallway has enough space in the event of an emergency. He must report the results of the this log to the Administrator at the monthly QA Meeting.	12/28/2024
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353	A. **Corrective Action:** Sprinkler Heads will be cleaned once a month? Maintenance Supervisor will Keep a log of the cleaning schedule.	12/28/2024

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K 353	Continued From page 2 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: Based on observation, interview, the facility failed to: A. Ensure fire sprinklers were continuously maintained. The periodic inspection, testing, and maintenance of the automatic sprinkler system is essential in identifying if any problems exist that could affect the activation and effective operation of the sprinkler components for the dispersion of water in an event of a fire. B. Conduct a fifty-year sprinkler test. These deficient practices had the potential to negatively affect the sprinkler system or result in system failure. These deficient practices affected three of three smoke compartments. Findings: A. During a concurrent observation and interview on 12/05/24 at 8:57 a.m. with the MS in the corridor across from rm#5, the sprinkler head in the ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 8:58 a.m. with the MS in the corridor across from rm#14, the sprinkler head in the ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 8:59 a.m. with the MS in the corridor across from rm#15, the sprinkler head in the	K 353	**Identification of Others at Risk:** All residents have the potential to be affected by the sprinkler heads. Facility will ensure the sprinkler heads are cleaned monthly so as not to affect their performance in the event of a fire. **Measures/Systemic Changes:** Maintenance Supervisor will keep a cleaning log of the sprinkler heads. Review the log monthly at QA Meeting with the Administrator. **Monitoring Performance:** Administrator will review the sprinkler head cleaning log monthly at the QA Meeting to ensure that the sprinkler heads are being cleaned. **B. 50 Year Sprinkler Test** **Corrective Action:** The 50 year sprinkler test was Completed by Alta Pro Fire on July 27, 2021. Paperwork was not readily available to the Life Safety inspector at the time of Survey. Administrator will ensure that the Maintenance Supervisor keeps an updated binder which will include all sprinkler tests. This binder will be available to the surveyor during any visit.	12/28/2024 12/28/2024

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K 353	Continued From page 3 ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 9:02 a.m. with the MS in the corridor across from the dietary entry door, the sprinkler head in the ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 9: 12 a.m. with the MS in nurse station #2, the sprinkler head in ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 9:13 a.m. with the MS in the corridor across from rm#21, the sprinkler head in ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 9:30 a.m. with the MS in the room housing the sprinkler riser, the sprinkler head in the ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 9:33 a.m. with the MS in the laundry room, the sprinkler head in the ceiling positioned over the washing machine had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 10:03 a.m. with the MS in shower rm #2, the sprinkler head positioned in the ceiling had cobwebs and dust on it. The MS acknowledged the findings.	K 353	**Identification of Others at Risk:** All residents have the potential be at risk. Administrator will ensure that the Maintenance Supervisor keeps an updated binder which will include all sprinkler tests. This binder will be available to the surveyor during any visit. **Measures/Systemic Changes:** Administrator will ensure that the Maintenance Supervisor keeps an updated binder which will include all sprinkler tests. This binder will be available to the surveyor during any visit. **Monitoring Performance:** Administrator will review the Maintenance Binder monthly at the QA Meeting to ensure it's accurate and up to date.	12/28/2024

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K 353	Continued From page 4 During a concurrent observation and interview on 12/05/24 at 10:22 a.m. with the MS in restroom #4, the sprinkler head in the ceiling had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:26 p.m. with the MS in rm #38, the sprinkler head located in the ceiling over bed C had cobweb and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:36 p.m. with the MS in rm #27, the sprinkler heads located over bed C and in the restroom had cobwebs and dust on them. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:38 p.m. with the MS in rm #5, the sprinkler heads located over beds A and B had cobwebs and dust on them. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:45 p.m. with the MS in rm #15, the sprinkler head located over bed B had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:48 p.m. with the MS in rm #14, the sprinkler head located in the restroom had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:50 p.m. with the MS in rm #11, the sprinkler head located in the	K 353		

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K 353	Continued From page 5 restroom had cobwebs and dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 12/05/24 at 2:54 p.m. with the MS in rm #7, the sprinkler head located over bed A had cobwebs and dust on it. The MS acknowledged the findings. B. During a concurrent interview and record review on 12/05/2024 at 4:21 p.m. with the Admin and MS, the Admin stated, "the business has been around for many years but did not know for sure the exact date the sprinkler system has installed.". During record review of the fire sprinkler testing reports on 12/05/2024, there was no documentation to indicate that the facility conducted the 50 year sprinkler testing. The administrator stated, he would check with the owner to ascertain that information but was unable to get the information prior to the conclusion of the exit conference.	K 353		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511	**Corrective Action:** Facility will ensure dryer vent is being cleaned regularly and make sure log is being signed for accuracy. **Identification of Others at Risk:** All residents have the potential to be at risk. Facility staff will clean dryer vent regularly and sign log showing it was done.	12/28/2024

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K 511	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review the facility failed to maintain the facility's one dryer free from the excessive accumulation of lint and debris. This deficient practice has the potential to create a fire hazard due to the excessive lint accumulation. This deficient practice affected one of three smoke compartments. During a concurrent observation, interview and record review on 12/05/2024 at 9:32 a.m. with the MS in the laundry room, the dryer vent filter had a large accumulation of lint buildup. The MS stated,,"the dryer's vent is cleaned multiple times a day". A review of the dyer vent filter cleaning log sheet indicated the vent had not been cleaned yet for that day even though the log sheet's first scheduled cleaning was scheduled for 8:30 am. The MS acknowledged the findings.	K 511	**Measures/Systemic Changes:** MS will monitor lint vents and the cleaning log to make sure the dryer vents are being cleaned regularly and logged appropriately. **Monitoring Performance:** Maintenance Supervisor will report all findings to Administrator monthly at the QA Meeting.	12/28/2024
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712	Obtained copies of all fire drills from this year. We did meet the requirement and have proof of all 12 tests for the year. Unfortunately our Maintenance Binder was not up to date showing proof of all the tests during the Survey visit. We will now maintain an updated log that will be made available to CDPH anytime it is requested to show proof of our compliance. The Administrator will check the Maintenance Binder monthly during the QA Meeting to ensure all tests are being done quarterly on each shift, and that the paperwork is updated and placed in the Maintenance Binder.	12/20/2024

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K 712	Continued From page 7 by: Based on interview and record review, the facility staff failed to provide supporting documentation that fire drills (a practice of the emergency procedures to be used in case of fire) were conducted not less than quarterly for each shift, for 12 of 12 drills. This deficient practice had the potential for staff not to respond accordingly in the event of a need for evacuation, potentially delaying or preventing evacuation. This deficient practice affected three of three smoke compartments. Findings: During the entrance conference on 12/05/2024 at 8:00 a.m. with the Administrator and Maintenance Supervisor, a request was made for documents that showed fire drills were conducted within the last 12 months. During a concurrent interview and record review on 12/05/2024 at 11:23 a.m., the fire drill records presented were incomplete, and did not show fire drills were conducted at least quarterly on each shift. Missing fire drill records included the following:1st Q (2nd shift and 3rd shift), 3rd Q (1st shift) and the 4th Q (3rd shift). The MS acknowledged the findings.	K 712		
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.	K 753	**Corrective Action:** Fake Trees were treated with fire retardant spray by Maintenance Supervisor on 12/17/2024.	12/17/2024

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K 753	Continued From page 8 o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that no decorations (three artificial trees) of a highly flammable character were used within the facility in accordance with NFPA 101, 2012 Edition, Section 19.7.5.6 and NFPA 701, 2010 Edition, affecting three of three smoke compartments. This deficient practice has the potential to increase the fire load and that may compromise the containment of smoke and/or fire during a fire emergency, affecting the safety of residents, staff, and visitors. During a concurrent observation and interview on 12/05/2024 at 9:00 a.m. with the MS in the front lobby of the facility, a six-foot artificial Christmas tree was observed stationed near the front entry door. The MS stated, "he did not know if the tree was fire retardant but would get the storage box to find the labeling and instructions". During a concurrent observation and interview on 12/05/2024 at 9:55 a.m. with the MS in the dayroom of the facility, an eight-foot artificial Christmas tree was observed stationed in the corner of the room. The MS stated, "he did not	K 753	**Identification of Others at Risk:** This could potentially affect all residents. Facility will only use Christmas trees that are fire retardant or treated with a fire retardant spray. **Measures/Systemic Changes:** Facility will only buy fire retardant fake trees or make sure the current trees are treated with fire retardant spray. **Monitoring Performance:** Administrator will ensure the facility only purchases fire retardant fake trees in the future. Administrator will ensure that the current fake trees are treated with fire retardant spray by Maintenance Supervisor.	12/28/2024

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K 753	Continued From page 9 know if the tree was fire retardant but would get the storage box to find the labeling and instructions". During a concurrent observation and interview on 12/05/2024 at 9:59 a.m. with the MS in the dining room of the facility, an eight-foot artificial Christmas tree was observed stationed in the corner of the room. The MS stated, "he did not know if the tree was fire retardant but would get the storage box to find the labeling and instructions". During a record review on 12/05/2024 at 1:47 p.m. with the MS, a copy of the tree installation instructions was provided. The instructions did not indicate if the artificial trees were flame-retardant. The MS acknowledged the findings.	K 753		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 761	**Corrective Action:** All Fire Doors were tested on 12/17/2024 and passed. **Identification of Others at Risk:** All residents have the potential to be affected by this. Fire doors will be tested annually in accordance with state and federal requirements. **Measures/Systemic Changes:** Maintenance Supervisor will meet with Administrator monthly to review Maintenance binder and make sure everything is up to date and in place.	12/28/2024

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K 761	Continued From page 10 Based on interview and record review, the facility failed to inspect and test three of three fire door assemblies (doors that automatically close when the fire alarm is triggered) in the facility. This deficient practice has the potential for issues with the fire door assemblies to do unnoticed and unaddressed which has the potential to affect the safety of the residents, staff, and visitors to the facility. This deficiency affected three of three smoke compartments. Findings: During a concurrent interview and record review 12/05/2024 at 4:21 pm with MS, the fire door assemblies service record was not provided. The MS stated he would contact his service provider for a copy of the record. At the exit conference the MS stated he was unable to obtain documentation that the fire door assemblies service was conducted. The MC acknowledged the findings.	K 761	**Monitoring Performance:** Maintenance Supervisor will meet with Administrator monthly to review Maintenance binder and make sure everything is up to date and in place. The outcomes of this meeting will be reviewed and reported monthly at the QA Meeting	12/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is not in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care (LTC) Facilities. Census:91	E 000	Marlora Post Acute Rehabilitation Hospital submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors.	12/28/2024
E 041 SS=D	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA	E 041	The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner averse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fawad Gul	Administrator	12/28/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. BUILDING _____ B. WING _____	12/05/2024

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E 041	Continued From page 1 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call	E 041	**Corrective Action:** Facility will ensure that the emergency generator has enough fuel as well as a way to replenish the fuel during an emergency. The facility had a contract in place already with a third party vendor that states that in the event of an emergency, the vendor will supply fuel for the facility emergency generator. **Identification for Others as Risk:** The generator affects the entire building and the potential to affect all residents. Facility will ensure the generator has enough fuel and that the facility has a plan in place to obtain and replenish the fuel in the event of an emergency. YAY construction INC will provide fuel for the generator in the event of an emergency.	12/28/2024

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E 041	Continued From page 2 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility f failed to indicate how the facility would maintain the generator's fuel source to ensure the generator was in proper working order, during an emergency. This deficient	E 041	**Measures/Systemic Changes:** Facility has updated it's EOP to include the process and persons responsible to ensure that there is enough fuel to run the generator in the event of an emergency. In the event of an emergency, Maintenance Supervisor, Administrator or Designee will obtain and replenish fuel for facility generator. As a backup, YAY Construction INC will provide fuel for the generator in the event that Maintenance Supervisor, Administrator or Designee is unable to do so. **Monitoring Performance:** Maintenance Supervisor will report at least monthly to the Administrator any issues with the generator. Maintenance Supervisor will continue to perform his regular generator tests weekly and monitor the fuel to ensure the tank is full. If any issues are discovered with the generator, that will be reported immediately to the Administrator and will be fixed ASAP.	12/28/2024

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E 041	Continued From page 3 practice affected all residents and staff and could result in an unexpected inadequate power supply in the event of an emergency. Findings: During an interview on 12/05/2024, at 9:17 a.m. with the Administrator (Admin) and Maintenance Supervisor (MS), the admin stated, "in case of an emergency the facility would obtain fuel from the vendor they contract with to service the generator". During a review of the records on 12/05/2024, at 4:21p.m. with the MS, the MS stated there was no written document that stated they contracted with a vendor to obtain fuel in case the emergency generator runs low of fuel. The MS acknowledged the findings.	E 041		