STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING **02** B. WING _____	**09/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAYA SPRINGS HEALTH CARE CENTER	**8625 LAMAR STREET** **SPRING VALLEY, CA 91977**

(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 of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is not in substantial compliance with 42 CFR §483.73 for Long Term Care Facilities. Census = 48	E 000	*Amaya Springs Health Care submits this response and plan of correction as part of the requirements under the state and federal law. The Plan of Correction 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 plan of correction with the intention that is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, director, or shareholders. 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 adverse to the interests of the provider either by the governmental agencies or third party. The facility desires that this plan of correction be considered the facility's allegation of compliance.* *"Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law."*	
E 041 SS=F	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 12-5, and TIA 12-6), Life Safety Code (NFPA 101	E 041		

RECEIVED
By Rocio Casper at 1:39 pm, Oct 07, 2024

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

Trevor Bruce | 9/27/2024

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.

10/08/2024: POC accepted per Jose GOnzalez, SSM-1

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E 041	Continued From page 1 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 202-741-6030, or go to:	E 041	**E041 (F) - Hospital CAH and LTC Emergency Power** **1. Immediate Corrective Action** The facility contacted its main contractor in place to inspect and monitor the performance of the facility generator on 9/18/2024. The vendor's name is Global Power, and they were able to provide the generator's manufacturer documents. These documents include the specs and features of the generator, including the fuel consumption rate. Per this document, the facility's generator (assuming fuel is 100% full) will last 107 hours. **2. How to identify Other residents affected** The immediate corrective action affected all other residents. **3. System Changes** The documents and updated policy were added to the facility Emergency Operations Plan on 9/25/24. **4. Monitoring** The Emergency Operations Manual will be updated at least annually, or as needed, by the Administrator or designee. Compliance is achieved for this deficient practice, but its performance will be monitored annually.	

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E 041	Continued From page 2 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, record review and interview, the facility failed to maintain their emergency power systems. This was evidenced by the failure to provide policies and procedures in their Emergency Operations Plan (EOP) to keep their emergency power systems operational	E 041		

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E 041	Continued From page 3 during an emergency. This could cause power loss during an emergency. This affected visitors, staff, and 48 of 48 residents. Findings: On 9/18/24, during a facility tour and record review with the Plant Operations Director (POD), the Emergency Power System was observed and the EOP was reviewed. 1. At 8:51 a.m., the POD was unable to indicate how long the generator fuel would last if the emergency power system was activated. The facility had a 31-kilowatt propane generator which indicated 80% full. 2. At 10:44 a.m., during a record review of the EOP, there were no policies and procedures for determining the generator fuel consumption rate, or to determine when more fuel would be required if the facility was under emergency power. The POD phoned the vendor, who was unable to state the fuel consumption rate. At 12:00 p.m., the Administrator acknowledged the findings at the exit conference.	E 041		
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1994 K7 SURVEY UNDER: EXISTING STRUCTURE TYPE: ONE STORY with Basement open to grade, CONSTRUCTION TYPE V(111), FULLY SPRINKLERED. Resident Certified Beds: 50	K 000		

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K 000	Continued From page 4 Resident Census: 48 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 Facilities.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered	K 161		

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K 161	Continued From page 5 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire-rated construction. This was evidenced by an unsealed penetration in a common wall. During a fire, this could allow smoke and flames to pass through the penetration. This affected visitors, staff, and 31 of 48 residents in one of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 4.5.7 System Design/Installation. Any fire protection system, building service equipment, feature of protection, or safeguard provided to achieve the goals of this Code shall be designed, installed, and approved in accordance with applicable NFPA standards. 8.2.3.1* The fire resistance of structural elements and building assemblies shall be determined in accordance with test procedures set forth in ASTM E 119, Standard Test Methods for Fire	K 161	**K161 (D) – Building Construction type and Height** **1. Immediate Corrective Action** All penetrations identified during the Life Safety survey have been repaired by the Maintenance Director and are compliant with K161. Penetration repairs were completed 9/25/24. **2. How to identify Other residents affected** The Maintenance Director surveyed the facility for other unsealed penetrations. No other unsealed penetrations were discovered in this audit. Audit completed 9/26/24. **3. System Changes** The Maintenance Director, or designee, will audit the Maintenance Log daily to review reports of any unsealed penetrations in the building's construction. Repairs will be completed as soon as practicable. **4. Monitoring** The Maintenance Director will conduct weekly audits x 4 weeks and monthly audits x 2 months to ensure unsealed penetrations are identified and repaired. This will begin the week of 9/30/24.	

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K 161	Continued From page 6 Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the authority having jurisdiction. 8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. 8.4.4 Penetrations. The provisions of 8.4.4 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke partitions. 8.4.4.1 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a smoke partition shall be protected by a system or material that is capable of limiting the transfer of smoke. Findings: On 9/18/24, during a facility tour with the Plant Operations Director (POD), the fire-rated construction was observed. At 10:34 a.m., in the Conference room, a penetration measuring approximately 1 1/2 inches by 1 inch went through the common wall	K 161		

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K 161	Continued From page 7 to the corridor. The penetration was in the area around a cluster of cables. The POD stated he had sealed the area but somebody had been working in the area and unsealed it. At 12:00 p.m., the Administrator acknowledged the finding at the exit conference.	K 161		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222	**K222 (E) – Egress Doors** **1. Immediate Corrective Action** The Maintenance Director created and labeled the key to the discharge gate and placed it at the nursing station – a central location in the facility. This was completed on 9/20/24. **2. How to identify Other residents affected** On 9/20/24, the Maintenance Director audited all egress doors and identified no other areas of concern. **3. System Changes** On 9/23/24, the Maintenance Director educated all Department Managers and charge nurses of the location of the key to ensure rapid response in opening the gate in the event of an emergency. **4. Monitoring** The Maintenance Director will conduct weekly audits x 4 weeks and monthly audits x 2 months to ensure keys are labeled and placed in the correct locations within the facility for facility personnel to utilize in the event of an emergency. This will begin the week of 9/30/24.	

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K 222	Continued From page 8 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their egress doors. This was evidenced by a locked discharge gate which could not be rapidly opened by anyone in the facility. This could cause delay or confusion during an emergency evacuation. This affected visitors, staff, and 17 of 48 residents in one of three smoke compartments.	K 222		

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K 222	Continued From page 9 Findings: On 9/18/24, during a facility tour with the Plant Operations Director (POD), the egress doors were observed. At 9:17 a.m., the POD was unable to rapidly open the locked exit gate leading from the Rehab Patio. He stated the key was kept in the Nursing Station. After trying several keys he was able to open the discharge gate after a delay of several minutes. He stated that staff do not carry the key for the gate. At 12:00 p.m., the Administrator acknowledged the finding at the exit conference.	K 222		
K 300 SS=F	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain building protection. This was evidenced by a roof covered with combustible material. This could degrade the fire rating of the roofing material and increase the rapid spread of	K 300	**K 300 (F) – Protection** **1. Immediate Corrective Action** The facility roof was cleared of its combustible material (pine needles) on 9/23/24 by Deseret Landscape. **2. How to identify Other residents affected** The Maintenance Director performed an audit of the facility landscaping and discovered no other combustible materials. This audit was completed on 9/20/24. **3. System Changes** The Administrator contracted a dedicated landscaping company on 9/23/24 and concluded that part of their weekly maintenance services will be to clear the combustible materials from the roof. This began 9/23/24 and will continue weekly. If, for any reason, the services are not rendered by the contracted landscape company, the Maintenance Director, or designee, will remove any combustible materials from the roof.	

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K 300	Continued From page 10 smoke and flames during a fire. This affected the entire roof of the facility and included visitors, staff, and 48 of 48 residents. NFPA 101-Life Safety Code, 2012 Edition. 19.1.1.1.3 General. The provisions of Chapter 4, General, shall apply. 4.2.2 Structural Integrity. Structural integrity shall be maintained for the time needed to evacuate, relocate, or defend in place occupants who are not intimate with the initial fire development 4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. Findings: On 9/18/24, during a facility tour and interview with the Plant Operations Director (POD) and Administrator, the building protection was observed. At 8:40 a.m., the roof of the building was covered in brown vegetation resembling pine needles. The POD stated that the gardener comes every two weeks to remove the pine needles, but he did not show up on schedule. The Administrator stated he might remove the trees which shed the needles. At 12:00 p.m., the Administrator acknowledged the finding at the exit conference.	K 300	**4. Monitoring** The Maintenance Director will audit the performance of the facility's contracted landscaping company weekly x 4 weeks and monthly x 2 months to ensure the combustible material is removed as contracted. This will begin the week of 9/30/24.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance	K 324		

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K 324	Continued From page 11 with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain their UL-300 fire suppression (Ansul) system. This was evidenced by discharge nozzles which did not reach required areas, and by discharge nozzles missing protective components. This could cause a delay in suppressing a cooktop fire and lead to the rapid spread of smoke and flames. This affected visitors and kitchen staff with the potential to affect 48 of 48 residents in two adjoining smoke compartments. NFPA 101, Life Safety Code, 2012 Edition	K 324	**K 324 (F) – Cooking Facilities** **1. Immediate Corrective Action** The UL-300 Fire Suppression (Ansul) system was repaired on 9/18/24 by Coltrane Fire Protection. **2. How to identify Other residents affected** On 9/18/24, the Maintenance Director confirmed the repair of the Ansul system nozzles and identified no other concerns. **3. System Changes** The Dietary Manager educated the kitchen staff on the proper setup of the Ansul system, demonstrating the correct orientation of the nozzles and protective components and to report any necessary repairs to the Maintenance Director. This was completed on 9/19/24. **4. Monitoring** The Dietary Manager or Maintenance Director will perform audits on the Ansul system weekly x 4 weeks and monthly x 2 months to ensure the system is setup correctly and has the proper protective components. This will begin the week of 9/30/24.	

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K 324	Continued From page 12 19.3.2.5 Cooking Facilities. 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 10.2.3 Automatic fire-extinguishing systems shall comply with ANSI/UL 300 or other equivalent standards and shall be installed in accordance with the requirements of the listing. 10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (4) NFPA 17A 11.5 Inspection, Testing, and Maintenance of Listed Hoods containing Mechanical, Water Spray, or Ultraviolet Devices. Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 2009 Edition 5.5 Discharge Nozzles. All discharge nozzles	K 324		

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K 324	Continued From page 13 shall be located to minimize damage or misalignment and be within the limitations and constraints of the manufacturer's listed installation and maintenance manual. 4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. Findings: On 9/18/24, during a facility tour with the Plant Operations Director (POD) and fire suppression system vendor, the UL-300 fire suppression system was observed. 1. At 9:25 a.m., the two discharge nozzles of the UL-300 (Ansul) fire suppression system did not cover any of the gas burners of the cooktop. The nozzles had a spray pattern which were pointing at the rear of the cooktop unit. The suppression system vendor, who began servicing the system at 10:07 a.m., stated that he frequently finds the nozzles bent backward and has to note it in his report. He further stated that the nozzles were put out of place by the exhaust system vendor. Documentation review indicated the most recent exhaust system cleaning was performed 8/15/24. 2. At 10:10 a.m., the two discharge nozzles of the UL-300 fire suppression system were missing their protective blow-off caps. The suppression system vendor stated the caps were missing. The POD stated he could find new caps to put on the nozzles. At 12:00 p.m., the Administrator acknowledged the findings at the exit conference.	K 324		

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K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire alarm system. This was evidenced by a manual pull station that was inaccessible due to an obstruction, and by an unidentified fire alarm component. This could cause a delay in activating and servicing the alarm during a fire. This affected visitors, staff, and 31 of 48 residents in one of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 9.6.1.4 All systems and components shall be approved for the purpose for which they are installed. 9.6.1.5 * 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 Electrical Code, and NFPA 72, National Fire	K 345	**K 345 (D) – Fire Alarm System – Testing & Maintenance** **1. Immediate Corrective Action** On 9/18/24, the obstruction to the manual pull station was removed. On 9/19/24, the Maintenance Director labeled the fire alarm circuit breaker component. **2. How to identify Other residents affected** On 9/19/24, the Maintenance Director conducted an audit of the facility to identify any other obstructions to fire alarm pull stations. No other obstructions were found. **3. System Changes** The facility staff will be in-serviced by 10/13/24 on the facility's policy and Life Safety regulation of obstructing fire alarm pull stations. **4. Monitoring** The Maintenance Director will perform audits on the fire alarm pull stations weekly x 4 weeks and monthly x 2 months to ensure there are no obstructions. Any findings will be immediately rectified. This will begin the week of 9/30/24.	

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K 345	Continued From page 15 Alarm and Signaling Code. NFPA 99, Health Care Facilities Code, 2012 Edition 6.4.2.2.3.2 The life safety branch shall supply power for lighting, receptacles, and equipment as follows: (7) Fire alarms and auxiliary functions of fire alarm combination systems complying with NFPA 72, National Fire Alarm and Signaling Code NFPA 72: National Fire Alarm and Signaling Code, 2010 Edition Chapter 10 Fundamentals 10.5.5.2 Circuit Identification and Accessibility. 10.5.5.2.1 The location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. 10.5.5.2.2 For fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." 10.5.5.2.3 For fire alarm systems the circuit disconnecting means shall have a red marking. 17.14.5 Manual fire alarm boxes shall be installed so that they are conspicuous, unobstructed, and accessible. Findings: On 9/18/24, during a facility tour with the Plant Operations Director (POD), the fire alarm system was observed. 1. At 9:36 a.m., in the corridor opposite the Nursing Station, the manual fire alarm pull station was blocked from access by an over-the-bed table (see K-tag 355). The POD stated the table would be relocated.	K 345		

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K 345	Continued From page 16 2. At 9:43 a.m., the fire alarm disconnecting circuit, located in the Electrical room, was unlabeled and lacked a red marking. The POD was unable to locate the circuit until he phoned the fire alarm vendor, who told him to look on the fire alarm panel. The fire alarm panel indicated the location as Circuit 7 in the Electrical room. Circuit 7 was not labeled and did not have a red marking, and the printed legend on the front of the circuit breaker box did not identify the circuit. At 12:00 p.m., the Administrator acknowledged the findings at the exit conference.	K 345		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT 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 more than four hours in a 24-hour period, that the Authority Having Jurisdiction (AHJ) would be notified. This was evidenced by incomplete documentation. This affected visitors, staff, and 48 of 48 residents, and in the case of a fire alarm system shut-down, could potentially result in delayed notification of the AHJ, and the AHJ being unable to exercise oversight.	K 346	**K 346 (C) - Fire Alarm System - Out of Service** **1. Immediate Corrective Action** On 9/25/24, the Administrator updated the Emergency Operations Manual to reflect the proper Fire Watch policy & procedure and added that the California Department of Public Health, the facility's Authority Having Jurisdiction, will also be notified in the event that the facility fire alarm system is out of service for more than 4 hours in a 24-hour period. **2. How to identify Other residents affected** No other residents were identified as being affected after the immediate corrective action was completed. **3. System Changes** The documents and updated policy were added to the facility Emergency Operations Plan on 9/25/24. **4. Monitoring** The Emergency Operations Manual will be updated at least annually, or as needed, by the Administrator or designee. Compliance is achieved for this deficient practice, but its performance will be monitored annually.	

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K 346	Continued From page 17 Findings: On 9/18/24, during a record review and interview with the Plant Operations Director (POD), the fire alarm system fire watch policy was reviewed. At 11:40 a.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 more than four hours in a 24-hour period. The policy provided referenced five individuals/entities to be contacted. There were no references to notification of CDPH. The POD stated CDPH should be added to the contact list. At 12:00 p.m., the Administrator acknowledged the finding at the exit conference.	K 346		
K 353 SS=E	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 _____	K 353		

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K 353	Continued From page 18 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: Based on observation and interview, the facility failed to maintain their wet-pipe sprinkler system. This was evidenced by a sprinkler head contaminated with foreign material, and by an inaccessible sprinkler component. This could cause a malfunction of the sprinkler system during a fire, and a delay in servicing the system. This affected 31 of 48 residents in one of three smoke compartments. NFPA 101, Life Safety Code, 2012 edition 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 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 13.2.3 * All system valves shall be protected from physical damage and shall be accessible. Findings: On 9/18/24, during a facility tour with the Plant	K 353	**K 353 (E) - Sprinkler System Maintenance and Testing** **1. Immediate Corrective Action** On 9/18/24, the Maintenance Director cleaned and properly maintained the sprinkler identified by the Life Safety surveyor. On 9/19/24, the cardboard boxes, filters and other items blocking the Inspector Test Valve (ITV) in the Maintenance Storage were removed. **2. How to identify Other residents affected** On 9/19/24, the Maintenance Director performed an audit of all the facility's fire sprinklers and found 3 other sprinklers that required cleaning. 3/3 sprinklers were cleaned immediately. On 9/19/24, the Maintenance Director audited all other fire sprinkler systems to ensure there were no obstructions. No other obstructions were found. **3. System Changes** The Maintenance Director will inspect all fire sprinkler and testing at least monthly to ensure foreign materials are contaminating the fire sprinklers. Any findings will be immediately corrected	

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K 353	Continued From page 19 Operations Director (POD), the wet-pipe sprinkler system was observed. 1. At 9:31 a.m., the sprinkler located in the Admissions/Social Services office was contaminated with a foreign material. The POD stated the sprinkler vendor was due to arrive in the morning. 2. At 10:14 a.m., access to the Inspector Test Valve (ITV) in the Maintenance Storage room was blocked by cardboard boxes, filters, and other items. The POD had to remove several items to gain access to the ITV. He stated the sprinkler vendor never said anything about the blocked access. At 12:00 p.m., the Administrator acknowledged the findings at the exit conference.	K 353	**4. Monitoring** The Maintenance Director will perform audits on the fire sprinklers weekly x 4 weeks and monthly x 2 months to ensure there are no contaminated/dirty fire sprinklers. Any findings will be immediately rectified. This will begin the week of 9/30/24.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced	K 354		

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K 354	Continued From page 20 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 more than ten hours in a 24-hour period, that the Authority Having Jurisdiction (AHJ) would be notified. This was evidenced by incomplete documentation. This affected visitors, staff, and 48 of 48 residents, and in the case of a sprinkler system shut-down, could potentially result in delayed notification of the AHJ, and the AHJ being unable to exercise oversight. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 15.5.2 Before authorization is given, the impairment coordinator shall be responsible for verifying that the following procedures have been implemented: (5) The fire department has been notified. (6) The insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. 15.6 Emergency Impairments. 15.6.3 The coordinator shall implement the steps outlined in Section 15.5. 15.7 Restoring Systems to Service. When all impaired equipment is restored to normal working order, the impairment coordinator shall verify that the following procedures have been implemented: (1) Any necessary inspections and tests have been conducted to verify that affected systems are operational. The appropriate chapter of this standard shall be consulted for guidance on the type of inspection and test required. (2) Supervisors have been advised that protection	K 354	**K 354 (C) – Sprinkler System – Out of Service** **1. Immediate Corrective Action** On 9/25/24, the Administrator updated the Emergency Operations Manual to reflect the proper Fire Watch policy & procedure and added that the California Department of Public Health, the facility's Authority Having Jurisdiction, will also be notified in the event that the facility sprinkler system is out of service for more than 10 hours in a 24-hour period. **2. How to identify Other residents affected** No other residents were identified as being affected after the immediate corrective action was completed. **3. System Changes** The documents and updated policy were added to the facility Emergency Operations Plan on 9/25/24. **4. Monitoring** The Emergency Operations Manual will be updated at least annually, or as needed, by the Administrator or designee. Compliance is achieved for this deficient practice, but its performance will be monitored annually.	

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K 354	Continued From page 21 is restored. (3) The fire department has been advised that protection is restored. (4) The property owner or designated representative, insurance carrier, alarm company, and other authorities having jurisdiction have been advised that protection is restored. (5)The impairment tag has been removed. Findings: On 9/18/24, during a record review and interview with the Plant Operations Director (POD), the automatic sprinkler system fire watch policy was reviewed. At 11:40 a.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 Health (CDPH) if the sprinkler system was out of service for ten or more hours in a 24-hour period. The policy provided referenced five individuals/entities to be contacted. There were no references to notification of CDPH. The POD stated CDPH should be added to the contact list. At 12:00 p.m., the Administrator acknowledged the finding at the exit conference.	K 354		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K 355		

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K 355	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their portable fire extinguishers. This was evidenced by a fire extinguisher which was blocked from immediate access. During a fire, this could delay its access and use. This affected visitors, staff, and 31 of 48 residents in one of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 9.7.4 Manual Extinguishing Equipment. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 6.1.2 Extinguisher Readiness. Portable fire extinguishers shall be maintained in a fully charged and operable condition and shall be kept in their designated places at all times when they are not being used. 6.1.3 Placement. 6.1.3.1 Fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. 6.1.3.2 Fire extinguishers shall be located along normal paths of travel, including exits from areas. 6.1.3.3 Visual Obstructions. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. Findings: On 9/18/24, during a facility tour with the Plant	K 355	**K 355 (D) – Portable Fire Extinguisher** **1. Immediate Corrective Action** On 9/18/24, the obstruction to the fire extinguisher was removed. **2. How to identify Other residents affected** On 9/19/24, the Maintenance Director conducted an audit of the facility to identify any other obstructions to fire extinguishers. No other obstructions were found. **3. System Changes** The facility staff will be in-serviced by 10/13/24 on the facility's policy and Life Safety regulation of obstructing fire extinguishers. **4. Monitoring** The Maintenance Director will perform audits on the fire extinguishers weekly x 4 weeks and monthly x 2 months to ensure there are no obstructions. Any findings will be immediately rectified. This will begin the week of 9/30/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING **02** B. WING _____	**09/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 355	Continued From page 23 Operations Director (POD), the portable fire extinguishers were observed. At 9:35 a.m., an over-the-bed table blocked access to the fire extinguisher located opposite the Nursing Station. The POD stated he would relocate the table. At 12:00 p.m., the Administrator acknowledged the finding at the exit conference.	K 355		