STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055645	A. BUILDING **02** B. WING _____	**02/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION SKILLED NURSING & SUBACUTE CENTER	**410 NORTH WINCHESTER BOULEVARD** **SANTA CLARA, CA 95050**

(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: 48731 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: 48731 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 120	E 000		
K 000	INITIAL COMMENTS Surveyor: 48731 K3 BUILDING: 02 K6 PLAN APPROVAL: 10/01/1969 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.	K 000		

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

Electronically Signed | 03/04/2024

3/5/24: POC approved by Brian Fenton, SSM-I

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K 000	Continued From page 1 Representing the California Department of Public Health: 43380 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 120 Licensed Beds: 133	K 000		
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 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)	K 321		3/13/24

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K 321	Continued From page 2 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: 48731 Based on observation and interview, the facility failed to maintain the hazardous areas. This was evidenced by a corridor door to a hazardous area not equipped with a self-closing device. This affected 25 of 120 residents and one of four smoke compartments. This could result in the passage of smoke and fire in a hazardous area. Findings: During a tour of the facility and interview with the Maintenance Director on 2/13/24, the hazardous areas were observed. At 9:17 a.m., the corridor door to the Personal Protective Equipment Storage Room near Nursing Station 3 was observed without a self-closing device. The room was approximately twelve feet by five feet and contained approximately 40 cardboard boxes, 30 plastic shelves, 30 pieces of laminated paper, ten plastic bins, and two metal rolling racks. Upon interview, the Maintenance Director stated that the room was converted into personal protective equipment storage for the COVID 19 pandemic.	K 321	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation 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 the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. POC entered on behalf of Bradley Kikuta, Administrator K321--Hazardous Areas: Enclosure Maintenance supervisor visually inspected all the PPE closet doors for self closure and for proper working order and recorded the findings. No residents were affected. The Maintenance staff has been in-serviced on the regulation of all doors with PPE have a self closing device. Maintenance Supervisor will inspect the door for self closures and report the findings during the safety meeting for follow up.	

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K 321	Continued From page 3	K 321	The Maintenance Supervisor will report any negative findings to the Quality Assurance committee for 90 days for further recommendations.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance 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: Surveyor: 48731 Based on record review and interview, the facility failed to maintain the kitchen cooking equipment.	K 324	K324--Cooking Facilities Semi-annual kitchen hood suppression	3/13/24

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K 324	Continued From page 4 This was evidenced by the failure to provide the semi-annual kitchen hood fire suppression system service. This affected 25 of 120 residents and one of four smoke compartments. This could result in the increased risk of a kitchen fire. NFPA 101, Life Safety Code, 2012 Edition 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 11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1 * Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months. 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	K 324	system service has been scheduled. The maintenance staff will be in-serviced on regulation of a semi-annual kitchen hood suppression service being completed. The Maintenance Supervisor will report on the semi-annual kitchen hood suppression service being completed at the monthly safety meeting to ensure follow up. The Maintenance supervisor will report any negative findings to the Quality Assurance committee for 90 days for further recommendations.	

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K 324	Continued From page 5 and tested by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. Findings: During record review and interview with the Maintenance Director on 2/13/24, records of the kitchen maintenance were requested and reviewed. At 2:21 p.m., the facility failed to provide records of one of two semi-annual kitchen hood fire suppression system services. The most recent record provided for review was dated for 10/4/23. Upon interview, the Maintenance Director stated that he was contacting the vendor about previous hood fire suppression system services.	K 324		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on observation, record review, and interview, the facility failed to maintain the smoke detectors. This was evidenced by smoke detectors that failed to activate the fire alarm system when tested and the failure to provide the smoke detector sensitivity test. This affected 120 of 120 residents and four of four smoke compartments. This could result in a delay of	K 347	K347 Smoke Detection The smoke detectors labeled 37 and 38 have been repaired or replaced to activate the fire alarms. No residents were affected. The Maintenance supervisor will schedule a smoke detector sensitivity test for all the	3/13/24

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K 347	Continued From page 6 notification in the event of smoke and fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 10.15* Protection of Fire Alarm System. In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s), notification appliance circuit power extenders, and supervising station transmitting equipment to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity	K 347	smoke detectors and record the findings. The Maintenance Supervisor will test random smoke detectors quarterly and report the findings at the safety meeting to ensure compliance. The Maintenance Supervisor will report any negative findings to the Quality Assurance committee for further recommendations for 90 days.	

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K 347	Continued From page 7 range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. 14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained. 14.4.5.3.3.2 In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. 14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction 14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. 14.4.5.3.6 Smoke detectors or smoke alarms listed as field adjustable shall be permitted to either be adjusted within the listed and marked sensitivity range, cleaned, and recalibrated, or be replaced. 14.4.5.3.7 The detector or smoke alarm sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the	K 347		

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K 347	Continued From page 8 detector or smoke alarm. Findings: During record review and interview with the Maintenance Director on 2/13/24, the smoke detectors were observed and sensitivity test records were requested. 1. At 11:15 a.m., the smoke detector labeled as "38" located in the corridor between Resident Rooms 109 and 112 failed to activate the fire alarm system upon the use of a can of artificial smoke. The smoke detector was tested three times and failed. Upon interview, the Maintenance Director stated that the smoke detector was replaced about two months prior. 2. At 11:19 a.m., the smoke detector labeled as "37" located in the corridor next to Resident Room 111 failed to activate the fire alarm system upon the use of a can of artificial smoke. The smoke detector was tested three times and failed. Upon interview, the Maintenance Director stated that the smoke detector was last checked a month ago. 3. At 1:41 p.m., the facility failed to provide records that a smoke detector sensitivity test was conducted within the last two years. There were no previous smoke detector sensitivity tests provided for review. Upon interview, the Maintenance Director stated that the vendor forgot to conduct the testing. 4. At 2:07 p.m., the facility failed to provide records of 52 of 52 weekly battery powered smoke detector tests for the battery powered smoke detector in the Fire Panel Room near	K 347		

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K 347	Continued From page 9 Resident Room 215. Upon interview, the Maintenance Director stated that he conducted monthly testing of the smoke detector but did not have a log for it.	K 347		
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 _____ 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: 48731 Based on observation and interview, the facility failed to maintain the automatic fire sprinkler system. This was evidenced by the failure to maintain the sprinkler system components and the eighteen inch clearance between the deflectors and storage. This affected 93 of 120 residents and four of four smoke compartments. This could result in the improper operation of the sprinkler system.	K 353	K353---Sprinkler System/Maintenance and Testing The sprinkler heads in room 122, in the hall near the kitchen, 2 sprinkler heads in the laundry room, sprinkler head in bathroom in room 209, 2 sprinkler heads in bathroom of rooms 202 and 204 have been cleaned.	3/13/24

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K 353	Continued From page 10 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 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.1 Automatic Sprinklers. 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height 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 13, Standard for the Installation of Sprinkler Systems, 2010 Edition 8.5.6 * Clearance to Storage. 8.5.6.1 * Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. NFPA 25, Standard for the Inspection, Testing,	K 353	All sprinkler heads in the facility have been cleaned. No residents were affected. The cardboard bos in room 305 has been removed under the deflector of the sprinkler head. The cardboard box in the closet of the social service office has been removed from the top of the storage. The rooms and offices were inspected for compliance of being 18 inches from any sprinkler head. No other obstructions were found. No residents were affected. The staff will be in-serviced on the regulation of nothing closer than 18 inches to any sprinkler head. The Maintenance supervisor will monitor during weekly rounds to ensure compliance and report any negative findings at the safety committee meeting. The Maintenance supervisor will report any negative findings to the Quality Assurance Committee for 90 days for further recommendations.	

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K 353	Continued From page 11 and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 5.2.1 Sprinklers. 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). Findings: During a tour of the facility and interview with the Maintenance Director and the Administrator in Training on 2/13/24, the sprinkler heads were observed. 1. At 8:38 a.m., two of two sprinkler heads in Resident Room 122 near the Shower Room were covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the room was likely rushed when cleaned by housekeepers because it was recently used as a COVID 19 isolation room. 2. At 9:04 a.m., the sprinkler head in the corridor near the kitchen was covered by an accumulation of foreign material. Upon interview, the Administrator in Training stated that the sprinkler head was likely missed during cleanings. 3. At 9:28 a.m., two of four sprinkler heads in the Laundry Room near the Dining Room were covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the dryers in the Laundry Room cause the sprinkler heads to be coated in foreign material quickly. 4. At 9:34 a.m., the sprinkler head in the	K 353		

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K 353	Continued From page 12 Bathroom near Resident Room 209 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the sprinkler head was likely missed during cleanings. 5. At 10:17 a.m., the sprinkler head in Resident Room 305 near Nursing Station 3 did not have an eighteen inch clearance from the top of the storage to the deflector. A cardboard box was stored approximately ten inches directly under the deflector of the sprinkler head. Upon interview, the Maintenance Director stated that he moved the box the week prior but it was likely moved back by the resident. 6. At 10:22 a.m., the sprinkler head in closet of the Social Services Office did not have an eighteen inch clearance from the top of the storage to the deflector. A cardboard box was stored approximately ten inches directly under the deflector of the sprinkler head. Upon interview, the Maintenance Director stated that he checked the closet for clearance the week prior. 7. At 10:26 a.m., one of two sprinkler heads in Resident Room 204 near Resident Room 202 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the sprinkler head was likely missed during cleanings. 8. At 10:27 a.m., the sprinkler head in the Bathroom of Resident Rooms 202 and 204 was covered by an accumulation of foreign material. Upon interview, the Maintenance Director stated that the sprinkler head was likely missed during cleanings.	K 353		

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	055645	A. BUILDING **02** B. WING _____	**02/13/2024**

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K 363	Continued From page 13	K 363		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		3/13/24

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K 363	Continued From page 14 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by corridor doors that failed to latch and corridor doors that were obstructed from latching. This affected 120 of 120 residents and four of four smoke compartments. This could result in the spread of fire or smoke in the event of a fire. Findings: During a tour of the facility and interview with the Maintenance Director on 2/13/24, the corridor doors were observed. 1. At 8:40 a.m., the corridor door to Resident Room 122 near the Shower Room was obstructed from latching by an oxygen concentrator. The door remained open approximately five and a half feet wide. Upon interview, the Maintenance Director stated that the staff was moving a resident and likely left the oxygen concentrator there. 2. At 8:53 a.m., the corridor door to the Employee Lounge near the Medical Records Storage was equipped with a self-closing device and failed to latch when tested. Upon interview, the Maintenance Director stated that he checked the door the month prior. 3. At 9:23 a.m., the corridor door to Resident Room 304 near the Social Services Office was obstructed by a trash can. The door remained	K 363	K363---Corridor-Doors The door to rooms 122, 304, 410, 412, 111, 103, and 304 have been inspected and will be repaired or adjusted to stay open without any obstruction. The self closures on the doors for employee lounge and rehabilitation gym will be repaired or replaced so the doors latch when being closed without assistance. The maintenance staff inspected the facility doors and no other closure issues were found. No residents were affected. The Maintenance Supervisor will monitor during weekly rounds to ensure compliance and report any negative findings at the safety meeting for follow up. The Maintenance Supervisor will report any negative finding to the Wuality Assurance Committee for 90 days.	

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K 363	Continued From page 15 open approximately five feet wide. Upon interview, the Maintenance Director stated that the staff likely did resident care and forgot to move the trash can. 4. At 9:52 a.m., the corridor door to Resident Room 410 near Resident Room 412 was obstructed by a trash can. The door remained open approximately five and a half feet wide. Upon interview, the Maintenance Director stated that the staff likely did resident care and forgot to move the trash can. 5. At 10:01 a.m., the corridor door to Resident Room 111 near Resident Room 109 was obstructed by a trash can. The door remained open approximately five feet wide. Upon interview, the Maintenance Director stated that the staff likely did resident care and forgot to move the trash can. 6. At 10:05 a.m., the corridor door to Resident Room 103 near the Activity Storage Room was obstructed by a trash can. The door remained open approximately five feet wide. Upon interview, the Maintenance Director stated that the staff likely did resident care and forgot to move the trash can. 7. At 10:08 a.m., the corridor door to the Rehabilitation Gym near Resident Room 102 was equipped with a self-closing device and failed to latch when tested. Upon interview, the Maintenance Director stated that he checked the door the week prior. 8. At 10:10 a.m., the corridor door to the Shower Room near Resident Room 120 was equipped with a self-closing device and failed to latch when	K 363		

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K 363	Continued From page 16 tested. Upon interview, the Maintenance Director stated that he checked the door the week prior. 9. At 10:19 a.m., the corridor door to Resident Room 301 near the Social Services Office was obstructed by a trash can. The door remained open approximately five feet wide. Upon interview, the Maintenance Director stated that the staff likely did resident care and forgot to move the trash can.	K 363		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		3/13/24

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K 741	Continued From page 17 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on observation and interview, the facility failed to maintain the smoking areas. This was evidenced by cigarette butts mixed with combustible items. This affected 9 of 120 residents and one of four smoke compartments. This could result in the increased risk of fire. Findings: During a tour of the facility and interview with the Maintenance Director on 2/13/24, the designated smoking area was observed. At 8:47 a.m., four of four smoking receptacles in the designated smoking area were observed with combustibles intermingled with cigarette butts. Upon interview, the Maintenance Director stated that he does not remember the last time the receptacles were emptied.	K 741	K741---Smoking Regulations The smoking receptacles have been emptied and a metal trash can has been added to the smoking area for trash disposal. The maintenance staff inspected the trash receptacles in the facility and no combustible items were found. No residents were affected. The maintenance staff will inspect the smoking receptacles and metal trash cans daily for any mixing of combustibles and report the findings to the safety committee. The Maintenance Supervisor will repprt amy negative findings to the Quality Assurance Committee for 90 days for recommendations.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		3/13/24

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K 918	Continued From page 18 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 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: 48731 Based on record review and interview, the facility failed to maintain the essential electrical system. This was evidenced by the failure to provide the annual fuel quality test and the four-hour load bank test. This affected 120 of 120 residents and four of four smoke compartments. This could result in the malfunction of the emergency generator. NFPA 101 Life Safety Code, 2012 edition 19.5.1.1 Utilities shall comply with the provisions	K 918	K918---Electrical systems-essential electric systems The mmaintenance supervisor has scheduled a four-hour load bank test for the generator. The maintenance staff will schedule inspection and maintenance of the generator after the four-bank load test for the generator. No residents were affected.	

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K 918	Continued From page 19 of Section 9.1. 9.1 Utilities. 9.1.3 Emergency Generators and Standby Power Systems. Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition. 8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 The permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. 8.4 Operational Inspection and Testing.	K 918	The Maintenance Supervisor will be in-serviced by the Administrator in Training on the regulation of having a four-hour bank test for the generator. The Administrator in Training will review the logs on a monthly basis and report the findings to the safety committee to ensure compliance. The Maintenance Supervisor will report any negative findings to the Quality Assurance committee for 90 days for recommendations.	

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K 918	Continued From page 20 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. Findings: During record review and interview with the Maintenance Director on 2/13/24, the generator testing records were requested and reviewed. 1. At 1:33 p.m., the facility failed to provide the record of the four-hour load bank test for the 80 kilowatt diesel generator. There were no previous records provided for review to when the last four-hour load bank test was conducted. Upon interview, the Maintenance Director stated that he needs to check the records of load bank tests. 2. At 2:08 p.m., the facility failed to provide records that a fuel quality test was conducted on	K 918		

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K 918	Continued From page 21 the 80 kilowatt diesel generator within the last year. There were no previous records provided for review to when the last fuel quality test was conducted. Upon interview, the Maintenance Director stated that the vendor likely forgot to conduct the test.	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 48731 Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by unlabeled circuit breakers. This affected 93 of 120 residents and three of four smoke compartments. This could result in staff inability to identify circuit breakers in the event of an emergency. NFPA 101, Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.	K 919	K919---Electrical Equipment-Other The circuit breakers 1, 2, 3, 5, 34, 35 and 37 will be labeled in the electrical panel near room 320. The circuit breakers 23, 39, 41 will be labeled in the electrical panel labeled "Panel K". The panel is located in the kitchen near the storage room. The circuit breaker 3 will be labeled in the electrical panel labeled "Panel E" located in the laundry storage area. The circuit breakers 15, 17, 18 and 19 will be labeled in the electrical panel labeled "Panel LE" located in the fire panel room near room 215.	3/13/24

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K 919	Continued From page 22 NFPA 70, National Electrical Code, 2011 Edition 408.4 Field Identification Required. 408.4(A) Circuit Directory or Circuit Identification. Every circuit and circuit modification shall be legibly identified as to its clear, evident, and specific purpose or use. The identification shall include sufficient detail to allow each circuit to be distinguished from all others. Spare positions that contain unused overcurrent devices or switches shall be described accordingly. The identification shall be included in a circuit directory that is located on the face or inside of the panel door in the case of a panelboard, and located at each switch or circuit breaker in a switchboard. No circuit shall be described in a manner that depends on transient conditions of occupancy. Findings: During a tour of the facility and interview with the Maintenance Director on 2/12/24, the electrical equipment was observed. 1. At 9:02 a.m., breakers 1, 2, 3, 5, 6, 34, 35, and 37 were in use and unlabeled to what they served in the electrical panel in the Minimum Data Sheet Office near Resident Room 320. Upon interview, the Maintenance Director stated that no one has ever checked for the labeling of the circuit breakers before. 2. At 9:13 a.m., breakers 23, 39, and 41 were in use and unlabeled to what they served in the electrical panel labeled "Panel K." The panel was located in the kitchen near the Storage Room. Upon interview, the Maintenance Director stated that no one has ever checked for the labeling of the circuit breakers before.	K 919	The Maintenance Supervisor checked the circuit breakers in the panels in the facility and no other missing labels were found. No residents were affected. The Maintenance Supervisor will monitor during rounds and report any negative findings at the safety committee meeting. The Maintenance Supervisor will report any negative findings for 90 days at the Quality Assurance committee meeting for recommendations.	

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K 919	Continued From page 23 3. At 9:31 a.m., breaker 3 was in use and unlabeled to what it served in the electrical panel labeled "Panel 'ME.'" The panel was located in the Laundry Storage Area of the Laundry Room. Upon interview, the Maintenance Director stated that no one has ever checked for the labeling of the circuit breakers before. 4. At 9:39 a.m., breakers 15, 17, 18, and 19 were in use and unlabeled to what they served in the electrical panel labeled "Panel LE." The panel was located in the Fire Panel Room near Resident Room 215. Upon interview, the Maintenance Director stated that no one has ever checked for the labeling of the circuit breakers before.	K 919		