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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555252	A. BUILDING 02 B. WING ______	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VIEW CENTER	8777 SKYWAY PARADISE, CA 95969

(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: 37135 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: 37135 Census: 86	E 000	**DISCLAIMER STATEMENT** **Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **This Plan of Correction is submitted as the facility's credible allegation of compliance.**	
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing ...	E 006		

LABOR[redacted] TITLE Administrator (X6) DATE 3/2/18

Any de[redacted]tion may be excused from correcting providing it is determined that other s[redacted]r nursing homes, the findings stated above are disclosable 90 days followin[redacted]omes, 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.

3/5/18 — Approved by Cynthia WC

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E 006	Continued From page 1 * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to base the emergency plan on a risk assessment. This was evidenced by the failure to identify potential natural, man-made, and facility specific hazards based on risk assessment unique to the facility, community, and geographic location. This affected three of three smoke compartments and could result in the facility being inadequately prepared for hazards that could be identified by a risk assessment. Findings: During document and interview with the Administrator on 2/15/18, the risk assessment was requested. 1. At 12:41 p.m., the facility failed to provide a risk assessment to identify potential hazards for the facility. Upon interview, Administrator confirmed the finding and stated they did not remember seeing a risk assessment.	E 006	**E 006** 1) Upon detailed review of the facility Emergency Preparedness Plan the Hazards Risk assessment was completed for Pine View Center on 10/10/2017. 2) All residents have the potential to be affected by this deficient practice. Facility Administrator reviewed the Emergency preparedness plan on 2/15/2018 printed out all pages and placed in the Emergency Plan Binder located at both nursing stations so staff can easily identify the facility individual plan prepared for the center based on the Hazard Risk Assessment. 3) Administrator will re-in-service staff on **3/9/2018** with the focus on Emergency Preparedness Hazard Assessment so staff can address the identified Natural Disaster for our facility and be aware of what steps to take to ensure safety is provided at all times to our residents.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to	E 039		

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E 039	Continued From page 2 test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO]	E 039	4) Administrator/Designee will evaluate and update Emergency Plan as needed to ensure the plan is the most accurate for the potentials changing weather conditions. Administrator will will bring any updated plans to the monthly QA&A meeting for further review and discussions. 3/15/18	

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E 039	Continued From page 3 must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to participate in a full-scale exercise that was community-based. This was evidenced by the failure provide documentation that indicated they had participate in a full-scale community-based exercise or demonstrate the efforts made to identify the availability of a full-scale community-based exercise. This affected three of three smoke compartments and could result in a delayed response to a full-scale community wide emergency. Findings: During document review with the Administrator on 2/15/18, records of emergency preparedness training drills were requested. 1. At 1:10 p.m., there were no records provided that indicated that there was a community-based drill or that community entities were contacted to	E 039	**E 039** 1) Facility Administrator contacted BUTTE county Emergency events center on 3/1/2018 to sign up for 2018 table top community disaster drill. 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director (MD) and Administrator will attend the next table top community disaster drill to ensure the facility staff are knowledgeable if a community wide emergency occurs. 3) MD will in-service staff immediately after attending tabletop drill in 2018 to educate staff on emergency steps and a plan to assist the community or community assistance for facility in the event of 4) Facility MD will bring all updated plans from the community based exercise to the monthly QA&A meeting for further review and discussions. **3/1/2018**	

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E 039	Continued From page 4 attempt a full-scale community-based emergency exercise drill. Upon interview, the Administrator stated the former Maintenance Supervisor did contact someone regarding community-based drill being held in May 2018. The Administrator stated they would need to contact the former Maintenance Supervisor to get correspondence from them that indicated they made contact with community entities. The facility was given until 5:00 p.m. on 2/15/18 to provide documentation indicating an attempt to be part of a community based drill to the California Department of Public Health (CDPH). At 5:00 p.m. on 2/15/18, CDPH did not receive documentation from the facility indicating an attempt to be part of a community based drill.	E 039		
K 000	INITIAL COMMENTS Surveyor: 37135 K3 BUILDING: 01 K6 PLAN APPROVAL: 1987 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY WITH PARTIAL BASEMENT, CONSTRUCTION TYPE V, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public	K 000		

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K 000	Continued From page 5 Health: 37135 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 86	K 000	**K 161** 1) Room 12 & 49 were immediately repaired/replaced on **2/15/2018** and no longer have any visible penetrations that would affect smoke departments in an event of a fire. 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director will inspect cable cover plates and smoke detectors monthly to ensure there are no penetrations visible. 3) Facility Maintenance Director was in-serviced by facility Administrator on **3/1/2018** on the importance of sealing all visible penetrations that would affect smoke department within the facility per regulations. 4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions. **3/15/2018**	
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 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered	K 161		

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K 161	Continued From page 6	K 161		

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:
Surveyor: 37135
Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by unsealed penetrations in the walls and ceiling. This affected two of three smoke compartments and could result in the spread of fire and smoke in the event of a fire.

Findings:

During a tour of the facility and interview with Maintenance Technician 1 and the House Keeping Manager on 2/15/18, the walls and ceilings were observed.

1. At 10:40 a.m., the Resident Room 12 was observed. There was a cable cover plate located behind Bed B that was missing the bottom screw. The cover plate had shifted to the side, creating an approximately 1-1/2 inch by 1 inch penetration. Upon interview, Maintenance Technician 1 confirmed the finding.

2. At 11:21 a.m., Resident Room 49 was observed. The smoke detector had separated from the ceiling, creating an approximately 4 inch diameter penetration. Upon interview,

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K 161	Continued From page 7 Maintenance Technician 1 and the House Keeping Manager confirmed the finding.	K 161	**K 345**	
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: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the manual alarm boxes. This was evidenced by one the manual alarm box that was obstructed and obscured from view. This affected one of three smoke compartments and could result in the inability to locate and/or obtain the manual alarm box in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.4.2.2 Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that both of the following criteria are met: (1) Such manual fire alarm boxes are visible and continuously accessible. (2) Travel distances required by 9.6.2.5 are not exceeded. Findings:	K 345	1) Decorative tree was immediately removed from in front of the emergency wall pull station located near the entrance of the facility on **2/15/2018.** 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director will inspect pull stations weekly to ensure there are no obstructions preventing usage in case of an emergency. 3) Facility Maintenance Director was in-serviced by facility Administrator on **3/1/2018** on the importance of having nothing obstructing any of the facilities emergency pull stations which could have a negative effect on the facility if an emergency was to occur. 4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions. **3/15/2018**	

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K 345	Continued From page 8 During a tour of the facility and interview with Maintenance Technician 1 on 2/15/18, the the manual alarm boxes were observed. 1. At 10:30 a.m., the manual alarm box located in the Entry Lobby was observed. There was a decorative tree placed directly in front of the the manual alarm box. The manual alarm box was not visible. Upon interview, Maintenance Technician 1 confirmed the finding.	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _______________ b) Who provided system test _______________ c) Water system supply source _______________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the automatic sprinkler system and its components. This was evidenced	K 353	**K 353** 1) Maintenance Director (MD) immediately repaired all identified sprinkler head plates and now has no signs of escutcheon. In addition MD created a log to visually inspect the pressure valve gauge and riser system and will continue to inspect them on a monthly basis effective **2/15/2018.** 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director will continue to inspect sprinkler heads, risers' valves and, pressure valves to ensure they are not tapered with and are in proper working order per facility policy and regulations.	

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K 353	Continued From page 9 by the absence of 9 of 12 complete monthly inspections and one sprinkler head that had an escutcheon plate that had separated from the ceiling. This affected three of three smoke compartments and could result in the malfunction of the automatic sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 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 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by the 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. 4.3 Records 4.3.1* Records shall be made inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 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).	K 353	3) Maintenance Director was in-serviced by facility Administrator on **3/1/2018.** Focus was on having logs to provide proof of inspections per regulations and to ensure all are in properly working order to prevent a negative effect on the facility if not functioning properly if an emergency event was to occur. 4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions. **3/15/2018**	

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K 353	Continued From page 10	K 353		

13.4.1.1* Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following:
(1) The gauges indicate normal supply water pressure is being maintained.
(2) The valve is free of physical damage.
(3) All valves are in the appropriate open or closed position.
(4) The retarding chamber or alarm drains are not leaking.

13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly.

Findings:

During document review and interview with the Administrator, Maintenance Technician 1, and the House Keeping Manager on 2/15/18, the automatic sprinkler system records were requested.

1. At 11:26 a.m., records provided indicated that the monthly inspections of the pressure gauge were reviewed. There were no records provided that indicated that monthly visual inspections for the alarm and system riser check valves for the following months were completed: March, April, May, June, August, September, October, and November of 2017 and January of 2018. Upon interview, Maintenance Technician 1 and the Administrator confirmed the finding.

2. At 11:00 a.m., the sprinkler head located in the corridor area outside the Dinning Room was observed. The sprinkler escutcheon plate had separated from the ceiling, creating an

2018 MAR -5 PM 12:47

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K 353	Continued From page 11 approximately 2 inch diameter penetration. Upon interview, Maintenance Technician 1 and the House Keeping Manager confirmed the finding.	K 353		
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.	K 363	**K 363** 1) Maintenance Director (MD) immediately repaired the clean linen closet and now is in functional order. Beds were placed in the correct positions in each identified room, hangers were removed from all rooms identified as being obstructed and all doors close without any obstructions. **2/15/2018.** 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director will inspect during daily facility rounds all residents' doors to ensure they are not obstructed with any beds and or other items that prevent closure per facility policy and regulations.	

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PINE VIEW CENTER	8777 SKYWAY PARADISE, CA 95969

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 12 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by one corridor door that did not latch when tested and three corridor doors that were obstructed from closing. This affected two of three smoke compartments and could result in the inability to contain smoke and/or fire to a room. NFPA 101, Life Safety Code, 2012 Edition. 19.3.6.3.10* Doors shall not be held open be devices other then those that release when the door is pushed or pulled. Findings: During a tour of the facility and interview with Maintenance Technician 1 and the House Keeping Manager on 2/15/18, the corridor doors were observed. 1. At 10:35 a.m., the corridor door to the Clean Linen Closet by Resident Room 3 did not latch when tested. The door was equipped with a self closing device. 2. At 10:48 a.m., the corridor door to the Resident Room 24 was obstructed from closing by two plastic clothing hangers that were hanging on the door handle.	K 363	3) Maintenance Director was in-serviced by facility Administrator on **3/1/2018.** Focus was to ensure all doors are in properly working order to prevent a negative effect on the facility if not functioning properly if an emergency event was to occur. 4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions. **3/15/2018**	

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K 363	Continued From page 13 3. At 10:51 a.m., the corridor door to the Resident Room 27 was obstructed from closing by the foot of Bed A. 4. At 10:58 a.m., the corridor door to the Resident Room 47 was obstructed from closing by the bed comforter of Bed A. Upon interview, the House Keeping Manager stated that Bed A was vacant and they would talk to house keeping staff regarding this issue. These findings were all confirmed by Maintenance Technician 1 and the House Keeping Manager.	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.	K 741	**K 741** 1) Maintenance Director (MD) In-serviced staff on **2/22/2018.** Focused on facility policy where Designated Smoking Areas are for staff emphasized that it is clearly identified with visible signage where the smoking area is located. 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director will inspect during daily facility rounds employee smoking areas to ensure that employees are complaint with facility policy and regulations.	

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K 741

Continued From page 14

(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.
18.7.4, 19.7.4

This REQUIREMENT is not met as evidenced by:
Surveyor: 37135
Based on document review, observation, and interview, the facility failed to maintain the smoking regulations. This was evidenced by cigarette butts that were found at locations that were designated as non-smoking areas. This affected one of three smoke compartments and could result in the ignition of fire.

Findings:

During a tour of the facility, document review, and interview with Maintenance Technician 1 and the House Keeping Manager on 2/15/18, the non-smoking areas were observed and the smoking policy was reviewed.

1. At 11:28 a.m., the area outside the exit of Nurse Station 2 was observed. To the left of the exit was the 30 kilowatt diesel generator and to the right was the empty oxygen storage with 13 empty oxygen E tanks. There was a no smoking sign posted on the wall above the generator and on the generator itself and on the wall above the oxygen tanks. There were seven cigarette butts on the ground approximately 10 feet from the generator and empty oxygen storage. Upon interview, Maintenance Technician 1 and the House Keeping Manager confirmed the finding. The House Keeping Manager stated that staff may be smoking in this area during NOC shift.

K 741

3) Maintenance Director was in-serviced by facility Administrator on **3/1/2018.** Focus was on continue to conduct facility rounds on designated smoking areas to ensure compliance of staff that they are knowledgably where designated smoking area is located and that this is the only area where staff are to smoke for the safety of all residents and staff.

4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions.

3/15/2018

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K 741	Continued From page 15 At 1:15 p.m., the facility's smoking policy stated that smoking is only allowed in designated smoking areas.	K 741		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review, observation, and interview, the facility failed to maintain the electrical system and its components. This was evidenced by the absence of an annual electrical receptacle test for all non-hospital grade receptacles located in patient bed locations. This	K 914	**K 914** 1) Maintenance Director (MD) on **2/17/2018** after further review was able to locate the logs for inspections on the Hospital grade and non-hospital grade receptacles. Binder is now assessable upon agency request. 2) All residents have the potential to be affected by this deficient practice. Facility Maintenance Director will maintain all binders for immediate retrieval upon agency requests, will continue to inspect hospital grade and non- hospital grade receptacles monthly per facility policy and regulations.	

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K 914	Continued From page 16 affected two of three smoke compartments, and could result in an increased risk of an electrical fire. NFPA 99, Health Care Facilities Code, 2012 Edition. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. 6.3.4.2.1.1 A record shall be maintained of the tests required by this chapter and associated repairs or modification. 6.3.4.2.1.2 At a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. Findings: During document review, a tour of the facility, and interview with Maintenance Technician 1 on 2/15/18, the electrical receptacle records were requested. 1. At 9:55 a.m., no annual receptacle test for all non-hospital grade receptacles located in patient bed locations had been completed. Upon interview, Maintenance Technician 1 stated they were not sure if they had non-hospital grade receptacles in patient bed locations, but would check their records. At 10:39 a.m., Resident Room 10 was observed with non-hospital grade receptacles. At 10:55 a.m., Resident Room 47 was observed	K 914	3) Maintenance Director was in-serviced by facility Administrator on **3/1/2018.** Focus was on availability of records pertaining to Hospital grade and non- hospital grade inspections of receptacles, so upon request can show proof of maintenance inspections per facility policy and regulations. 4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions. **3/15/2018**	

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K 914	Continued From page 17 with non-hospital grade receptacles. At 1:20 p.m., during an interview, Maintenance Technician 1 stated they were not able to find any records for annual testing on non-hospital grade receptacles located in patient bed locations. This issue was also found during last year's Life Safety Code annual re-certification survey completed on 1/24/17.	K 914		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918	**K 918** 1) Maintenance Director (MD) contacted facility generator vendor on **2/17/2018.** MD requested from vendor that per regulations, the fuel in the generator must have a quality test annually. Per MD Vendor agreed and upon next service date for generator inspection a sample of the fuel will be taken and results will be made available on facility records upon agency request 2) Residents have the potential to be affected by this deficient practice. Facility Maintenance Director will maintain records for fuel quality per regulation and have results available per agency requests.	

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K 918		K 918		

Continued From page 18

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: 37135
Based on document review and interview, the facility failed to maintain the emergency power system. This was evidenced by the absence of annual fuel quality test for the 30 KW diesel generator. This affected three of three smoke compartments and could result in the failure of the generator in the event of a power outage.

NFPA 99, Health Care Facilities Code, 2012 Edition.
6.4.4.1.1.3 Maintenance shall be preformed In accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8.

NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition
8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.

Findings:

During document review and interview with Maintenance Technician I on 2/15/18, the records for the 30 KW diesel generator were requested.

3) Maintenance Director was in-serviced by facility Administrator on **3/1/2018.** Focus was to maintain documentation on the generator fuel quality and to have the records available so they can be presented upon request of agency per facility policy and regulations.

4) Facility Maintenance will bring any identified issues to the monthly QA&A meeting for further review and discussions.

3/15/2018

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K 918	Continued From page 19 1. At 9:43 a.m., there was no records indicating that a fuel quality test had been completed for the generator. Upon interview, Maintenance Technician 1 confirmed the finding.	K 918		