STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056213	A. BUILDING **02** B. WING _____	**12/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMPICO TERRACE CARE CENTER	**130 TAMPICO** **WALNUT CREEK, CA 94598**

(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: 32973 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: 32973 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities	E 000		
E 041 SS=D	Census: 82 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	E 041		3/31/23

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

Electronically Signed | 01/05/2023

1/06/2023: POC accepted per Brian Fenton, SSM-1

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E 041	Continued From page 1 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 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	E 041		

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E 041	Continued From page 2 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: 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: Surveyor: 32973	E 041	E041 Hospital CAH and LTC	

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E 041	Continued From page 3 Based on document review and interview, the facility failed to maintain Emergency Preparedness Plan (EPP) Policy and Procedure. This was evidenced by the failure to provide a policy for maintaining the operation of the facility's emergency generator and on-site fuel source during an emergency unless it evacuated. This affected 82 of 82 residents and could result in a delayed response to an emergency power outage. Findings: During document review and interview with Administrative Staff (AS) on 12/15/22, the EPP, was requested and reviewed. At 1:58 p.m., the facility's EPP did not provide a policy and procedure that addressed how it would keep the 10-kilowatt generator and on-site propane fuel supply operational during an emergency unless it evacuated. Upon interview, AS3 confirmed the finding after review of the EPP, and said that they would include an emergency operational plan for the generator in the facility's plan.	E 041	Emergency Power CFR(s): 483.73(e) Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. I. Corrective Action On 12/16/2022, 1:1 Inservice on Policy & Procedure of Fuel Outage and Emergency Generator Testing and Maintenance was conducted to Maintenance Director by Administrator (Attachment 1). On 12/16/2022 the facility Emergency Operations Plan (EOP) was updated and revised to include a policy & procedure Fuel Outage and Emergency Generator Testing and Maintenance (Attachment 2). II. Identify Other Residents at Risk No residents were affected by this deficient practice. III. Systematic Changes On 12/16/2022 and 01/04/2023, Inservice was conducted to facility staff to be informed of the policy & procedure Generator Testing and Maintenance and Fuel Outage during an emergency (Attachment 3). Changes to EOP Manual was updated on 12/16/2022 and reviewed by QA Committee on 01/04/2023. (Attachment 4). Next review of EOP Manual will be on 12/2023. IV. Monitoring Process Maintenance Director will review EOP	

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E 041	Continued From page 4	E 041	Manual including policy & procedure of Fuel Outage and Emergency Generator Testing and Maintenance monthly. Findings will be reported to Administrator. Administrator will report findings to QA Committee monthly for 3 months or until compliance is met. V. Completion Date 03/31/2023	
K 000	INITIAL COMMENTS Surveyor: 32973 K3 BUILDING: 01 K6 PLAN APPROVAL: 7/9/1970 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 re-certification 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 Health: 32973 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 82	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		4/30/23

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K 345	Continued From page 5 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: 32973 Based on observation and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by expired Fire Alarm Control Unit (FACU) back-up batteries. This affected 82 of 82 residents and could result in a system malfunction or delay in notification in the event of a fire related power outage. 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* General. 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 Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. Chapter 14 Inspection, Testing, and Maintenance 14.1 Application. 14.1.1 The inspection, testing, and maintenance	K 345	K345 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. I. Corrective Action On 12/20/2022, the contracted vendor Denalect Alarm Company replaced two (2) sealed-lead acid type back up batteries for the Fire Alarm System (FAS) (Attachment 5). Per NFPA 72 batteries for FAS must be replaced within 5 years after manufacture or more frequently as needed. II. Identify Other Residents at Risk No residents were affected by this deficient practice. III. Systematic Changes On 01/03/2023, the facility purchased TELS software application which tracks	

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K 345	Continued From page 6 of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. Table 14.4.5 Testing Frequencies. 6. Batteries - fire alarm systems (d) Sealed lead-acid type (1) Charger test (Replace battery within 5 years after manufacture or more frequently as needed.) 14.6.2 Maintenance, Inspection, and Testing Records. 14.6.2.1 Records shall be retained until the next test and for 1 year thereafter. 14.6.2.4* A record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number Findings: During a facility tour and interview with staff on 12/15/22, the FAS, was observed. At 1:10 p.m., 3 of 3 sealed-lead acid type back-up batteries installed in the FACU, were outdated. The installation dates marked on the batteries were 1/11/17. The expiration dates were greater than 5 years. Upon interview, Staff 3 confirmed	K 345	and gives recurring alerts on preventative maintenance and life safety tasks that have to be completed on a daily, monthly, quarterly or annual basis (Attachment 6). The Changing battery for FAS will be added to the TELS system. TELS will provide training to the Maintenance Director before TELS will go live on 1/13/2023. IV. Monitoring Process The TELS installation process will be completed on 1/13/2023. Preventive maintenance and Life safety tasks, which included changing the batteries to the FAS, were added to the TELS. The Maintenance Director will check and report to the Administrator completed tasks of changing batteries of the FAS monthly for 3 months. The Administrator will report the completed TELS alerts on Changing batteries of the FAS during the monthly QA committee meeting for 3 months or until compliance is achieved. V. Completion Date 04/30/2023	

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K 345	Continued From page 7 and acknowledged the findings, and said they would follow-up with the vendor.	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: 32973 Based on observation and interview, the facility failed to maintain fire sprinkler system valve components. This was evidenced by the malfunction of fire department connection (FDC) valves. This affected 82 of 82 residents and could result in the ineffective operation of a water-based sprinkler system in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5 Extinguishment Requirements.	K 353	K353 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	3/31/23

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K 353	Continued From page 8 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 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. Chapter 13 Valves, Valve Components, and Trim 13.1 General. 13.1.1 Minimum Requirements. 13.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged.	K 353	I. Corrective Action The fire sprinkler dual valve component FDC observed at the facility located outside in the front area next to the main entrance was able to be rotated and loosened on the next day, 12/16/2022 after applying warm temperature water on the valves. On 01/04/2023, Maintenance Director contacted vendor Aquamatic Fire Protection by phone for consultation of the observed fire sprinkler dual valve not being able to rotate. Spoke with Representative, Gabriel and scheduled on Thursday, 01/05/23 to service valves. Per report the FDC is in normal operation condition. (Attachment 7). II. Identify Other Residents at Risk No residents were affected by this deficient practice. III. Systematic Changes On 12/16/2022, had 1:1 Inservice with Maintenance Director on rotation of valves and contacting vendor to add scheduled services for them (Attachment 1). A manual log has been created to perform checks on the valves assuring that swivels are able to be easily rotated (Attachment 8). Aquamatic Fire Protection scheduled to service FDC valves quarterly. IV. Monitoring Process Maintenance Director or designee will perform daily checks on both valves turning both swivels. Then weekly checks after one month and as needed based on the weather conditions. Tracking log includes a column for the temperatures of the day to determine and measure when the swivels freeze. In addition,	

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K 353	Continued From page 9 (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. Findings: During a facility tour and interview with staff on 12/15/22, the automatic fire sprinkler system, was observed. At 12:13 p.m., the dual valve FDC, located outside at the front entrance, was observed. Both swivels did not rotate. Upon interview, Staff 2 confirmed and acknowledged the finding, and said they would have the valves serviced.	K 353	Maintenance Director will monitor services being completed quarterly by Aquamatic Fire Protection. Findings will be reported to Administrator. Administrator will report any findings to QA Committee monthly for 3 months or until compliance is met. V. Completion Date 03/31/2023	
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 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by an extinguisher that was obstructed from view and access. This affected 22 of 82 residents and could result in the inability of staff to readily locate and access the fire	K 355	K355 Portable Fire Extinguishers CFR(s): NFPA 101 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or	4/30/23

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K 355	Continued From page 10 extinguisher in the event of a fire. NFPA 101 Life Safety Code, 2012 edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* 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. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. Findings: During a facility tour and interview with staff on 12/15/22, the portable fire extinguishers, were observed. At 12:40 p.m., the wall mounted K-Type portable fire extinguisher located in Dietary, was obstructed from view and access by two storage baskets stationed directly in front of the extinguisher. Upon interview, Staff 3 confirmed the finding, and removed the items.	K 355	conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. I. Corrective Action On 12/15/2022, items obstructing the fire extinguisher observed was immediately removed by kitchen staff. On 01/04/2023 the observed K-Type portable fire extinguisher located in the facility kitchen was adjusted to a higher position on the same wall to prevent obstruction by placing any objects directly in front of the extinguisher. Posted a Keep Clear sign in front of extinguisher (Attachment 9). II. Identify Other Residents at Risk There are total of 2 fire extinguishers in the kitchen and other fire extinguisher was checked and was clear of any obstruction. No other deficient practice was identified. III. Systematic Changes In-service on Plan of Correction for K355 for dietary staff titled Kitchen K-Extinguisher was conducted by DSD on 01/04/2023 (Attachment 9-1). On 01/04/2023, for existing Dietary Cleaning List a line item was added Assure no obstructions for all Fire Extinguishers in the kitchen (Attachment 10). On 01/04/2023, inservice titled Daily Clean Checklist on added line item into the existing Dietary Cleaning List was conducted by DSD for dietary staff (Attachment 11). Dietary Aides will perform a daily check to assure there are no obstructions in front of fire extinguishers in the kitchen.	

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TAMPICO TERRACE CARE CENTER	**130 TAMPICO** **WALNUT CREEK, CA 94598**

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K 355	Continued From page 11	K 355	IV. Monitoring Process Dietary Aides will perform daily check per the Dietary Cleaning List. Dietary Manager will check weekly for one month, then monthly for 2 consecutive months. Findings will be reported to the Administrator. Administrator will report any findings and trends monthly to the QA Committee for 3 months or until compliance is met. V. Completion Date 04/30/2023	
K 363 SS=D	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	K 363		4/30/23

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	056213	A. BUILDING **02** B. WING _____	**12/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMPICO TERRACE CARE CENTER	**130 TAMPICO** **WALNUT CREEK, CA 94598**

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K 363	Continued From page 12 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 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a door that was obstructed from fully closing and latching. This affected 32 of 82 residents and could result in the inability to contain smoke and/or fire to rooms and smoke compartments. Findings: During a facility tour and interview with staff on 12/15/22, the corridor doors, were observed. At 12:48 p.m., the corridor door to Resident Room 4, was observed. The door was obstructed from fully closing and latching due to a cubicle curtain stationed in the swing path of the door. Upon interview, Staff 3 confirmed the finding, and said that they would install a holder for the curtain.	K 363	K363 Corridor - Doors CFR(s): NFPA 101 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. I. Corrective Action The curtain tracks screwed to the ceiling has been dismounted and re-installed in a proper location to allow the corridor door to fully close without obstruction from the privacy curtain (Attachment 12). Maintenance Director performed reinstallation of curtain tracks on 01/04/2023. The observed corridor door to Resident Room 4 is now able to be fully closed without obstruction from	

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K 363	Continued From page 13	K 363		

the privacy curtain.
On 12/16/2022, 1:1 inservice on Corridor Doors being cleared for obstruction of privacy curtains conducted to Maintenance Director by Administrator (Attachment 1).

II. Identify Other Residents at Risk

Maintenance Director checked all other corridor doors to assure no obstruction by privacy curtains 01/04/2023. No residents were affected by this deficient practice.

III. Systematic Changes

Purchased TELS software application through Direct Supply on 01/03/2023. TELS provides an organized system of all maintenance tasks on a daily, monthly, quarterly, and annual basis. It will alert and notify due dates for maintenance on equipment and tasks (Attachment 6). TELS will provide training to the Maintenance Director before TELS will go live on 1/13/2023. Adding task of Resident Doors for No Obstruction will be added into TELS System. Maintenance Director will check all resident room doors to fully close and assuring privacy curtains do not obstruct the doorway on a weekly basis for one month and then monthly thereafter.

IV. Monitoring Process

TELS will be completed by 01/13/2023. Maintenance Director will report findings of checking obstruction of corridor doors to the Administrator. Administrator will report any findings to the QA Committee for 3 months or until compliance is achieved.

V. Completion Date

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K 363	Continued From page 14	K 363	04/30/2023	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on document review and interview, the facility failed to maintain the required fire drills. This was evidenced by the failure to conduct drills quarterly on each shift. This affected 82 of 82 residents and could result in staff being untrained and unaware of shift-specific roles and responsibilities during an emergency. Findings: During document review and interview with staff on 12/15/22, the fire drill records, were reviewed. 1. At 1:14 p.m., no documentation was available for a P.M. shift drill, for the fourth quarter (October, November, December) 2021-2022. 2. At 1:30 p.m., no documentation was available	K 712	K712 Fire Drills CFR(s): NFPA 101 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. I. Corrective Action Inservice conducted by our DSD for all staff on fire drills dated 12/16/2022, 12/23/2022, and 12/28/2022, including quiz related to fire safety & prevention (Attachment 13). Contracted with Fire Safety Service on 01/03/2023 to provide fire drills for all staff on each shift every quarter	1/31/23

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K 712	Continued From page 15 for an A.M. shift drill, third quarter (July, August, September) 2022. 3. At 1:32 p.m., no documentation was available for a NOC shift drill, third quarter (July, August, September) 2022. Upon interview, Staff 2 confirmed the findings after record review, and stated that they had changed the company that did the drills.	K 712	(Attachment 14). II. Identify Other Residents at Risk No residents were affected by this deficient practice. III. Systematic Changes 1:1 inservice conducted with DSD by Administrator on 12/16/2022 (Attachment 15). Fire Safety Service (FSS) scheduled to provide fire drill in-service on 01/06/2023 for each shift. Fire Drill in-services will be included in the mandatory in-service calendar quarterly by the DSD. IV. Monitoring Process Each fire drill conducted by FSS includes recognized methods of procedure, a critique and discussion immediately following the drill, and a written documentation for each drill. All signed in-service drills will be reviewed by the DSD quarterly and findings will be reported to the Administrator. Administrator will report any findings to the QA Committee for 3 months or until compliance is met. V. Completion Date 01/31/2023	
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.	K 918		4/30/23

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K 918	Continued From page 16 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing 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: 32973 Based on observation, document review, and interview, the facility failed to maintain the emergency power supply system (EPSS). This was evidenced by the storage of items inside the enclosure area that were used for other purposes not directly related to the maintenance of the EPSS, and the failure to conduct available load testing for four consecutive hours every three years on a spark ignited propane fueled generator. This affected 82 of 82 residents and	K 918	K918 Electrical Systems - Essential Electric System CFR(s): NFPA 101 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal	

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K 918	Continued From page 17 could result in a fire hazard and/or malfunction of the generator in the event of a power outage. NFPA 101 Life Safety Code, 2012 edition 19.5.1 Utilities, Utilities shall comply with the provisions of section 9.1 19.5.1.1 Utilities shall comply with the provisions of section 9.1 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. 7.11 Protection. 7.11.1 The room in which the EPS equipment is located shall not be used for other purposes that are not directly related to the EPS. Parts, tools, and manuals for routine maintenance and repair shall be permitted to be stored in the EPS room. 8.3 Maintenance and Operational Testing. 8.3.4 A permanent record of the EPSS inspections, tests, exercises, operations, and repairs shall be maintained and readily available. 8.4 Operational Inspection and Testing. 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. Findings:	K 918	and state law. I. Corrective Action On 12/16/2022, 1:1 inservice on Generator Area Cleanliness and Generator 4-hour testing every 3 years conducted to Maintenance Director by Administrator (Attachment 1). On 12/16/2022 the area all around the EPSS has been cleared from all items, including the observed items of patio sliding doors screens, lighting replacement covers, and fixtures (Attachment 16). On 01/03/2023, for the emergency power supply system (EPSS) observed, the vendor C&D Power was notified to perform a Load Test for 4 consecutive hours. A quote was prepared and signed on 01/03/2023 (Attachment 17). Technician able to conduct Load Test upon weather conditions when not raining. II. Identify Other Residents at Risk No residents were affected by this deficient practice. III. Systematic Changes Tasks of EPSS area cleaned and cleared and EPSS load testing 4 consecutive hours will be added into TELS System for Maintenance Director to check daily on EPSS area cleaned and cleared and annually for Generator 4-hour load testing. Purchased TELS software application through Direct Supply on 01/03/2023. TELS will provide training to the Maintenance Director before TELS go live on 1/13/2023. TELS provides an organized system of all maintenance tasks on a daily, monthly, quarterly, and annual basis. It will alert and notify due dates for maintenance on equipment and	

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K 918	Continued From page 18 During a facility tour, document review, and interview with staff on 12/15/22, the EPSS, was observed, and records requested. 1. At 12:20 p.m., the generator enclosure, was observed. Patio sliding door screens, and lighting replacement covers, and fixtures were stored beside the generator inside the enclosure room. Upon interview, Staff 3 confirmed the findings, and said that they would have them removed. 2. At 1:03 p.m., no documentation was available and/or submitted for the required load testing performed every three years for four consecutive hours on the propane fueled generator. Upon interview, Staff 3 said that they were not aware of the requirement for this.	K 918	tasks (Attachment 6). IV. Monitoring Process TELS will be completed by 01/13/2023. Tasks updated and checked by Maintenance Director. Findings will be reported to the Administrator. Administrator will report any findings to the QA Committee for 3 months or until compliance is met. V. Completion Date 04/30/2023	