STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555140	A. BUILDING **03** B. WING _____	**06/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY COURT	**675 E BRADLEY** **EL CAJON, CA 92021**

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E 000	Initial Comments Surveyor: 46410 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: 46410 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 56	E 000	This document will serve as a credible allegation of our intent to correct the deficient practice identified. 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 conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
K 000	INITIAL COMMENTS Surveyor: 46410 K3 BUILDING: 01 K6 PLAN APPROVAL: 1990 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. Resident Certified Beds: 56 Resident Census: 56 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	K 000		

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

Jacob Schlottman *Jacob Schlottman* | Administrator | 7/6/23

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

7/06/2023: POC accepted per Jose Gonzalez, SSM-1

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K 000	Continued From page 1 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: 46410 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 6/21/23, the half inch crescent shaped ceiling penetration created by a sprinkler escutcheon that was not properly seated was repaired by the Maintenance Director and now there is no ceiling penetration. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 7/6/23, the maintenance department completed an inspection of the facility's sprinkler escutcheons and no other ceiling penetrations were identified. C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff on how to identify sprinkler escutcheons that are not properly seated that create ceiling penetrations. The maintenance department staff will inspect/document sprinkler escutcheons to ensure there are no ceiling penetrations monthly. Any negative finding will be corrected immediately and reported to the Administrator/designee. Continued on page 3	7/6/23

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K 161	Continued From page 2 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by a penetration in the ceiling. This could result in the spread of smoke and fire. This affected Building 1, and 28 of 28 residents in three of three smoke compartments. Findings: During facility tour and interview with the Administrator and Maintenance Director (MD) on 6/21/23, the building construction was observed. At 10:31 a.m., in Building 1 Room 7 a sprinkler escutcheon was not flushed with the ceiling creating an approximately half inch crescent shaped penetration. Upon interview, the MD stated that he would adjust the escutcheon to cover penetration.	K 161	Continued from page 2 D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff have completed the monthly inspection to identify sprinkler escutcheons that are not properly seated that could create ceiling penetrations. The Maintenance Director/designee will also conduct a random ceiling penetration inspection monthly to ensure compliance. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324	See page 4	

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K 324	Continued From page 3 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: 46410 Based on document review and interview, the facility failed to maintain the kitchen cooking equipment. This was evidenced by the failure to provide kitchen equipment maintenance documentation. This affected Building 2, and staff in one of three smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.3.2.5 Cooking Facilities.	K 324	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 6/30/23, the annual kitchen equipment inspection was completed and documented by the Maintenance Director and maintenance department staff. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff that the annual kitchen equipment inspection must be completed/documented annually. The Maintenance Director and maintenance department staff will inspect and document kitchen equipment annually. The kitchen staff will notify the maintenance department upon suspicion that any kitchen equipment may not be functioning properly. Any negative finding will be corrected immediately and reported to the Administrator. D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff have completed/ documented the annual kitchen equipment inspection. The Maintenance Director/designee will also conduct a random kitchen equipment inspection to ensure compliance and safety of kitchen equipment. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	7/6/23

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K 324	Continued From page 4 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 11.7.1 Inspection and servicing of the cooking equipment shall be made at least annually by properly trained and qualified persons. 11.7.2 Cooking equipment that collects grease below the surface, behind the equipment, or in cooking equipment flue gas exhaust, such as griddles or char broilers, shall be inspected and, if found with grease accumulation, cleaned by a properly trained, qualified, and certified person acceptable to the authority having jurisdiction. Findings: During document review and interview with the Administrator and Maintenance Director (MD) on 6/21/23, the facility's kitchen maintenance documentation was reviewed. At 3:21 p.m., the facility failed to provide the annual kitchen equipment maintenance documentation. Upon interview, the MD stated	K 324		

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K 324	Continued From page 5 that the kitchen equipment was inspected but the inspections were not documented.	K 324		
K 347 SS=D	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: 46410 Based on observation and interview, the facility failed to maintain the smoke detectors. This was evidenced by smoke detectors not securely mounted to the ceiling. This could result in a delay during an emergency and malfunction of the smoke detectors. This affected Building 1, 9 of 28 residents, and one of three smoke compartments. 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 Code, 2010 Edition 14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance.	K 347	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 6/28/23, the smoke detector that was not flush and securely attached to the ceiling was repaired by a licensed facility vendor and is now flush and securely attached to the ceiling. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 7/6/23, the maintenance department completed an inspection of the facility's smoke detectors and all were found to be mounted flush and securely attached to the ceiling. C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff on how to identify smoke detectors that are not flush and securely attached to the ceiling. The maintenance department staff will inspect/ document smoke detectors to ensure they are flush and securely attached to the ceiling monthly. Any negative finding will be corrected immediately and reported to the Administrator/designee. Continued on page 7	7/6/23

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K 347	Continued From page 6 14.2.1.2 Impairments. 14.2.1.2.1 The requirements of Section 10.19 shall be applicable when a system is impaired. 10.19 * Impairments. 10.19.1 The system owner or their designated representative shall be notified when a fire alarm system or part thereof is impaired. Impairments to systems shall include out-of-service events. 10.19.2 A record shall be maintained by the system owner or designated representative for a period of 1 year from the date the impairment is corrected. 10.19.3 * Where required, mitigating measures acceptable to the authority having jurisdiction shall be implemented for the period that the system is impaired. 10.19.4 The system owner or owner's designated representative shall be notified when an impairment period is completed or discontinued. Findings: During facility tour and interview with the Maintenance Director (MD) and Administrator on 6/21/23, the smoke detectors were observed. At 9:57 a.m., in the corridor between Room 4 and 7 a smoke detector was not flush and securely attached to the ceiling. Upon interview, the MD stated that a screw had got loose.	K 347	Continued from page 6 D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff have completed the monthly inspection of the smoke detectors. The Maintenance Director/designee will also conduct a random smoke detector inspection monthly to ensure compliance. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353	See page 8	

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K 353	Continued From page 7 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: 46410 Based on observation and interview, the facility failed to maintain the automatic fire sprinkler system. This was evidenced by the failure to provide maintance records for sprinklers, a bent sprinkler head deflector and corrosion buildup on the sprinkler heads. This could result in the malfunction and delay of the sprinkler system during an emergency or fire. This affected Building 1 and Building 2, and 56 of 56 residents. 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.	K 353	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 7/5/23, the room 4 bathroom sprinkler deflector that was bent and had corrosion buildup, the shower room sprinkler escutcheon and deflector that had corrosion buildup, the sprinkler escutcheon and deflector in the closet of room 10 that had corrosion buildup were repaired and replaced by a licensed facility vender. On 6/30/23, the monthly visual inspection documentation for the sprinkler control valve and tamper switches was completed/documented by the Maintenance Director. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 7/6/23, the maintenance department completed an inspection of the facility's sprinkler system with no similar findings. C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff on how to identify sprinklers that show any of the following signs: leakage, corrosion, physical damage, loss of fluid in the glass bulb responsive element, loading, and painting unless painted by the sprinkler manufacturer. The maintenance department staff will inspect/document sprinklers are free from the above signs monthly. The maintenance department staff will also visually inspect/document sprinkler control valve and tamper switches. Any negative finding will be corrected immediately and reported to the Administrator/ designee. Continued on page 9	7/6/23

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K 353	Continued From page 8 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 Finding 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). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1)Leakage (2)Corrosion (3)Physical damage (4)Loss of fluid in the glass bulb heat responsive element (5)Loading (6)Painting unless painted by the sprinkler manufacturer 5.2.1.1.3 * Any sprinkler that has been installed in the incorrect orientation shall be replaced. 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation. 13.3.2 Inspection. 13.3.2.1.1	K 353	Continued from page 8 D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff have completed and documented the monthly inspection of the sprinkler system. The Maintenance Director/designee will also conduct a random sprinkler system inspection monthly to ensure compliance. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	

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K 353	Continued From page 9 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.4 System Valves. 13.4.1 Inspection of Alarm Valves. Alarm valves shall be inspected as described in 13.4.1.1 and 13.4.1.2. 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 Backflow Prevention Assemblies. 13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. 13.6.1.2.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. Findings: During facility tour and interview with the Maintenance Director (MD) and Administrator on 6/21/23, the automatic fire sprinklers were observed. 1. At 9:56 a.m., in the bathroom of Room 4 a sprinkler deflector was bent and had corrosion buildup. Upon interview, the MD stated he would replace the sprinkler.	K 353		

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K 353	Continued From page 10 2. At 10:19 a.m., in the Shower Room a sprinkler escutcheon and deflector had corrosion buildup. Upon interview, the MD stated he would replace the sprinkler. 3. At 10:26 a.m., in the closet of Room 10 a sprinkler escutcheon and deflector had corrosion buildup. Upon interview, the MD stated he would replace the sprinkler. 4. At 3:32 p.m., the facility failed to provide monthly visual inspection documentation for the sprinkler control valve and tamper switches. Upon interview, the MD stated that sprinklers are inspected on a monthly basis but inspections are not documented.	K 353		
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	K 363	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 6/21/23, the trash bin that obstructed the door in room 11 was relocated by the Maintenance Director so the door could properly close. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 7/6/23, the maintenance department completed an inspection of the facility's corridor doors with no similar findings. Continued on page 12	7/6/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 11 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 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain their corridor doors. This was evidenced by a trash bin that blocked a corridor door from closing. This could result in the spread of smoke and fire in the case of a fire. This affected Building 1, and 28 of 56 residents in one of three smoke compartments. Findings: During facility tour and interview with the Maintenance Director (MD) and Administrator on 6/21/23, the corridor doors were observed. At 10:25 a.m., in Room 11 a trash bin obstructed the corridor door from closing. Upon interview, the MD stated the resident moved the trash bin.	K 363	Continued from page 11 C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff on how to properly identify obstructed corridor doors. The maintenance department staff will inspect/document corridor doors are free from obstructions monthly. Any negative finding will be corrected immediately and reported to the Administrator/ designee. D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff have completed/ documented the monthly inspection of the corridor doors. The Maintenance Director/designee will also conduct a random corridor door inspection monthly to ensure compliance. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555140	A. BUILDING **03** B. WING _____	**06/21/2023**

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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. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Surveyor: 46410 Based on observation and interview, the facility failed to maintain the smoking area. This was evidenced by cigarette butts on the floor surrounding the smoking area. This affected Building 2, and 28 of 28 residents in three of three smoke compartments.	K 741	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 6/21/23, the 3 cigarette butts in the smoking area on the floor surrounding the ashtrays were properly discarded by the Maintenance Director. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 6/29/23, the maintenance department did a completed an inspection of the facility's smoking area with no similar findings. C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff on how to properly identify cigarette butts on the ground that have not been discarded into the appropriate receptacle. The maintenance department staff will inspect/document smoking areas to verify that they are free of cigarette butts monthly. Any negative finding will be corrected immediately and reported to the Administrator/designee. D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff have completed/ documented the monthly inspection of the smoking areas. The Maintenance Director/designee will also conduct a random smoking areas inspection monthly to ensure compliance. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	7/6/23

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K 741	Continued From page 13 Findings: During facility tour and interview with the Administrator and Maintenance Director (MD) on 6/21/23, the smoking area was observed. At 10:06 a.m., the smoking area had approximately 3 cigarette butts on the floor surrounding the ashtrays. Upon interview, the Administrator stated he would have the cigarette butts picked up.	K 741		
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	K 918	A. How corrective action was accomplished for those residents found to have been affected by the deficient practice. On 6/29/23, the three-year 4-hour load test was completed by a licensed facility vender. B. How the facility identified other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 6/29/23, 4-hour load test was completed by a licensed facility vender. C. What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur. On 6/30/23, the Administrator in-serviced facility and maintenance department staff that the 4-hour load test needs to completed/documented by a licensed facility vendor every 3 years. The 4-hour load test was added to the facility testing schedule to be completed every 3 years. The facility vendor will complete the 4-hour load test every 3 years. Continued on page 15	7/6/23

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K 918	Continued From page 14 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: 46410 Based on document review and interview, the facility failed to maintain the emergency standby generator. This was evidenced by the failure to provide generator maintenance records. This could result in a delay in the generator back up response in the case of a power outage. This affected Building 1 and Building 2, and 56 of 56 residents . NFPA 101 Life Safety Code, 2012 edition 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. 8.4.9 * Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the	K 918	Continued from page 14 D. How the facility plans to monitor its performance to make sure the solutions are sustained. The Maintenance Director/designee will monitor/verify maintenance department staff contact facility vendor to complete the three-year 4-hour load test. The Maintenance Director/designee will also contact facility vendor to ensure the three-year 4-hour load test is completed. Any significant findings will be corrected immediately; reported to the Administrator; and forwarded to the QAPI Committee for evaluation, analysis and review.	

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K 918	Continued From page 15 duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 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. 8.4.9.7 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 document review and interview with the Maintenance Director (MD) on 6/21/23, the generator records were requested and reviewed. At 3:18 p.m., the facility failed to provide a three-year 4-hour load test for the 75-kilowatt propane generator. The last 4-hour load test was unknown. Upon interview, the MD stated he did not have the 4-hour load test record.	K 918		