STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555713	A. BUILDING **02** B. WING _____	**07/18/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWOOD A HEALTH AND REHABILITATION CENTER	**3110 WAGNER HEIGHTS ROAD** **STOCKTON, CA 95209**

(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: 43379 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: 43379 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 61	E 000		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		8/10/22

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

Electronically Signed | 07/29/2022

8/8/22: POC approved by Cynthia Luc, SSM-I

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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the 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. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 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 response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on record review and interview, the facility failed to develop and maintain the emergency preparedness training and testing programs. This was evidenced by the absence of a full-scale community-based exercise. This could result in not having the necessary planning and preparation in place to protect the health and safety for 61 of 61 residents. Findings: During record review and interview with the Administrator on 7/18/22, the emergency preparedness training and testing programs were requested. At 3:25 p.m., the facility failed to provide records for a full-scale community-based exercise that was performed within a year. Upon interview, the Administrator confirmed the finding.	E 039	1. The facility held table top exercises on June 6th, 2021 and June 24, 2021. The evidence of reaching out to entity regarding community based drill was emailed and faxed to the department on 8-5-22. 2. The DSD will schedule future Table top exercises twice a year on a routine calendar basis. A Table Top exercise has been scheduled for August 10th, 2022 for this plan of corrections and twice a year there after. 3. The Administrator will monitor follow through by the DSD to complete the Table Tope Exercise. 4. The facility QAPI Committee will monitor the plan of correction and make revisions as necessary. 5. The plan of correction will be completed by August 10th, 2022.	
K 000	INITIAL COMMENTS Surveyor: 43379 K3 BUILDING: 01	K 000		

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K 000	Continued From page 10 K6 PLAN APPROVAL: 10/10/1997 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 100 Resident Census: 61 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 Health: 43779 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	K 161		7/19/22

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K 161	Continued From page 11 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 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: 43379 Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by an unsealed penetration in a wall. This affected five of 61 residents and could result in the spread of fire and smoke in the event of a fire. Findings:	K 161	1.The identified wall penetration in the Sequoia Living Room was closed up and sealed by the EVS Manager on July 19th, 2022. 2. The EVS Manager reviewed all areas of the facility for additional penetrations no others were found. 3. The EVS Manager will continue to monitor the facility during his weekly	

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K 161	Continued From page 12 During a tour of the facility and interview with the Environmental Services Supervisor on 7/18/22, the ceiling and walls were observed. At 10:22 a.m., an unsealed penetration approximately 16 inches by nine inches was observed on the lower portion of the west wall in the Sequoia Living Room. Upon interview, the Environmental Services Supervisor confirmed the finding and stated that the penetration was due to water damage and stated that the facility has identified the cause of the leak and was actively working towards fixing the issue.	K 161	rounds for other wall penetrations. 4. The Director of Maintenance will monitor follow through by the EVS. 5. The facility QAPI Committee will monitor the weekly wall penetration rounds and make recommendations for revisions to the plan as necessary. 6. The plan of correction will be completed July 19th, 2022.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Surveyor: 43379	K 341	1.The facility EVS Manager replaced the	7/19/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWOOD A HEALTH AND REHABILITATION CENTER	**3110 WAGNER HEIGHTS ROAD** **STOCKTON, CA 95209**

(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 341	Continued From page 13 Based on observation and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by the seal lead acid batteries that were installed past 5 years. This affected 61 of 61 residents, and could result in a non-detected system malfunction in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1* 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 Table 14.4.5 Testing Frequencies. 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	K 341	back up batteries for the Fire Alarm system on 7-19-22. The annual fire alarm testing was completed on July 20th, 2022. 2. The facility EVS Manager will monitor the replacement of the back up batteries for replacement during his monthly fire drills. The EVS Manager will arrange for annual testing during each calendar year. 3. The Director of Maintenance will monitor follow through by the EVS by reviewing his findings during monthly fire drills. 4. The facility QAPI Committee will monitor the plan of correction and may revisions if necessary. 5. The plan of correction was completed on 7-19-22.	

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K 341	Continued From page 14 (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(S) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) Findings: During a facility tour and interview with Environmental Services Supervisor on 7/18/22, the FAS was observed.	K 341		

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K 341	Continued From page 15 At 10:02 a.m., the FAS system was observed with two Sealed Lead Acid Batteries that were dated 6/17/17, which were required to replace within five years after manufacture or more frequently as needed. Upon interview, the Environmental Services Supervisor confirmed the finding.	K 341		
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: 43379 Based on observation, record review, and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by the failure to maintain sprinklers free of foreign materials and missing an annual sprinkler inspection report. This affected 61 of 61 residents and could result in an ineffective sprinkler	K 353	1. The EVS Manager immediately cleaned the debris and cob webs off the 2 fire sprinklers in the Harmony Courtyard on July 18th, 2022. The identified fire sprinkler in the Administrative Office was immediately corrected on July 18th, 2022 to be flush with the ceiling concealing the fire sprinkler pipe.	7/19/22

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K 353	Continued From page 16 coverage. NFPA 101 Life Safety Code, 2012 edition 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition Table 2-1 Summary of Sprinkler System	K 353	2. No other fire sprinklers were affected. 3. The annual Fire Sprinkler Inspection was completed on 7-19-22 by facility contracted vendor Johnson Controls. 4. The EVS Manager will collect the documents regarding the fire sprinkler inspections. 5. Cob webs, other debris covering the fire sprinkler and fire sprinkler escusions will be monitored monthly by the EVS Manager. 6. The Director of Maintenance will monitor follow through by the EVS Manager by reviewing his findings during monthly rounds. 7. The facility QAPI Committee will monitor and make recommendations for revisions to the plan of correction if necessary. The plan of corrections will be completed by July 19, 2022.	

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K 353	Continued From page 17 Inspection, Testing, and Maintenance Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Findings: During a tour of the facility, record review, and interview with the Environmental Services Supervisor on 7/18/22, the automatic sprinkler system was observed.	K 353		

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K 353	Continued From page 18 1. At 9:46 a.m., two of two sprinklers in the Harmony Courtyard exit area was observed covered with cobwebs and foreign material. Upon interview, the Environmental Services Supervisor confirmed the finding. 2. At 10:06 a.m., one of three sprinklers was observed not flushed to the ceiling and exposed the sprinkler pipe in the Administration Office area. Upon interview, the Environmental Services Supervisor confirmed the finding. 3. At 2:16 p.m., the facility failed to provide an annual sprinkler inspection report. The last annual sprinkler inspection report was unknown. The facility was given until 10 a.m. on 7/19/22 to provide the annual sprinkler inspection report to the California Department of Public Health (CDPH). No reports were provided.	K 353		
K 355 SS=C	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: 43379 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by an obscured instructions on the front of fire extinguisher. This affected the Administration Office area and could result in delayed use of the fire extinguishers in the event	K 355	1. The fire extinguisher identified to be facing the wrong way was corrected by the EVS Manager on July 18th, 2022. No other fire extinguishers were affected. 2. The EVS Manager will monitor all fire extinguishers monthly to make sure they are facing with directions visible.	7/18/22

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K 355	Continued From page 19 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 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers. 6.1.3.10 Cabinets. 6.1.3.10.3 Fire extinguishers mounted in cabinets or wall recesses shall be placed so that the fire extinguisher's operating instructions face outward. Findings: During a tour of the facility and interview with the Environmental Services Supervisor on 7/18/22, the facility's fire extinguishers were observed. At 10:06 a.m., the fire extinguisher located in the Administration Office area was placed backward in the wall cabinet, obscuring the fire extinguisher's instruction. Upon interview, the Environmental Services Supervisor confirmed the finding.	K 355	3. The Director of Maintenance will monitor follow through by the EVS Manager. 4. The facility QAPI Committee will monitor the plan of correction and make revisions to the plan if necessary. 5. The plan of corrections was completed on 7-18-22.	

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K 363	Continued From page 20	K 363		
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 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		7/18/22

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K 363	Continued From page 21 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a corridor door that was obstructed from closing. This could result in the passage of smoke in the event of a fire, and affected 15 of 61 residents. Findings: During a tour of the facility and interview with the Environmental Services Supervisor on 7/18/22, the corridor doors were observed. At 11:24 a.m., the corridor door to the Storage/Attic Access Room in the Harmony Wing failed to latch when allowed to self-close. The Strike Plate had a chunk of paper preventing the door from latching. Upon interview, the Environmental Services Supervisor confirmed the finding and stated that the chunk of paper was placed by staff to allow quicker access to the room.	K 363	1. The EVS Manager immediately removed the chunk of paper identified to be causing the door to no close on July 18, 2022. No other doors were affected by this practice. 2. The EVS Manager will monitor all doors during his weekly rounds of the facility to ensure they are not obstructed from closing. 3. The Director of Maintenance will monitor the follow through by the EVS Manager for compliance. 4. The facility QAPI Committee will monitor and make revisions to the plan if necessary. 5. The plan of correction will be completed by July 18th, 2022.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		8/12/22

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K 521	Continued From page 22 This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on record review and interview, the facility failed to maintain the Fire/Smoke Dampers. This was evidenced by an expired damper report. This affected 61 of 61 residents, and could result in malfunction of the Fire/Smoke dampers. NFPA 101 Life Safety Code, 2012 edition 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications, unless otherwise modified by 19.5.2.2. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 edition. 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall	K 521	1. The Director of Maintenance will schedule the fire/smoke damper inspection with the facility contracted vendor and the date is pending at this time. 2. The EVS Manager will monitor the activation and functioning of the fire/smoke dampers during monthly fire drills for the next 3 months. 2. The Director of Maintenance will schedule the fire/smoke damper inspection every 4 years going forward per NFPA 101. 3. The facility QAPI Committee will monitor and make revisions to the plan as necessary. 4. The plan of correction will be completed by August 12, 2022.	

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K 521	Continued From page 23 be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80, Standard for Fire Doors and Other Opening Protectives, for inspection and maintenance of fire dampers, ceiling dampers, and combination fire/smoke dampers, 2010 edition Chapter 19 - Installation, Testing and Maintenance of Fire Dampers 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. Findings: During record review and interview with the Environmental Services Supervisor on 7/18/22, the Fire Damper inspection was requested and reviewed. At 2:42 p.m., the facility failed to provide a current fire/smoke damper inspection report, which was required every four years. The facility provided a fire/smoke damper inspection that was performed in 2017. Upon interview, the Environmental Services Supervisor stated that he was under the impression that the fire damper inspection was performed every six years.	K 521		
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all	K 711		7/26/22

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K 711	Continued From page 24 patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility's staff failed to demonstrate basic knowledge on how to utilize the fire suppression system. This was evidenced by a staff member failing to demonstrate how to extinguished a grease fire in the Kitchen. This affected the kitchen area and could result in the delay of fire extinguishment in the event of a kitchen fire. Findings: During a tour of the facility and interview with the Environmental Services Supervisor on 7/18/22, the cooking facility was observed. At 11:49 a.m., a Kitchen Staff member was interviewed regarding how to utilize the kitchen's fire suppression system. The Kitchen Staff member was unaware on what suppression tools to utilize to extinguish a grease fire. Upon interview, the Environmental Services Supervisor confirmed the finding.	K 711	1. The EVS Manager provided inservice training to the dietary staff regarding how to use the fire suppression system in the dietary department on 7-26-22. 2. The EVS Manager will provide training on the fire suppression system every 4 months. 3. The Director of Maintenance will monitor follow through by the EVS Manager. 4. The QAPI Committee will monitor the plan and make revisions as needed. 5. The plan of correction will be completed by July 26th, 2022.	
K 712 SS=D	Fire Drills	K 712		8/10/22

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K 712	Continued From page 25 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: 43379 Based on record review and interview, the facility failed to perform fire drills. This was evidenced by missing fire drill records. This affected of 61 of 61 Residents, and could result in the lack of staff knowledge in the event of a emergency. Findings: During record review and interview with the Environmental Services Supervisor on 7/18/22, the fire drill records were requested and reviewed. At 1:19 p.m., the facility failed to provide a NOC shift third quarter and a AM shift fourth quarter of 2021. No documented orientation training program related to the current fire plan were provided in lieu of the fire drills during a Public Health Emergency (PHE). Upon interview, Environmental Services Supervisor confirmed the finding.	K 712	1. The facility conducts fire drills monthly. No residents were affected by this practice. The EVS Manager conducted a fire drill on the day shift on July 27, 2022. Fire drills on the pm and noc shift will be conducted by August 10th, 2022. 2. The EVS Manager will conduct a fire drill monthly on varied times on each shift each quarter during the calendar year. 3. The Director of Maintenance will monitor the follow through of the EVS Manager. 4. The QAPI Committee will monitor the plan of correction and make revisions as necessary. 5. The plan of correction will be completed by August 10th, 2022.	

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K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and 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: 43379	K 918	1. The preventative maintenance vendor	8/12/22

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K 918	Continued From page 27 Based on record review and interview, the facility failed to maintain the Emergency Power Supply System (EPSS). This was evidenced by the absence of a three-year-four hour load test. This affected 61 of 61 residents, and could result in a malfunction of the EPSS in the event of an emergency. NFPA 101, Life Safety Code, 2012 Edition 19.5 Building Services. 19.5.1 Utilities. 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. Chapter 8 Routine Maintenance and Operational Testing 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.1.1 If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:	K 918	inspected the facility generator and completed the three-year four-hour load testing on July 26th, 2022. 2. The EVS Manager will continue to schedule the three-year four-hour load testing as required for skilled nursing facilities. 3. The Director of Maintenance will monitor follow through by the EVS Manager. 4. The QAPI Committee will monitor the plan of correction and make revisions as necessary. 5. The plan of correction will be completed 8-12-22.	

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K 918	Continued From page 28 (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.7* EPSS circuit breakers for Level 1 system usage, including main and feed breakers between the EPS and the transfer switch load terminals, shall be exercised annually with the EPS in the "off" position. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. Findings: During record review and interview with the Environmental Services Supervisor on 7/18/22, the load testing documentation for the EPSS was requested. At 2:10 p.m., the facility failed to provide the a three-year four-hour load testing documentation for the diesel generator upon request. The last three-year four-hour load testing was unknown. Upon interview, the Environmental Services Supervisor confirmed the finding. The facility was given until 10 a.m. on 7/19/22 to	K 918		

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K 918	Continued From page 29 provide the missing documentation to the California Department of Public Health (CDPH). No reports were received.	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility failed to maintain the electrical equipment . This was evidenced by obstructions to the electrical panels. This affected the Laundry Area and could result in delayed access to electrical equipment. NFPA 101, Life Safety Code, 2012 Edition 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, National Electrical Code, 2011 Edition	K 919	1. The EVS Manager immediately removed the boxes blocking the electrical panel in the facility laundry area on July 18th, 2022. All other electrical panel areas of the facility were reviewed for boxes or other obstructions and no others were found. 2. The EVS Manager provided inservice to the laundry staff on 7-26-22 regarding not storing boxes in front of electrical systems. 3. The EVS Manager will monitor for compliance weekly during his rounds of the facility. 4. The Director of Maintenance will monitor follow through by the EVS Manager by reviewing the weekly rounds. 5. The facility QAPI committee will monitor the plan and make revisions as needs. 6. The plan of correction will be completed by July 26th, 2022.	7/26/22

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K 919	Continued From page 30 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (2) Width of Working Space. The width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. Findings: During a tour of the facility and interview with Environmental Services Supervisor on 7/18/22, the electrical equipment were observed. At 9:55 a.m., five electrical equipment (3 unlabed equipments, washers equipment 1, 2, and 3) behind the laundry areas were blocked and obscured by multiple cardboard boxes containing bleach products. Upon interview, the Environmental Services Supervisor confirmed the finding.	K 919		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		7/18/22

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K 920	Continued From page 31 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by a power strip that was suspended off the floor. This affected the Medical Records Room, and could result in an electrical fire. NFPA 101, Life Safety Code, 2012 Edition 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. Chapter 9 Building Service and Fire Protection Equipment 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be	K 920	1. The suspended power strip identified was secured July 18th, 2022. The EVS Manager checked the remaining facility for any more suspended power strips and no others were found. 2. The EVS Manager will perform monthly checks for suspended power strips to ensure that it conforms to NFPA 20. 3. The Director of Maintenance will review the monthly inspections performed by the EVS Manager to monitor for follow through. 4. The QAPI Committee will review the monthly inspections by the EVS Manager and make revisions to the plan as necessary. 5. The plan of correction will be completed by July 18th, 2022.	

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K 920	Continued From page 32 permitted to be continued in service. NFPA 70, National Electrical Code, 2011 Edition 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (7) Where subject to physical damage Findings: During a facility tour and interview with the Environmental Services Supervisor on 7/18/22, the electrical equipment were observed. At 10:07 a.m., a power strip in the Medical Records Room was observed suspended approximately three inches off the ground. Upon interview, the Environmental Services Supervisor confirmed the finding.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		7/25/22

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K 923	Continued From page 33 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 43379 Based on observation and interview, the facility failed to maintain the gas equipment. This was evidenced by the failure to maintain a oxygen storage room with a means to prohibit from unauthorized entry. This affected six of 61 residents and could result in damage to the oxygen cylinder tanks. NFPA 99, Health Care Facilities Code, 2012 edition	K 923	1. The EVS Manager installed a locking door knob on the Oxygen storage closet July 25th, 2022 identified in the survey. 2. The EVS Manager will monitor the Oxygen Storage room during weekly rounds to ensure door is locked. 3. The Director of Maintenance will monitor the follow through by the EVS Manager. 4. The facility QAPI Committee will monitor the plan of corrections and make revisions to the plan as necessary. 5. The plan of correction will be	

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K 923	Continued From page 34 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (3) Cylinders shall be protected from tampering by unauthorized individuals. Findings: During a tour of the facility and interview with the Environmental Services Supervisor on 7/18/22, the Oxygen Storage Room was observed. At 11:29 a.m., the oxygen storage room next to Resident Room 106 was observed with no locking mechanism to prohibit unauthorized entry. The room was housing six H-tanks and 23 E-tanks. Upon interview, the Environmental Services Supervisor confirmed the finding.	K 923	completed 7-25-22.	