STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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: 43380 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: Federal ID Number 43380 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 100	E 000		
E 032	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E 032		6/2/21

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

Electronically Signed | 06/01/2021

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.

6/1/21 Accepted by Cynthia Luc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 032	Continued From page 1 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to provide a communication plan that included accurate information for primary and alternate means of communication. This could result in the lack of notification to staff, federal and state officials, tribal, regional and local emergency management agencies in the event of an emergency, and affected 100 of 100 residents. Findings: During document review and interview with Maintenance Staff on 5/18/21, the EPP was requested and reviewed. At 9:41 a.m., a satellite phone and HAM radio were included as alternate means of communication in the EPP's communication plan. When interviewed, Maintenance Supervisor confirmed the finding that the facility did not utilize these forms of alternate communication in emergency situations.	E 032	Preparation 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 it is required by the provisions of Health and Safety Code Section 1280 and 42CFR405.1907 E032 Correction: Administrator and maintenance supervisor updated the facilities EPP□s communication plan. We removed the Satellite phone as one of the alternate means of communication. Administrator ordered a new HAM radio on 6-2-21. The HAM radio will be included in the EPP as alternate means of communication. The EPP plan will be reviewed annually. Any changes to EPP will updated at the monthly safety meeting. Maintenance supervisor will monitor EPP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 032	Continued From page 2	E 032	binder and report any changes to the monthly QA committee.	
K 000	INITIAL COMMENTS Surveyor: 43380 K3 BUILDING: 02 K6 PLAN APPROVAL: 1963 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 43380 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census = 100	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	K 161		5/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 161	Continued From page 3 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered 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: 43380 Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by penetrations	K 161	Correction: Maintenance assistant sealed the two penetrations caused by the data cables in the ceiling of the dietary office with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 161	Continued From page 4 in the ceiling. This could result in the spread of smoke in the event of a fire and affected two of four smoke compartments. Findings: During a tour of the facility and interview with Maintenance Staff on 5/18/21, the walls and ceilings were observed. 1. At 2:08 p.m., data cables were observed coming through two penetrations in the ceiling of the Dietary Supervisor's Office. The first penetration was approximately one and a half inches in diameter and the second penetration was approximately one quarter inch in diameter. 2. At 2:31 p.m., data cables were observed coming through a penetration in the ceiling of the Classroom. The penetration was approximately three quarters of an inch by one half inch. When interviewed, the Maintenance Supervisor confirmed the findings.	K 161	approved fire chalking on 5/19/21. Maintenance assistant sealed the penetration caused by the data cable in the classroom on 5/19/21 with approved fire chalking. During monthly safety rounds maintenance staff will look for any Penetrations and repair them as soon as possible. Maintenance supervisor will report any finding to the monthly QA committee.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 293		5/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 293	Continued From page 5 Surveyor: 43380 Based on observation and interview, the facility failed to maintain all exit signs. This was evidenced by an exit sign that did not remain illuminated when tested. This could result in delayed evacuation in the event of an emergency and affected one of four smoke compartments. Findings: During a tour of the facility and interview with Maintenance Staff on 5/18/21, the exit signs were observed and tested. At 3 p.m., the exit sign on the ceiling outside Resident Room 42, did not remain illuminated when tested. When interviewed, the Maintenance Supervisor confirmed the finding.	K 293	Maintenance supervisor replaced the battery in the ceiling exit sign outside of room 42 on 5/18/21. During monthly safety rounds maintenance staff will check batteries and ensure all exit signs are illuminated. Maintenance supervisor will report any finding to the monthly QA committee.	
K 353	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.	K 353		6/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 353	Continued From page 6 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the fire sprinklers. This was evidenced by items in a storage room stored less than 18 inches from a sprinkler head, paint on a sprinkler in the walk in freezer, and a ceiling fan that obstructed a sprinkler head in an office. This could result in the malfunction of the sprinklers in the event of a fire, and affected one of four smoke compartments. 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 NFPA 13, Standard for the Installation of Sprinkler	K 353	Correction: The shelf on the south wall of the storage room was lowered 12 inches to ensure containered goods would be stored no closer than 18 inches below the fire sprinkler. 5/26/21 Maintenance supervisor called our vendor to replace the sprinkler head in the walk-in refrigerator. Vendor will be out on 6/1/21 to replace the sprinkler head. The ceiling fan/light near the north wall of dietary office will be replaced with a regular light fixture. Maintenance staff will replace ceiling fan on 5/30/21 During Monthly safety rounds maintenance staff will ensure sprinkler heads are not blocked by any fixtures or have an paint on them. Maintenance supervisor will report any finding to the monthly QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 353	Continued From page 7 Systems, 2010 Edition 8.10.6.3 * Obstructions That Prevent Sprinkler Discharge from Reaching the Hazard. 8.10.6.3.1 Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 8.10.6.3. Findings: During a tour of the facility and interview with Maintenance Staff on 5/18/21, the automatic sprinkler system was observed. 1. At 2:02 p.m., containered goods were observed on the top shelf of a shelving unit on the south wall of the South Storage Room, approximately 13 inches below a fire sprinkler. 2. At 2:04 p.m., the pendent sprinkler in the walk-in freezer inside the Kitchen was observed with paint on the deflector of the sprinkler. 3. At 2:08 p.m., a ceiling fan installed near the north wall of the Dietary Supervisor's Office was observed too close to one of two sprinklers in the office. The ceiling fan had six blades. They measured six inches wide by 12 inches long and were approximately seven inches below the sprinkler deflector. When interviewed, the Maintenance Supervisor confirmed the findings.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101	K 363		6/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 8 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 protection ratings, automatics closing devices, etc.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 9 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by two corridor doors that did not latch and one that was obstructed from closing. This affected two of four smoke compartments and could result in the spread of fire or smoke in the event of a fire. Findings: During a tour of the facility and interview with Maintenance Staff on 5/18/21, the corridor doors were observed. 1. At 2:02 p.m., the south corridor door to the Main Dining Room did not latch when tested. The door was equipped with a self-closing device. 2. At 2:59 p.m., the corridor door to Resident Room 42 did not latch when tested. 3. At 2:26 p.m., the corridor door to the Rehabilitation Department/Physical Therapy/Occupational Therapy/Speech Therapy Room was obstructed from closing by a wooden chair that was placed directly in front of the door, which prevented it from being able to close. When interviewed, the Maintenance Supervisor confirmed the findings.	K 363	Correction: The facilities door vendor will be here on 6/3/21 to adjust/repair the door in the south corridor to the main dinning room. They will also repair/adjust the door in room 42 to ensure that both doors close and latch properly. 1) The wooden chair that was obstructing the corridor door to rehab gym was removed immediately. 2) Maintenance supervisor removed wall saver disk from wall in the therapy gym to ensure door would have enough space to attach to wall magnet holder. 5/26/21 During Monthly safety rounds maintenance staff will ensure all facility door hold, close and latch properly. Maintenance supervisor will report any finding to the monthly QA committee.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		5/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING **02** B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	**4635 COLLEGE OAK DRIVE** **SACRAMENTO, CA 95841**

(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 712	Continued From page 10 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: 43380 Based on observation and interview, the facility failed to ensure that all employees received fire safety training. This was evidenced by staff's inability to communicate procedures for extinguishing a fire. This could result in delayed extinguishment in the event of a fire, and affected one of four smoke compartments. Findings: During a tour of the Kitchen with Maintenance Staff on 5/18/21, Kitchen Staff were interviewed. At 2:15 p.m., two Kitchen Staff were interviewed regarding the procedure for extinguishing a fire within the Kitchen. One of the two staff interviewed communicated the correct procedures for extinguishing a large grease fire on the stove. When interviewed, the Maintenance Supervisor confirmed the finding.	K 712	Correction: The one kitchen staff that was unable to answer how to properly extinguish a large grease fire in the kitchen was given a one-on-one in-service on how to extinguish a grease fire in the kitchen on 5/25/21. All dietary staff we be reeducated on how to extinguish grease fires in the kitchen on 5/31/21. Maintenance supervisor will in-service dietary staff annually and new kitchen staff will be educated on how to extinguish a grease fire in the kitchen during new hire orientation. Dietary supervisor will ensure all dietary staff attend in-services training on extinguishing grease fires in the kitchen. Maintenance supervisor will report any finding to the monthly QA committee.	