STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING **02** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

(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: 40325 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: 40325 The facility is not in substantial compliance with 42 CFR §483.73 for Long Term Care Facilities. Census = 71	E 000	**RECEIVED** ***By LSC at 9:03 am, Jul 07, 2021***	
E 032 SS=C	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	This plan of correction is the facility's credible allegation of compliance with Federal and State Regulations. Preparation and/or execution of this pla n does not constitute admission o r agreement by the provider of the truth o f facts alleged or conclusions set forth in th e statement of deficiencies. The plan o f correction is prepared and/or execute d solely because it is required by th e provisions of Federal and State law. Non e of the actions taken by the facility pursuan t to the Plan of Correction should b e considered an admission that a deficienc y existed or that additional measures shoul d have been in place at the time of th e survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Nursing Home Administrator | (X6) DATE: 07/03/2021

Verified by PDFFiller
07/03/2021

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.

7/15/21 Accepted by Jose Gonzalez

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AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

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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: 40325 Based on record review and interview, the facility failed to maintain their Communication plan, as part of their Emergency Operations Plan (EOP). This was evidenced by incorrect information regarding the facility's internal communication devices. This could cause delay and confusion during an emergency, and affect visitors, staff, and 71 of 71 residents. Findings: On 6/15/21, during a record review with the Administrator and Maintenance Director (MD), the EOP Communication Plan was reviewed. At 2:13 p.m., on Page 87 of the EOP binder, the facility lists amateur/ham radio as one of their devices. The Administrator stated they did not have that device or the required licensed operator. The Administrator acknowledged the finding at the exit conference.	E 032	E 032 It is the expectation of the facility to maintain our Communication plan as part of our Emergency Operations Plan (EOP). 1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Emergency Operations Plan (EOP) was revised and updated to reflect our current Communication Plan by Facility Administrator (FA) on 7/1/2021. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The Emergency Operations Plan (EOP) was reviewed in detail by the Maintenance Director (MD) and Facility Administrator (FA). Any sub-section(s) of the plan not updated were subsequently revised and updated to reflect the current plan. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Emergency Operations Plan (EOP) will be reviewed following a pre-determined schedule of each sub-section monthly during the facility Safety Meeting to ensure the plan is reflective of current practice. 4. How the facility plans to monitor its performance to make sure that solutions are sustained: Updates to the Emergency Operations Plan (EOP) will be reviewed with the Quality Assurance and Performance Improvement (QAPI) Committee monthly to validate continued compliance. The QAPI Committee will review findings and make recommendations to the Facility Administrator (FA) and corrective action as needed will be taken. 5. Date the corrective action will be completed: July 15, 2021	
E 041 SS=D	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 041		

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E 041	Continued From page 2 §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source	E 041		

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E 041	Continued From page 3 to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition,	E 041	E 041 It is the expectation of the facility to provide policies an d procedures to keep our emergency power systems operation al during an emergency – specially to include arrangement for fue l delivery during an emergency event. 1. How corrective action(s) will be accomplished for th ose residents found to have been affected by the deficient practice: The Emergency Operations Plan (EOP) was revised and u pdated to reflect our current generator vendor on 7/1/2021 by the Fac ility Administrator (FA). The generator vendor was additio nally contracted to provide fuel delivery in the event of an emergency. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: The Emergency Operations Plan (EOP) was reviewed in detail by the Maintenance Director (MD) and Facility Administra tor (FA). Any vendor, service provider, community partner suppo rting the plan and the requirements therein not updated was su bsequently revised and updated to reflect the current vendors an d service requirements. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that the deficie nt practice does not recur: The Emergency Operations Plan (EOP) will be revi ewed following a pre-determined schedule of each sub-section monthly during the facility Safety Meeting to ensure the plan is reflective of current vendors, service providers and communit y partners to facilitate the plan. 4. How the facility plans to monitor its perf ormance to make sure that solutions are sustained: Updates to the Emergency Operations Plan (EOP) will be reviewed with the Quality Assuran ce and Performance Improvement (QAPI) Committee monthly to validate continued compliance. The QAPI Committee will review findings and make recommendations to the Facility Administrator (F A) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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E 041	Continued From page 4 issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on record review and interview, the facility failed to provide policies and procedures to keep their emergency power systems operational during an emergency. This was evidenced by missing or incorrect documentation in their Emergency Operations Plan (EOP) to include arrangements for fuel delivery during an emergency event. This could cause power loss during an emergency, and result in injury to visitors, staff, and 71 of 71 residents. Findings: On 6/15/21, during a record review with the Administrator and Maintenance Director (MD), the EOP was reviewed. At 1:57 p.m., the facility had a 14.4-kilowatt diesel-powered emergency generator. During a review of the EOP, no record was found of a vendor to supply diesel fuel during an emergency. The EOP listed Bay City as the generator vendor, but the MD stated the EOP was incorrect, and	E 041		

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E 041	Continued From page 5 that the actual vendor was Global Power. The EOP did not specifically indicate that the vendor would supply fuel during an emergency. The MD further stated that the facility had recently changed generator vendors. The Administrator acknowledged the finding at the exit conference.	E 041		
K 000	INITIAL COMMENTS Surveyor: 40325 K3 BUILDING: 01 K6 PLAN APPROVAL: 1988 K7 SURVEY UNDER: 2012 Existing STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (000), 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: 40325 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census = 71	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101	K 161		

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K 161	Continued From page 6 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered 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	K 161		

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K 161	Continued From page 7 plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain their fire-rated construction. This was evidenced by unsealed penetrations in ceilings and walls. During a fire, this could allow smoke and flames to pass through the penetrations and affect visitors, staff, and 71 of 71 residents. This affected two of nine smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 4.5.7 System Design/Installation. Any fire protection system, building service equipment, feature of protection, or safeguard provided to achieve the goals of this Code shall be designed, installed, and approved in accordance with applicable NFPA standards. 8.2.3.1* The fire resistance of structural elements and building assemblies shall be determined in accordance with test procedures set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the authority having jurisdiction. 8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing	K 161	K 161 It is the expectation of the facility to maintain our fire-rate d construction – specially to seal penetrations in ceiling and walls. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: Ceiling and wall penetrations in the MDS Nurse office , and Bladder Scanner room were repaired on 7/1/2 021 by Maintenance Director (MD). 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: The MD or designee will complete a facility-wide audit to identify any additional ceiling and wall penetrations. Correcti ve action was taken as needed by July 15, 2021. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that the deficie nt practice does not recur: The MD was educated by the Facility Administrat or (FA) on the maintenance of our fire-rated construction. The M D or designee will complete a facility-wide visual audit of ceili ngs and walls divided monthly for 3 months to identity potent ial deficient practice and ensure continued compliance. 4. How the facility plans to monitor its per formance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Co mmittee monthly to validate continued compliance. The QAPI Com mittee will review findings and make recommendations to the Faci lity Administrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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K 161	Continued From page 8 through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. 8.4.4 Penetrations. The provisions of 8.4.4 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke partitions. 8.4.4.1 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a smoke partition shall be protected by a system or material that is capable of limiting the transfer of smoke. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the fire-rated construction was observed. 1. At 9:50 a.m., in the MDS Nurse office, a circular penetration measuring approximately 1/4 inch diameter went through the ceiling. A series of data cables went into the ceiling through the penetration. The sealant was hanging loose. The MD stated he needed to re-seal the area. 2. At 9:58 a.m., in the Bladder Scanner room, located off the Oceana Nurse Station, the side-mounted fire sprinkler had a escutcheon not flush with the wall, revealing a circular penetration measuring approximately 1/4 inch in diameter. The MD stated he was not aware of the penetration. The Administrator acknowledged the findings at the exit conference.	K 161		

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K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain their hazardous areas. This was evidenced by a hazardous room which did not have a working self-closing door. During a fire,	K 321	K 321 It is the expectation of the facility to maintain our hazardou s areas – specially to ensure hazardous rooms have worki ng self-closing doors. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the defici ent practice: The Communications room self-closing mechani sm and latch was repaired to ensure self-closure b y the Maintenance Director (MD) on June 15, 2021. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient pract ice and what corrective action will be taken: The MD or designee will complete a facility-wide audit to identify any deficient self-closing hazardous room s doors. Corrective action will be taken as needed by July 15, 2021. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that th e deficient practice does not recur: The MD was educated by the Facility Administ rator (FA) on the maintenance of hazardous areas. The MD or designee will complete a facility-wide audit monthly fo r 3 months to identity potential deficient practice and ens ure continued compliance. 4. How the facility plans to monitor its performance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Co mmittee monthly to validate continued compliance. The Q API Committee will review findings and make recommendatio ns to the Facility Administrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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K 321	Continued From page 10 this could cause smoke and flames to pass through the open door and affect visitors, staff, and 71 of 71 residents. This affected one of nine smoke compartments. NFPA 101, Life Safety Code, 2012 edition 19.3.2 Protection from Hazards 19.3.2.1.3 The doors shall be self-closing or automatic-closing. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the hazardous areas were observed. At 10:17 a.m., in the Communications room, the door failed to self-close and lock. The MD stated the door needed adjusting. The room measured approximately 13 feet by 10 feet and contained the fire alarm control panel and various electrical panels containing energized electrical equipment. The Administrator acknowledged the finding at the exit conference.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 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	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING **02** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

(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 324	Continued From page 11 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: 40325 Based on observation and interview, the facility failed to maintain their kitchen hood fire suppression system. This was evidenced by a nozzle on the system lacking required protective equipment. This could allow a buildup of grease and other contaminants in the unprotected nozzle. This could cause failure of the system during a kitchen fire, and could harm staff. This affected the kitchen. NFPA 101, Life Safety Code, 2012 Edition 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.	K 324	K 324 It is the expectation of the facility to maintain our kitchen hood fir e suppression systems. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: The protective blow-off cap for one of three nozzles part o f the fire suppression system was added by a licensed, cont racted vendor on June 16, 2021. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: An audit of the kitchen hood fire suppression s ystem was completed by the MD on 7/1/2021. No additional deficient practice was identified. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that the deficie nt practice does not recur: The MD was educated by the Facility Administrato r (FA) on the maintenance of the kitchen hood fire suppressio n system. The MD or designee will complete an audit monthly fo r 3 months of the kitchen hood fire suppression system to ident ity potential deficient practice and ensure continued compliance. 4. How the facility plans to monitor its per formance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Committee m onthly to validate continued compliance. The QAPI Committee wi ll review findings and make recommendations to the Facility Administrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

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K 324	Continued From page 12 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition 10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (4) NFPA 17A 11.5 Inspection, Testing, and Maintenance of Listed Hoods containing Mechanical, Water Spray, or Ultraviolet Devices. Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings. NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 2009 Edition 4.3.1.5 All discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the kitchen hood fire suppression system was observed. At 10:35 a.m., the facility had a 6-burner gas-fueled cooktop with a fire suppression system comprising three nozzles. One of the three nozzles did not have its protective blow-off cap in place. The MD acknowledged the cap was	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 324	Continued From page 13 not in place. The Administrator acknowledged the finding at the exit conference.	K 324		
K 344 SS=D	Fire Alarm - Control Functions CFR(s): NFPA 101 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 40325 Based on observation and interview, the facility failed to maintain the control functions of their fire alarm system. This was evidenced by a device that failed to actuate during testing. This could cause delay in notification of a fire and harm kitchen staff. This affected the kitchen. NFPA 101, Life Safety Code, 2012 edition 19.3.4.4 Fire Safety Functions. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5.) 9.6.7 Annunciation. 9.6.7.1 Where alarm annunciation is required by another section of this Code, it shall comply with 9.6.7.2 through 9.6.7.7. 9.6.7.2 Alarm annunciation at the control center shall be by means of audible and visible indicators.	K 344	K 344 It is the expectation of the facility to maintain the contro l functions of our alarm system – specially to ensure audibl e and visual notification of emergency. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: Audible and visual notification of emergency will be add ed to the alarm system within the kitchen area by the lice nsed, contracted vendor by July 15, 2021. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient pract ice and what corrective action will be taken: A facility-wide audit of the fire alarm notification s ystem was completed by the MD on 7/1/2021. No additional deficient practice was identified. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that th e deficient practice does not recur: The Maintenance Director (MD) was educated b y the Facility Administrator (FA) on the maintenance of the cont rol functions of our fire alarm system. The MD or designee wil l complete an audit monthly for 3 months of the control function s of the fire alarm system to identity potential deficient practi ce and ensure continued compliance. 4. How the facility plans to monitor its per formance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Co mmittee monthly to validate continued compliance. The Q API Committee will review findings and make recommendatio ns to the Facility Administrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 344	Continued From page 14 Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the fire alarm control functions were observed. At 11:28 a.m., the fire alarm system was tested. The surveyor stood in the kitchen where there was no audible indication of the test. There was a single flashing light, which illuminated a single corridor in the kitchen. The light could not be seen unless one was standing in that single corridor, nearly under the light. There was a bell on the adjacent wall to the light, but it did not sound. The MD stated he did not know if the bell was connected to the fire alarm system or whether it was supposed to sound. The Administrator acknowledged the finding at the exit conference.	K 344		
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 _____	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING **02** B. WING _____	**06/15/2021**

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K 353	Continued From page 15 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: 40325 Based on observation and interview, the facility failed to maintain their wet-pipe sprinkler system. This was evidenced by material stored too close to a sprinkler, and by missing or illegible signage. During a fire, this could cause a delay in extinguishment, a malfunction of the sprinkler system and a failure of the sprinkler's water spray to reach required areas. This could harm visitors, staff, and 71 of 71 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. 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 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 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	K 353	K 353 It is the expectation of the facility to maintain the wet-pipe sprinkle r system – specifically to ensure material is not stored too close to a sprinkler; and ensure signage in in place and legible. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: The large box in the Admissions Office was removed on 6 /15/21 by the Maintenance Director (MD) or designee. The sign fo r the outdoor inspector test valve was replaced with a new, legible sign on 6/16/21 by the MD or designee. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: A facility-wide audit of was completed by the MD on 7/ 1/2021 to identity items potentially stored too close to the sprink lers, and faded or illegible safety signage. No additional deficient practice was identified. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that the deficie nt practice does not recur: The Maintenance Director (MD) was educated b y the Facility Administrator (FA) on the maintenance of the wet-p ipe sprinkler system. The MD or designee will complete an audit monthly for 3 months of the wet-pipe sprinkler system to ident ity potential deficient practice and ensure continued compliance. 4. How the facility plans to monitor its per formance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Committee m onthly to validate continued compliance. The QAPI Committee wi ll review findings and make recommendations to the Facility Admi nistrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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K 353	Continued From page 16 be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. 5.2.1.3 Stock, furnishings, or equipment closer to the sprinkler deflector than permitted by the clearance rules of the installation standard shall be corrected. 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.1 * Each control valve shall be identified and have a sign indicating the system or portion of the system it controls. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition 8.5.5.2 * Obstructions to Sprinkler Discharge Pattern Development. 8.5.5.2.1 Continuous or noncontinuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.5.5.2. 8.5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special requirements of Section 8.6 through Section 8.12 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. 8.5.5.3 * Obstructions That Prevent Sprinkler Discharge from Reaching the Hazard. 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 8.5.5.3. 8.5.5.3.1 Sprinklers shall be installed under fixed	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 17 obstructions over 4 ft (1.2 m) wide such as ducts, decks, open grate flooring, cutting tables, and overhead doors. 8.5.5.3.2 Sprinklers shall not be required under obstructions that are not fixed in place such as conference tables. 8.5.5.3.3 * Sprinklers installed under open gratings shall be of the intermediate level/rack storage type or otherwise shielded from the discharge of overhead sprinklers. 8.5.6 * Clearance to Storage. 8.5.6.1 * Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4, or 8.5.6.5 are met, the clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the wet-pipe fire sprinkler system was observed. 1. At 9:37 a.m., in the Admissions Office closet, a large box, containing plastic bottles, was stored approximately one foot from the sprinkler head. The MD stated he observed the box only after he looked in the room during the survey. 2. At 11:10 a.m., at the outdoor inspector test valve, the sign was faded and illegible. The MD stated they needed a new sign. The Administrator acknowledged the findings at the exit conference.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers	K 355		

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K 355	Continued From page 18 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: 40325 Based on observation and interview, the facility failed to maintain their portable fire extinguishers. This was evidenced by a fire extinguisher not securely mounted. This could cause the fire extinguisher to fall over during a seismic or other event, becoming a hazard or impediment to use, delaying its operation during a fire. This could harm visitors, staff, and 71 of 71 residents. This affected the kitchen. NFPA 101, Life Safety Code, 2012 Edition 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, 2010 Edition 6.1.3.1 Fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more	K 355	K 355 It is the expectation of the facility to maintain our portable fir e extinguishers. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: The fire extinguisher in the kitchen was secured on 6/17/ 21 by the Maintenance Director (MD). 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: A facility-wide audit of fire extinguishers will be complet ed by the MD by 7/15/2021. Corrective action will be impl emented as needed. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that the deficie nt practice does not recur: The Maintenance Director (MD) was educated b y the Facility Administrator (FA) on the maintenance of portable fire extinguishers. The MD or designee will comp lete an audit monthly for 3 months of the portable fire extinguisher s to identify potential deficient practice and ensure continued compliance. 4. How the facility plans to monitor its per formance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Committee m onthly to validate continued compliance. The QAPI Committee wi ll review findings and make recommendations to the Facility Admi nistrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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K 355	Continued From page 19 than 5 ft. (1.53 m) above the floor. 6.1.3.8.2 Fire extinguishers having a gross weight greater than 40 lb. (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 31/2 ft. (1.07 m) above the floor. 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm). 6.1.3.4 * Portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means: (1) Securely on a hanger intended for the extinguisher (2) In the bracket supplied by the extinguisher manufacturer (3) In a listed bracket approved for such purpose (4) In cabinets or wall recesses 6.1.3.5 Wheeled fire extinguishers shall be located in designated locations. 6.1.3.6 Fire extinguishers installed under conditions where they are subject to dislodgement shall be installed in manufacturer's strap-type brackets specifically designed for this problem. 6.1.3.7 Fire extinguishers installed under conditions where they are subject to physical damage (e.g., from impact, vibration, the environment) shall be protected against damage. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the portable fire extinguishers were observed. At 10:30 a.m., in the Kitchen, the ABC extinguisher was freestanding inside a cabinet. The MD stated the fire extinguisher was not	K 355		

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K 355	Continued From page 20 secure. The Administrator acknowledged the finding at the exit conference.	K 355		
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.	K 363	K 363 It is the expectation of the facility to maintain our doors – specifically to ensure doors properly latch. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: The resident sleeping room 311 door and latch mec hanism were repaired on 6/15/2021 by the Maintenance Directo r (MD) or designee. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: A facility-wide audit of resident sleeping room doors and latch mechanism was completed by the MD on 6/15 /2021. No additional deficient practice was identified. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that th e deficient practice does not recur: The Maintenance Director (MD) was educated b y the Facility Administrator (FA) on the maintenance of corri dor doors and latches. The MD or designee will complete an audi t monthly for 3 months of corridor doors and latches to ident ity potential deficient practice and ensure continued compliance. 4. How the facility plans to monitor its perf ormance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Co mmittee monthly to validate continued compliance. The Q API Committee will review findings and make recommendatio ns to the Facility Administrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING **02** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD** **ENCINITAS, CA 92024**

(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 21 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: 40325 Based on observation and interview, the facility failed to maintain their doors. This was evidenced by a door with a failed latch mechanism. This could cause delay in evacuation during a fire, and could harm visitors, staff, and 71 of 71 residents. This affected one of nine smoke compartments. NFPA 101, Life Safety Code, 2012 edition 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.10* A latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the doors were observed. At 11:28 a.m., in resident sleeping room 311, the door handle did not actuate the latch mechanism sufficiently to open the door. If the door was closed and latched, it could not be opened unless continuous force was applied to the handle to the	K 363		

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K 363	Continued From page 22 point where the door would shake. The door was tested three times by the MD, who stated the door latch needed service. The Administrator acknowledged the finding at the exit conference.	K 363		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918	K 918 It is the expectation of the facility to maintain our essentia l electric system – specifically to conduct a monthly test of th e battery electrolyte or conductance test. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: The test of battery electrolyte or conductance test wi ll be performed by the MD by July 15, 2021. 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: The Maintenance Director (MD) will secure the equipment, training, and testing capability to perform the conduct ance test by July 15, 2021. The MD will schedule in the compu ter-based preventative maintenance program (TELS) and p erform the conductance test monthly. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that th e deficient practice does not recur: The Maintenance Director (MD) was educated b y the Facility Administrator (FA) on the maintenance of the essen tial electric system. The MD or designee will perform the co nductance test monthly and report to the FA monthly any findings for 3 months to ensure continued compliance. 4. How the facility plans to monitor its perf ormance to make sure that solutions are sustained: Completed preventative maintenance work o rders in TELS will be reviewed with the Quality Assuran ce and Performance Improvement (QAPI) Committee monthly to validate continued compliance. The QAPI Committee will r eview findings and make recommendations to the Facility Admi nistrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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K 918	Continued From page 23 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: 40325 Based on observation, interview and record review, the facility failed to main their essential electric system. This was evidenced by no monthly test of the battery electrolyte or conductance test. During a power outage, this could cause failure of the generator and increase the risk to residents, visitors, and staff. This affected staff, visitors, and 71 of 71 residents. NFPA 99 Health Care Facilities Code, 2012 Edition 6.4.4.1.1.3 Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power System Chapter 8. NFPA 110, Standard for Emergency and Standby Power System, 2010 Edition 8.3 Maintenance and Operational Testing. 8.3.7 * Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.3.7.2 Defective batteries shall be replaced	K 918		

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K 918	Continued From page 24 immediately upon discovery of defects. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director, the essential electric system was observed. At 1:25 p.m., the facility had a 14.4-kilowatt diesel-powered generator, with a maintenance-free sealed battery. There was no record of a monthly conductance test. The MD stated he did not have the testing capability to perform the conductance test. The Administrator acknowledged the finding at the exit conference.	K 918		
K 920 SS=E	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 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.	K 920		

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K 920	Continued From page 25 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: 40325 Based on observation and interview, the facility failed to maintain electrical safety. This was evidenced by a power strip that was electrically overloaded. This could cause sparking, smoke and fire, and could harm visitors, staff, and 71 of 71 residents. NFPA 99, Health Care Facilities Code, 2012 Edition 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cart-mounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2)* The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)* The electrical and mechanical integrity of the assembly is regularly verified and documented. (5)* Means are employed to ensure that additional devices or nonmedical equipment	K 920	K 920 It is the expectation of the facility to maintain electrical safety – specially to ensure the proper and compliance use of powe r strips. 1. How corrective action(s) will be accomplished for t hose residents found to have been affected by the deficient practice: The overloaded power strip in the Admissions Offic e was removed on 6/15/2021 by the Maintenance Director (MD). 2. How the facility will identify other residents hav ing the potential to be affected by the same deficient practice a nd what corrective action will be taken: A facility-wide electrical safety audit – specially addre ssing the proper and compliant use of power strips was comple ted by the MD on 6/15/2021. No additional deficient practice was identified. 3. What measures will be put into place or w hat systemic changes the facility will make to ensure that the deficie nt practice does not recur: The Maintenance Director (MD) and Inter-Dis ciplinary Team (IDT) were educated by the Facility Administ rator (FA) on electrical safety. The MD or designee will complete an electrical safety audit – specially addressing the proper a nd compliance use of power strips monthly for 3 months to ident ity potential deficient practice and ensure continued compliance. 4. How the facility plans to monitor its per formance to make sure that solutions are sustained: Audits will be reviewed with the Qual ity Assurance and Performance Improvement (QAPI) Co mmittee monthly to validate continued compliance. The QAPI Com mittee will review findings and make recommendations to the Faci lity Administrator (FA) and corrective action will be taken as needed. 5. Date the corrective action will be completed: July 15, 2021	

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K 920	Continued From page 26 cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe. Findings: On 6/15/21, during a facility tour with the Administrator and Maintenance Director (MD), the electrical equipment was observed. At 9:28 a.m., in the Admissions Office closet, a microwave, coffeemaker and refrigerator were connected to a Tripp-Lite UL-listed power strip. The ampere [unit measuring electric current flow drawn by equipment] of the microwave was 12.5 A [amperes or amps], the coffeemaker was also 12.5 A., and the refrigerator was 1.5 A. The devices totaled 26.50 A. The power strip was rated at 12 A. The maximum permissible is 9.00 A [12 x .75]. The power strip was therefore overloaded by 17.5 A. The MD stated he was not aware that the appliances were connected to a power strip, and that the power strip was overloaded. The Administrator acknowledged the finding at the exit conference.	K 920		