| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055557 | A. BUILDING **02**<br>B. WING _____ | **06/20/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CREEKSIDE POST ACUTE** | **35253 AVENUE H**<br>**YUCAIPA, CA 92399** |

| (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<br><br>Surveyor: 43035<br>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.<br><br>Representing the California Department of Public Health: 43035<br><br>The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.<br><br>Census = 47 | E 000 | | |
| E 007 SS=D | EP Program Patient Population<br>CFR(s): 483.73(a)(3)<br><br>§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** | E 007 | | 6/26/24 |

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

Electronically Signed | 07/10/2024

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.



7/11/2024: POC accepted per Brian Fenton, SSM-1

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| E 007 | Continued From page 1<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:<br>(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.<br><br>*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.]<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on record review and interview, the facility failed to maintain an Emergency Operations Plan (EOP). This was evidenced by missing information addressing the facility's patient population that would be at risk during an emergency event. This affected 47 of 47 residents and could result in the failure to properly react during an emergency.<br><br>Findings:<br><br>During document review and interview with the Maintenance Supervisor on 6/20/24, documentation for the facility's at risk patient population during an emergency event was requested.<br><br>At 1:59 p.m., the facility failed to include information that addressed the facility's resident population that would be at risk during an | E 007 | How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>A resident population mix matrix will be created and added to the EPP so that the facility will be informed & prepared to handle the resident population accordingly during an emergency<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur | |

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| E 007 | Continued From page 2<br>emergency. Upon interview, the Maintenance Supervisor confirmed the finding and stated that they did not have the information. | E 007 | The facility will review the EPP program annually in the safety committee meetings to facilitate changes, implement recommendations, and report to the QAPI committee annually for review.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI meeting was convened by the Administrator/Designee and DON on 06/26/24 to present the results of the standard Recertification survey and the POC.<br>The Administrator/ Designee and MD will present results of the updated policy and Resident Population Matrix to the QAPI monthly committee meeting for review and recommendations.<br>Corrective Action Compliance Date: 06/26/24 | |
| E 013 SS=D | Development of EP Policies and Procedures<br>CFR(s): 483.73(b)<br><br>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).<br><br>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness | E 013 | | 6/26/24 |

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| E 013 | Continued From page 3<br>policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.<br><br>*Additional Requirements for PACE and ESRD Facilities:<br><br>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For ESRD Facilities at §494.62(b):] Policies and | E 013 | | |

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| E 013 | Continued From page 4<br>procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on record review and interview, the facility failed to maintain an Emergency Operations Plan (EOP). This was evidenced by missing policies. This affected the 47 of 47 residents and could result in the failure to react during an emergency.<br><br>Findings:<br><br>During record review and interview with the Maintenance Supervisor on 6/20/24, the EOP was requested.<br><br>At 2:13 p.m., the facility was unable to provide policy documentation for missing residents or elopement risk. Upon interview, the Maintenance Supervisor confirmed the finding and stated that they did have a policy but could not provide. | E 013 | How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>The facility policy for missing resident/elopement will be added to the EPP binder for staff to review and be ready for emergencies regarding this concern.<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>The Administrator/Designee and MD will present the policy and procedure to the Safety Committee for review of | |

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| E 013 | Continued From page 5 | E 013 | compliance. The safety committee will review the EPP and policies annually and update accordingly to changing regulations.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI meeting was convened by the Administrator/Designee and DON on 06/26/24 to present the results of the standard Recertification survey and the POC.<br>The Administrator/ Designee and MD will present results of the monthly Safety Committee meeting to the QAPI monthly committee meeting for monitoring and recommendations.<br>Corrective Action Compliance Date: 06/26/24 | |
| E 033 SS=D | Methods for Sharing Information<br>CFR(s): 483.73(c)(4)-(6)<br><br>§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).<br><br>[(c) The [facility] must develop and maintain an | E 033 | | 6/26/24 |

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| E 033 | Continued From page 6<br>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:<br><br>(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.<br><br>(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]<br><br>(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).<br><br>*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.<br><br>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035 | E 033 | How corrective action(s) will be | |

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| E 033 | Continued From page 7<br>Based on record review and interview, the facility failed to maintain the Emergency Operations Plan (EOP). This was evidenced by missing a method for sharing documentation for residents under the facility's care with other health providers in the communication plan. This affected the 47 of 47 residents and could result in the delay of communication in the event of an emergency.<br><br>Findings:<br><br>During record review and interview with the Maintenance Supervisor on 6/20/24, the communication plan was requested and reviewed.<br><br>At 2:40 p.m., the facility was unable to provide a communication plan that outlined a means for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care. Upon interview, the Maintenance Supervisor confirmed the finding and stated that they did have a policy and would provide. No documentation was provided. | E 033 | accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>The facility policy for communication outlining the means for sharing information & medical documentation for facility residents will be reviewed & added to the facility EPP.<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>The Administrator/Designee and MD will present the policy and procedure to the Safety Committee for review of compliance. The safety committee will review the EPP and policies annually and update accordingly to changing regulations.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI meeting was convened by the Administrator/Designee and DON on 06/26/24 to present the results of the | |

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| E 033 | Continued From page 8 | E 033 | standard Recertification survey and the POC.<br>The Administrator/ Designee and MD will present results of the monthly Safety Committee meeting to the QAPI monthly committee meeting for monitoring and recommendations.<br>Corrective Action Compliance Date: 06/26/24 | |
| E 034 SS=D | Information on Occupancy/Needs<br>CFR(s): 483.73(c)(7)<br><br>§403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).<br><br>[(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:<br><br>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br><br>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. | E 034 | | 6/26/24 |

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| E 034 | Continued From page 9<br><br>*[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on record review and interview, the facility failed to maintain their Emergency Operations Plan (EOP). This was evidenced by a means of providing information about the facility's occupancy and needs missing from the communication plan. This affected 47 of 47 residents and could result in the delay of communication in the event of an emergency.<br><br>Findings:<br><br>During record review and interview with the Maintenance Supervisor on 6/20/24, the communication plan was requested and reviewed.<br><br>At 2:45 p.m., the facility's communication plan was missing a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Upon interview, the Maintenance Supervisor confirmed the finding and stated that they did have a policy. No policy was provided. | E 034 | How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>The facility policy for communication outlining the means for sharing our occupancy, needs and our ability to provide assistance will be reviewed and added to the facility EPP. □RediNet□ & □MHOAC□ (Medical & Health Operational Area Coordination) are our means of facilitating the availability of the information to the appropriate agency(s).<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>The Administrator/Designee and MD will present the policy and procedure to the Safety Committee for review of compliance. The safety committee will review the EPP and policies annually and | |

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| E 034 | Continued From page 10 | E 034 | update accordingly to changing regulations.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI meeting was convened by the Administrator/Designee and DON on 06/26/24 to present the results of the standard Recertification survey and the POC.<br>The Administrator/ Designee and MD will present results of the monthly Safety Committee meeting to the QAPI monthly committee meeting for monitoring and recommendations.<br>Corrective Action Compliance Date: 06/26/24 | |
| E 041 SS=D | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(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.<br><br>§483.73(e), §485.625(e), §485.542(e)<br>(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on | E 041 | | 6/26/24 |

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| E 041 | Continued From page 11<br>the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)<br>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.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)<br>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.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]<br>The standards incorporated by reference in this | E 041 | | |

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| E 041 | Continued From page 12<br>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.<br>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.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, | E 041 | | |

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| E 041 | Continued From page 13<br>2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on record review and interview, the facility failed to maintain an Emergency Operations Plan (EOP). This was evidenced by missing information in the emergency power supply system policy and procedure. This affected 47 of 47 residents and could result in the failure to properly react during an emergency.<br><br>Findings:<br><br>During record review and interview with the Maintenance Supervisor on 6/20/24, the EOP was requested.<br><br>At 2:58 p.m., the facility was missing a written and specified policy and procedure for maintaining emergency power during an outage such as, how back up fuel would be acquired and how long back up fuel could sustain emergency power. Upon interview, the Maintenance Supervisor confirmed the finding and stated that they have a fuel delivery contract. | E 041 | How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>The facility policy for managing a power outage and procedures for maintaining the generator during the power outage along with the fuel delivery agreement will be reviewed and added to the facility EPP.<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>The Administrator/Designee and MD will present the policy and procedure to the Safety Committee for review of compliance. The safety committee will review the EPP and policies annually and update accordingly to changing regulations.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must | |

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| E 041 | Continued From page 14 | E 041 | be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI meeting was convened by the Administrator/Designee and DON on 06/26/24 to present the results of the standard Recertification survey and the POC.<br>The Administrator/ Designee and MD will present results of the monthly Safety Committee meeting to the QAPI monthly committee meeting for monitoring and recommendations.<br>Corrective Action Compliance Date: 06/26/24 | |
| K 000 | INITIAL COMMENTS<br><br>Surveyor: 43035<br>K3 BUILDING: 01<br>K6 PLAN APPROVAL: 1966<br>K7 SURVEY UNDER: 2012 EXISTING<br><br>STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED.<br><br>Resident Certified Beds: 59<br><br>Resident Census: 47<br><br>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 - | K 000 | | |

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| K 000 | Continued From page 15<br>Health Care Facilities Code, 2012 Edition.<br><br>Representing the California Department of Public Health: 43035<br><br>The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. | K 000 | | |
| K 345 SS=D | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on document review and interview, the facility failed to maintain the fire alarm system. This was evidenced by the failure to provide documentation of semi-annual fire alarm system inspections, including fire alarm control panel battery testing. This affected four of four smoke compartments, 47 of 47 active residents, and could result in the failure to notify and evacuate occupants and extinguish fire in the event of an emergency.<br><br>NFPA 101 - Life Safety Code, 2012 Edition<br>19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6<br>9.6.1* General. | K 345 | How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>(1) As part of the Semi-Annual Fire Alarm System Inspections performed by Quick Response, it will be requested that their documentation be provided in a timely manner after each inspection. A | 6/26/24 |

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| K 345 | Continued From page 16<br>9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use.<br>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.<br><br>NFPA 72 - National Fire Alarm and Signaling Code, 2010 Edition<br>14.3 Inspection.<br>14.3.1 * Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction.<br>Table 14.3.1<br>3. Batteries<br>(d) Sealed lead-acid - Semiannually<br>9. Initiating devices<br>(b) Duct detectors - Semiannually<br>(e) Manual fire alarm boxes - Semiannually<br>(f) Heat detectors - Semiannually<br>(h) Smoke detectors - Semiannually<br>(i) Supervisory signal devices - Semiannually<br>14.4.2.2* Systems and associated equipment shall be tested according to Table 14.4.2.2.<br>5. Batteries-general tests. Prior to conducting any battery testing, the person conducting the test shall ensure that all system software stored in volatile memory is protected from loss.<br>(a) Visual inspection - Batteries shall be inspected for corrosion or leakage. Tightness of | K 345 | check list of the last performed inspection and documentation received will be added to the life and safety binder of logs.<br>(2) As part of the semi-annual fire alarm control panel inspection and testing. Quick Response will add battery load testing to their reports.<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>Quick Response will perform their semi-annual fire alarm system inspection as if it's an annual inspection to meet the requirements.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI meeting was be convened by the Administrator/Designee and DON on 06/26/24 to present the results of the standard Recertification survey and the Plan of Correction (POC).<br>The Maintenance Director (MD) will present the results of the Semi-Annual Fire Alarm System Inspection at the QAPI monthly meeting.<br>Corrective Action Completion Date: 06/26/24 | |

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| K 345 | Continued From page 17<br>connections shall be checked and ensured. If necessary, battery terminals or connections shall be cleaned and coated. Electrolyte level in lead-acid batteries shall be visually inspected.<br>(b) Battery replacement - Batteries shall be replaced in accordance with the recommendations of the alarm equipment manufacturer or when the recharged battery voltage or current falls below the manufacturer's recommendations.<br>(e) Load voltage test - With the battery charger disconnected, the terminal voltage shall be measured while supplying the maximum load required by its application. The voltage level shall not fall below the levels specified for the specific type of battery. If the voltage falls below the level specified, corrective action shall be taken and the batteries shall be retested. Exception: An artificial load equal to the full fire alarm load connected to the battery shall be permitted to be used in conducting this test.<br>14.4.5 * Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.<br>Table 14.4.5<br>6. Batteries-fire alarm systems<br>(d) Sealed lead-acid type<br>(3) Load voltage test - Semi-annually<br><br>Findings:<br><br>During document review and interview with the Maintenance Supervisor 6/20/24, the fire alarm system and battery control panel battery testing records were requested.<br><br>1. At 1:22 p.m., the facility was unable to provide | K 345 | | |

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| K 345 | Continued From page 18<br>1 of 2 semi-annual fire alarm system inspections. Upon interview, the Maintenance Supervisor confirmed the finding and stated that the vendor was not completing the inspections.<br><br>2. At 1:28 p.m., the facility was unable to provide documentation of fire alarm control panel battery semi-annual load voltage testing. Upon interview, the Maintenance Supervisor confirmed the finding and stated that the vendor was not completing the semi-annual inspections. | K 345 | | |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on document review and interview, the facility failed to maintain the sprinkler system. | K 353 | K353<br>How corrective action(s) will be accomplished for those residents found to | 6/26/24 |

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| K 353 | Continued From page 19<br>This was evidenced by missing quarterly sprinkler inspection records. This affected four of four smoke compartments and could result in the malfunction of the automatic sprinkler system in the event of a fire.<br><br>NFPA 101 Life Safety Code, 2012 Edition<br>19.3.5 Extinguishment Requirements.<br>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.<br>19.3.5.4 * The sprinkler system required by 19.3.5.1 or 19.3.5.3 shall be installed in accordance with 9.7.1.1(1).<br>9.7 Automatic Sprinklers and Other Extinguishing Equipment.<br>9.7.1 Automatic Sprinklers.<br>9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following:<br>(1) NFPA 13, Standard for the Installation of Sprinkler Systems<br>(2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes<br>(3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height<br>9.7.5 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.<br>9.7.7 All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and | K 353 | have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>The Maintenance Staff was educated on the regulation and deficient finding by the Administrator/Designee on 04/16/2024.<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>A checklist will be created by the Administrator/Designee to include quarterly fire sprinkler inspection and testing. Date last performed and documentation received. To be able to quickly check and see if all documentation for life and safety has been received.<br>The status of this checklist will be reported by the MD to the Administrator/ Designee monthly for further actions or recommendations.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system.<br>A special QAPI Meeting will be convened by the Administrator/Designee and | |

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| K 353 | Continued From page 20<br>testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system.<br>9.7.8 Testing and maintenance records required by NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location.<br><br>NFPA 25 Standard for the Installation of Sprinkler Systems, 2011 Edition<br>5.2.6* The hydraulic design information sign for hydraulically designed systems shall be inspected quarterly to verify that it is attached securely to the sprinkler riser and is legible.<br>13.7 Fire Department Connections.<br>13.7.1 Fire department connections shall be inspected quarterly to verify the following:<br>(1) The fire department connections are visible and accessible.<br>(2) Couplings or swivels are not damaged and rotate smoothly.<br>(3) Plugs or caps are in place and undamaged.<br>(4) Gaskets are in place and in good condition.<br>(5) Identification signs are in place.<br>(6) The check valve is not leaking.<br>(7) The automatic drain valve is in place and operating properly.<br>(8) The fire department connection clapper(s) is in place and operating properly.<br>13.7.4 Any obstructions that are present shall be removed.<br><br>Findings:<br><br>During document review, and interview with the Maintenance Supervisor on 6/20/24, the sprinkler system was observed and documents were requested. | K 353 | Director of Nursing on 06/26/24 to present the results of the standard Recertification survey and the POC.<br>The MD will present the results of the checklist in the monthly QAPI meeting x3 then quarterly moving forward.<br>Corrective Action Completion Date: 06/26/24 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 353 | Continued From page 21<br><br>At 1:42 p.m., the facility was unable to provide 2 of 4 quarterly sprinkler inspections. Upon interview, the Maintenance Supervisor confirmed the finding and stated that the vendor was not completing the inspections. | K 353 | | |
| K 511 SS=D | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43035<br>Based on observation and interview, the facility failed to maintain the electrical receptacles. This was evidenced by an outdoor receptacle missing the weatherproof covering. This affected one of four smoke compartments, 47 of 47 residents, and could result in the ignition and spread of fire.<br><br>NFPA 101 Life Safety Code, 2012 Edition<br>19.5 Building Services.<br>19.5.1 Utilities.<br>19.5.1.1 Utilities shall comply with the provisions of Section 9.1.<br>9.1.2 Electrical wiring and equipment shall be in accordance with NFPA 70 National Electrical | K 511 | K511<br>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>No residents were affected by the deficient finding.<br>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<br>No other residents were affected by the deficient finding.<br>The tension and polarity log will be updated to monitor weatherproof covering | 6/26/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055557 | A. BUILDING **02**<br>B. WING _____ | **06/20/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| K 511 | Continued From page 22<br>Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.<br><br>NFPA 70 National Electrical Code, 2011 Edition<br>406.6 Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface.<br>406.9(A) A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug cap not inserted and receptacle covers closed).<br><br>Findings:<br><br>During a tour of the facility and interview with the Maintenance Supervisor on 6/20/24, the electrical receptacles were observed.<br><br>At 10:01 a.m., the electrical receptacle located outside in the patio next to the smoking area was observed missing a weatherproof covering. Upon interview, the Maintenance Supervisor confirmed the finding and stated that there was usually a vending machine to block it. | K 511 | on all outside receptacles.<br>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur<br>The tension and polarity inspection report will be presented at the monthly safety committee meeting to ensure we comply with weatherproof protection on exterior receptacles.<br>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system<br>The Administrator/Designee and DON convened a special QAPI meeting on 06/26/24 to present the results of the standard Recertification survey and the POC.<br>Any concerns from the monthly safety committee meeting will be presented at the quarterly QAPI meeting by the Maintenance Director (MD).<br>Corrective Action Completion Date: 06/26/24 | |