STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. BUILDING 02 B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OROVILLE HOSPITAL POST-ACUTE CENTER	1000 EXECUTIVE PARKWAY OROVILLE, CA 95966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 43380 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. Representing the California Department of Public Health: 43380 The facility is in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 107	E 000		
K 000	INITIAL COMMENTS Surveyor: 43380 K3 BUILDING: 01 K6 PLAN APPROVAL: 9/11/1987 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 126 Resident Census: 107 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),	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/13/2023

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.

01/17/2023: POC accepted per Cynthia Luc, SSM-1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	555281	A. BUILDING **02** B. WING _____	**12/29/2022**

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K 000	Continued From page 1 National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 43380 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 163 SS=D	Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by a penetration in a wall. This could result in the spread of smoke in the event of a fire and affected 33 of 107 Residents. Findings: During a tour of the facility and interview with staff on 12/29/22, the walls and ceilings were observed.	K 163	"Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq." K163 Interior Nonbearing Wall Construction CFR(s): NFPA 101	12/29/22

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K 163	Continued From page 2 At 10:20 a.m., a one-half inch penetration was observed in the South wall of the East Janitors Closet next to Resident Room 216. Upon interview, the Maintenance Technician confirmed there was a penetration in the wall.	K 163	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • The wall penetration was repaired on 12/29/22 on the South wall of the Janitors closet. 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. • All residents have the potential to be affected and maintenance staff will provide monthly rounds to ensure that the walls are in good repair and without penetrations. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. • Maintenance Staff will complete monthly rounds to ensure that the walls are in good repair and there are no penetrations. Maintenance Staff will document inspections and repairs and provide the Executive Director with a monthly report. 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	

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K 163	Continued From page 3	K 163	evaluated for its effectiveness. The POC must be integrated into the quality assurance system; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. • The Maintenance Supervisor or designee will perform monthly rounds to ensure that the walls are in good repair and there are no penetrations. Findings of audits will be provided to the CQI Committee monthly for 90 days then quarterly thereafter for further action as needed.	
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	K 321		1/30/23

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K 321	Continued From page 4 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: 43380 Based on observation and interview, the facility failed to maintain the hazardous area enclosures. This was evidenced by doors that were obstructed from closing and doors that did not latch. This affected the kitchen and front office area and could result in the spread of smoke and fire. Findings: During a tour of the facility and interview with staff on 12/29/22, the hazardous enclosure areas were observed. 1. At 10:37 a.m., the door to the Dry Food storage room inside the Kitchen was equipped with a self-closing device and was held open by a wooden door wedge. The room was approximately 280 square feet and stored boxes and dry food. Upon interview, the Maintenance Technician confirmed the finding that the door was held open. 2. At 10:59 a.m., the door to the Medical Records Storage room inside the Medical Records Office failed to latch when tested. The door was	K 321	K 321 Hazardous Areas – Enclosure CFR(s): NFPA 101 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • The wedge in the Kitchen was removed on 12/30/22. • The latch to the Medical Records door was repaired on 12/29/22. 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. • All residents have the potential to be affected as this could result in the spread of smoke and fire. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.	

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K 321	Continued From page 5 equipped with a self-closing device and was tested three times. The room was approximately 100 square feet and stored paper medical records. Upon interview, the Maintenance Technician confirmed the finding that the door did not latch.	K 321	• Education regarding the use of wedges to prop open doors and nonfunctioning latches to all staff was started on 1/12/23 and will be completed with all staff by 1/30/23. • Maintenance Staff will complete monthly rounds to ensure that the doors are not propped open and latches are functioning. Maintenance Staff will document inspections and repairs and provide the Executive Director with a monthly report. 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; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. • The Maintenance Supervisor or designee will perform monthly rounds to ensure that the doors are not propped open and latches are functioning. Findings of audits will be provided to the CQI Committee monthly for 90 days then quarterly thereafter for further action as needed.	
K 351 SS=C	Sprinkler System - Installation CFR(s): NFPA 101	K 351		1/13/23

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K 351	Continued From page 6 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the fire sprinkler system. This was evidenced by an Inspector's Test Valve (ITV) sign that had been painted. This could result in not being able to locate of identify the valve and affected ITV sign area. NFPA 101: Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment.	K 351	K 351 Sprinkler System – Installation CFR(s): NFPA 101 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • New signs were ordered on 1/12/23. 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. • All residents have the potential to be affected as this could result in staff not being able to locate and identify the valve	

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K 351	Continued From page 7 9.7.1 Automatic Sprinklers. 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height NFPA 13: Standard for the Installation of Sprinkler Systems, 2010 Edition 6.7.4 * Identification of Valves. 6.7.4.1 All control, drain, and test connection valves shall be provided with permanently marked weatherproof metal or rigid plastic identification signs. 6.7.4.2 The identification sign shall be secured with corrosion-resistant wire, chain, or other approved means. Findings: During a tour of the facility and interview with staff on 12/29/22, the fire sprinkler system was observed. At 10:08 a.m., the Inspector's Test Valve on the Northwest side of the facility was observed with the identification sign partially painted over. Upon interview, the Maintenance Technician confirmed the finding that the sign was painted.	K 351	and affected ITV sign area. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. • Maintenance has updated the audit tool on 1/11/23 to include signage is visible and clear. Maintenance staff will complete monthly rounds to ensure signs are visible and clear. Maintenance Staff will document inspections and repairs and provide the Executive Director with a monthly report. 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; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. • Maintenance has updated the audit tool on 1/11/23 to include signage is visible and clear. Maintenance staff will complete monthly rounds to ensure signs are visible and clear. Findings of audits will be provided to the CQI Committee monthly for 90 days then quarterly thereafter for further action as needed.	

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K 353	Continued From page 8	K 353		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation, document review and interview, the facility failed to maintain the fire sprinklers. This was evidenced by obstruction to a sprinkler and the failure to perform one of four quarterly inspections. This could result in the malfunction of the sprinklers in the event of a fire and affected 107 of 107 Residents. NFPA 101: Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with	K 353	K 353 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • The binders were removed and the shelf lowered to clear the obstruction of the sprinklers. • Documentation was not readily available at the time of survey. Voltage Specialists have been contacted and all inspections	1/30/23

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K 353	Continued From page 9 Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.1 Automatic Sprinklers. 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems 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 13: Standard for the Installation of Sprinkler Systems, 2010 Edition 8.10.6.3 * Obstructions That Prevent Sprinkler Discharge from Reaching the Hazard. 8.10.6.3.1 Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 8.10.6.3. NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 4.3 Records. 4.3.1 * Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 5.1.1 Minimum Requirements.	K 353	were completed. 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. • All residents have the potential to be affected as this could result in the malfunction of the sprinklers in the event of a fire. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. • Education regarding obstructing sprinklers for all staff was started on 1/12/23 and will be completed with all staff by 1/30/23. • Maintenance Staff will complete monthly rounds to ensure that the sprinklers are not obstructed. Maintenance Staff will remove any obstructions and provide the Executive Director with a monthly report. 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; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey	

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K 353	Continued From page 10 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. 5.2.1 Sprinklers. 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 be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)* Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place.	K 353	Agency. • Maintenance Staff will complete monthly rounds to ensure that the sprinklers are not obstructed. Findings of audits will be provided to the CQI Committee monthly for 90 days then quarterly thereafter for further action as needed.	

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K 353	Continued From page 11 (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. Findings: During a tour of the facility and interview with staff on 12/29/22, the automatic sprinkler system was observed and records were requested and reviewed. 1. At 11:46 a.m., the sprinklers in the Director of Staff Developments (DSD) office were observed. There were binders stored on the top shelf above the DSD's desk that were approximately 10 inches below a sprinkler head. Upon interview, the Maintenance Technician confirmed the finding that the binders were obstructing the fire sprinkler. 2. At 12:40 p.m., the facility was observed with a wet automatic fire sprinkler system. Record for the quarterly inspection was not available for the third quarter (July, August, September) 2022. Upon interview, the Maintenance Technician confirmed the finding and stated that they have been having trouble getting the vendor to perform the quarterly inspections.	K 353		
K 363 SS=E	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	K 363		1/30/23

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	555281	A. BUILDING 02 B. WING	12/29/2022

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OROVILLE HOSPITAL POST-ACUTE CENTER	1000 EXECUTIVE PARKWAY OROVILLE, CA 95966

(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 12 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced corridor doors that were obstructed from closing and did not latch. This affected the	K 363	K 363 Corridor – Doors CFR(s): NFPA 101 How corrective action(s) will be accomplished for those residents found to	

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K 363	Continued From page 13 Kitchen area and service corridor and could result in the spread of fire or smoke in the event of a fire. Findings: During a tour of the facility and interview with staff on12/29/22, the corridor doors were observed. 1. At 10:27 a.m., the corridor door to the Nurse Practitioners Office did not latch when tested. The door was equipped with a self-closing device and was tested three times. Upon interview, the Maintenance Technician confirmed the finding that the door would not latch. 2. At 10:30 a.m., the corridor door to the Registered Dieticians office did not latch when tested. The door was equipped with a self-closing device and was tested three times. Upon interview, the Maintenance Technician confirmed the finding that the door would not latch. 3. At 10:34 a.m., the corridor door to the Kitchen across from the Maintenance Office was held open by a blue plastic wedge. Upon interview, the Maintenance Technician confirmed the finding and stated that kitchen staff were stocking the kitchen from a food delivery and had propped the door open so they could wheel the carts of food through them. 4. At 10:40 a.m., the corridor door to the kitchen near the Therapy Room was held open by a wooden wedge. Upon interview, the Maintenance Technician confirmed the finding that the door was held open by a wedge. 5. At 11:30 a.m., the corridor door to the	K 363	have been affected by the deficient practice; • The latch to the Nurse Practitioner door was repaired on 12/29/22. • The latch to the Registered Dieticians door was repaired on 12/29/22. • The wedge in the Kitchen door across from maintenance was removed on 12/30/22. • The wedge in the Kitchen near the therapy room was removed on 12/30/22. • The latch to the Chaplains door was repaired on 1/11/23. 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; • All residents have the potential to be affected as this could result in the spread of smoke and fire. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; • Education regarding the use of wedges to prop open doors and nonfunctioning latches to all staff was started on 1/12/23 and will be completed with all staff by 1/30/23.	

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K 363	Continued From page 14 Chaplain's Office did not latch when tested. The door was equipped with a self-closing device and was tested three times. Upon interview, the Maintenance Technician confirmed the finding that the door would not latch.	K 363	• Maintenance Staff will complete monthly rounds to ensure that the doors are not propped open and latches are functioning. Maintenance Staff will document inspections and repairs and provide the Executive Director with a monthly report. 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; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. • The Maintenance Supervisor or designee will perform monthly rounds to ensure that the doors are not propped open and latches are functioning. Findings of audits will be provided to the CQI Committee monthly for 90 days then quarterly thereafter for further action as needed.	
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	K 918		1/13/23

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K 918	Continued From page 15 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 43380 Based on document review and interview, the facility failed to maintain the emergency power supply system (EPSS). This was evidenced by the failure to perform monthly load test. This affected 107 of 107 Residents and could result in a loss of power due to a generator malfunction during an emergency power outage.	K 918	K 918 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ▪ Maintenance staff was inserviced on	

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K 918	Continued From page 16 NFPA 101, Life Safety Code, 2012 Edition 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1. 9.1.3.1 Emergency Generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition. Chapter 8 Routine Maintenance and Operational Testing 8.1* General. 8.1.1 The routine maintenance and operational testing program shall be based on all of the following: (1) Manufacturer's recommendations (2) Instruction manuals (3) Minimum requirements of this chapter (4) The authority having jurisdiction 8.3 Maintenance and Operational Testing. 8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 The permanent record shall include the following: (1)The date of the maintenance report (2)Identification of the servicing personnel (3)Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4)Testing of any repair for the time as recommended by the manufacturer 8.4 Operational Inspection and Testing. 8.4.1 * EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	K 918	1/12/23 assuring generator load test is performed monthly. 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. • All residents have the potential to be affected as this could result in the loss of power. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; • Maintenance Staff will complete monthly EPPS to ensure that the generator is functioning properly should there be a power outage. Maintenance Staff will document inspections and repairs and provide the Executive Director with a monthly report. 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; and include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency.	

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K 918	Continued From page 17 8.4.1.1 If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. 8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations. 8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 8.4.2.4 Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. Findings: During a document review, and interview with staff on 12/29/22, the EPSS was observed, and records were requested and reviewed. At 12:14 p.m., the monthly generator inspection and testing records were requested for the 65-kilowatt Generac back-up generator. The facility was unable to provide a generator load test record for the month of January 2022. Upon interview, the Maintenance Technician confirmed the finding and stated that the load test was not conducted in January 2022.	K 918	• Maintenance Staff will complete monthly EPPS to ensure that the generator is functioning properly should there be a power outage. Findings of audits will be provided to the CQI Committee monthly for 90 days then quarterly thereafter for further action as needed.	

State of California-Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

January 4, 2023

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Administrator
Oroville Hospital Post-Acute Center
1000 Executive Parkway
Oroville, CA 95966-5100

Dear Administrator:

On December 29, 2022, a Life Safety Code standard survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[X] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies in participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
A POC for the deficiencies must be submitted by **ten (10) days of receipt of the CMS – 2567**. Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- 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;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- 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; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by January 28, 2023.

NOTE: Providers registered to participate in the ASPEN Web: Electronic Plan of Correction (ePOC) application will review each deficiency and provide a POC for each tag electronically. The "Attestation of POC Submittal Terms and Conditions" will serve as an electronic signature; therefore, a hard copy signature is not required.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective March 29, 2023. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil

Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to our district office location detailed at the end of this notification. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) unless the follow-up revisit establishes continued non-compliance.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on December 29, 2022 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to our district office location detailed at the end of this notification.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

NOTE: Providers registered to participate in the ASPEN Web: Electronic Plan of Correction (ePOC) application may electronically submit their informal dispute resolution requests as an attachment using ASPEN Web: ePOC. If the Informal Dispute Resolution results in changes to a survey that has already been posted to ASPEN Web: ePOC, the DO will re-post the survey to ASPEN Web: ePOC once the changes are made. Facility users will receive a "Survey Results Re-Posted to Facility" email notification when the survey is re-posted. It will identify tags that have been changed and the reason for the re-posting.

All hard copy documentation submitted in response to this notification may be sent to:

Attention: Marian De Meire, SSM II, Chief
California Department of Public Health
Licensing and Certification Program
Life Safety Code Unit
685 E. Carnegie, Suite 210
San Bernardino, CA 92408

If you have questions concerning the instructions contained in this letter, please contact Cynthia Luc, Supervisor, at 916-263-5843.

Sincerely,

Juliann Alfaro, for:

Marian De Meire, SSM II, Chief
Life Safety Code Unit
Licensing and Certification Program

Enclosure: CMS-2567