STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055563	A. BUILDING 02 B. WING	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA MARIA POST ACUTE	820 W COOK ST SANTA MARIA, CA

RECEIVED
By CDPH LSC at 1:40 pm, Dec 17, 2024

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E 000	Initial Comments 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. The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 46	E 000	The following is submitted pursuant to California Health and Safety Code§ 1280(b) that requires a Plan of Correction and is not an admission of liability for any alleged act or omissions. *The deficiencies had the potential to cause harm to the residents involved and the failure in the system had the potential to harm all residents in the facility.*	12/17/24
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] 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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate	E 026	Upon receiving the statement of deficiencies, the following measures and systemic changes have been put in place in an effort to ensure that the deficient practices do not recur: 1. The facility cannot retroactively correct the deficiency. Identification of others with the potential to be affected: 2. All residents have the potential to be affected. The Facility Administrator has reviewed the requirement for policies and procedures for an 1135 waiver in our Emergency Operations Plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 12/17/2024

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.

12/19/24 POC Approved by Cynthia Luc, SSM-I

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E 026	Continued From page 1 care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain an Emergency Operations Plan (EOP). This was evidenced by the failure to include policies and procedures addressing the role of the facility under an 1135 waiver. This affected the facility and could result in the failure to properly react during an emergency. Findings: During record review and interview with the Administrator on 12/3/24, the EOP was requested. At 3:16 p.m., the facility was unable to provide an1135 waiver policy for the provision of care and treatment at an alternate care site identified by emergency management officials was missing. The EOP failed to address the facility's role in providing care and treatment under an 1135 waiver and who to coordinate with in an effort to obtain the waiver. Upon interview, the Administrator confirmed the finding and stated that they were not aware of the requirement.	E 026	Measures to correct: 3. The facility Administrator will draft policies and procedures addressing the role of the facility under an 1135 waiver and have them approved by the governing body. Additionally, the Administrator will identify outside agencies and facilities to coordinate efforts with during an emergency. 4. Facility will review EOP policies and procedures annually to ensure EOP is updated to comply with current regulations. This will be presented at QAPI meeting scheduled for January 16, 2025 where all management staff will sign.	1/16/25
K 000	INITIAL COMMENTS K3 BUILDING: 01	K 000		

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K 000	Continued From page 2 K6 PLAN APPROVAL: 1971 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 55 Resident Census: 46 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress. This was evidenced by an obstructed egress door. This	K 211	Corrective action for the residents affected: 1. The wheelchair and box of supplies were removed from the area and the emergency exit door is clear from all obstructions. 2. Other residents have the potential to be at risk for the practice. Measures to prevent recurrence: 3. DSD and Activities staff have been provided in-service on policy and procedure regarding emergency exits and means of egress being free from obstruction at all times.	12/03/24

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K 211	Continued From page 3 affected one of three smoke compartments, 9 of 46 residents, and could result in the delay or failure to evacuate in the event of an emergency. NFPA 101, Life Safety Code, 2012 edition 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. 7.1.10 Means of Egress Reliability. 7.1.10.1 * General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Findings: During a tour of the facility and interview with Staff 1 on 12/3/24, the means of egress was observed. At 10:02 a.m., the emergency exit door located in the dining area was observed being obstructed by a wheelchair and a box of supplies. Upon interview, Staff 1 confirmed the finding and stated that it was because they had just conducted an orientation and were in the process of moving the supplies out of the dining area that day.	K 211	The Maintenance Director will conduct audits 3x per week for 8 weeks, to ensure emergency exits remain free and clear of obstructions. Audit findings will be given to the Administrator. Monitoring Corrective Action: 4. Results of the findings will be reported to the QAPI committee monthly for the next 2 months.	2/03/25
K 293 SS=C	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination	K 293	Corrective action for the residents affected: 1. The batteries in the exit signs were tested and replaced where needed and the results documented.	12/6/2024

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K 293	Continued From page 4 also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the battery powered exit signs. This was evidenced by the failure to provide documentation for the annual testing of battery powered exit signs. This affected three of three smoke compartments, 46 of 46 residents, and could result in inability and failure to evacuate in the event of an emergency. NFPA 101 - Life Safety Code, 2012 Edition 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. 7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by	K 293	2. Other residents have the potential to be at risk for the deficient practice. Measures to prevent recurrence: 3. The Maintenance Director will visually inspect exit signs 2x monthly for 2 months and keep a record of inspections ongoing. Audit findings will be given to the Administrator. Monitoring Corrective Action: 4. Results of the findings will be reported to the QAPI committee monthly for the next 2 months. Inspections and testing ongoing.	Ongoing

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K 293	Continued From page 5 7.9.3.1.1(2). (2)* The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 11/ 2 hours. (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11/ 2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows:	K 293		

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K 293	Continued From page 6 (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 11/ 2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. Findings: During document review and interview with the Maintenance Director on 12/3/24, the exit sign testing records were requested. At 2:02 p.m., the facility was unable to provide documentation indicating the exit signs were being tested for 90 minutes annually. The last documented annual test was on 11/28/2023. Upon interview, the Maintenance Director confirmed the finding and stated that it was just missed.	K 293		
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.	K 321	Corrective action for the residents affected: 1. The Laundry Room door was closed. A sign stating: "Door to Remain Closed at All Times. Authorized Personnel Only" will be created and posted on the door.	12/3/2024

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K 321	Continued From page 7 When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous area safety. This was evidenced by a self-closing door in a hazardous area that was obstructed from closing. This affected one of three smoke compartments, 20 of 46 residents, and could result in the spread of fire in the event of an emergency. Findings: During a tour of the facility and interview with Staff 2 on 12/3/24, the hazardous areas were observed.	K 321	2. All residents have the potential to be at risk for the deficient practice. Measures to prevent recurrence: 3. The Maintenance Director will inspect the laundry room door daily, 5x per week for 2 months to ensure compliance. Results of the audit will be given to the Administrator. Monitoring Corrective Action: 4. Results of the findings will be reported to the QAPI committee monthly for the next 2 months.	2/3/2025

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K 321	Continued From page 8 At 10:20 a.m., the self-closing door to the Laundry Room was measured at approximately 100 square feet and was obstructed by a laundry cart that held the door open. Upon interview, Staff 2 confirmed the finding and stated that it was held open for easier access to the room.	K 321		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: 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 control panel battery testing. This affected three of three smoke compartments, 46 of 46 residents, and could result in the failure to notify and evacuate occupants and extinguish fire in the event of an emergency. NFPA 101 - Life Safety Code, 2012 Edition 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with section 9.6 9.6.1* General. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in	K 345	Corrective action for the residents affected: 1. A load voltage test on the fire alarm control panel battery was conducted. 2. All residents have the potential to be at risk for the deficient practice. Measures to prevent recurrence: 3. The Maintenance Director will schedule semi-annual load voltage tests for the fire alarm control panel batteries and replace as necessary. Documentation will be reported to the Administrator. Monitoring Corrective Action: 4. Results will be reported at the QAPI committee meeting on January 16, 2025, where updated emergency operation plans will be reviewed and approved for 2025. Inspections and testing ongoing.	12/17/2024 01/16/2025 Ongoing

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K 345	Continued From page 9 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. 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72 - National Fire Alarm and Signaling Code, 2010 Edition 14.3 Inspection. 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. Table 14.3.1 3. Batteries (d) Sealed lead-acid - Semiannually 9. Initiating devices (b) Duct detectors - Semiannually (e) Manual fire alarm boxes - Semiannually (f) Heat detectors - Semiannually (h) Smoke detectors - Semiannually (i) Supervisory signal devices - Semiannually 14.4.2.2* Systems and associated equipment shall be tested according to Table 14.4.2.2. 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. (a) Visual inspection - Batteries shall be inspected for corrosion or leakage. Tightness of connections shall be checked and ensured. If necessary, battery terminals or connections shall	K 345		

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K 345	Continued From page 10 be cleaned and coated. Electrolyte level in lead-acid batteries shall be visually inspected. (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. (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. 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. Table 14.4.5 6. Batteries-fire alarm systems (d) Sealed lead-acid type (3) Load voltage test - Semi-annually 15. Initiating Devices* (a) Duct detectors - Annually (e) Heat detectors - Annually (f) Manual fire alarm boxes - Annually (h) system smoke detectors - functional test - Annually (I) Supervisory signal devices - Annually Findings: During document review and interview with the	K 345		

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K 345	Continued From page 11 Maintenance Director on 12/3/24, the fire alarm control panel battery testing records were requested. At 2:46 p.m., the facility was unable to provide documentation for one of two semi-annual load voltage tests for the fire alarm control panel batteries. The last test was 12/2023. Upon interview, the Maintenance Director confirmed the finding and stated that they were not aware of the requirement.	K 345		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by portable fire extinguishers missing monthly inspections. This affected two of three smoke compartments, 37 of 46 residents, and could result in the delay to extinguish a fire in the event of an emergency. NFPA 101 Life Safety Code, 2012 Edition 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with	K 355	Corrective action for the residents affected: 1. Fire extinguishers in both water heater rooms were inspected and inspection documented. 2. All residents have the potential to be at risk for the deficient practice. Measures to prevent recurrence: 3. The Maintenance Director will inspect all portable fire extinguishers monthly for 3 months and copies of documentation will be given to the Administrator each month upon completion of the inspections. Monitoring Corrective Action: 4. Results will be reported at QAPI committee meeting for 3 months or until consistent compliance is achieved. Inspections ongoing.	12/04/2024 Ongoing

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	055563	A. BUILDING 02 B. WING	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA MARIA POST ACUTE	820 W COOK ST SANTA MARIA, CA 93458

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K 355	Continued From page 12 NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition 6.1.2 Portable fire extinguishers shall be maintained in a fully charged and operable condition and shall be kept in their designated places at all times when they are not being used. 6.1.3.1 Fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. 6.1.3.2 Fire extinguishers shall be located along normal paths of travel, including exits from areas. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. 6.1.3.4 * Portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means: (1) Securely on a hanger intended for the extinguisher (2) In the bracket supplied by the extinguisher manufacturer (3) In a listed bracket approved for such purpose (4) In cabinets or wall recesses 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. 6.1.3.8.2 Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm). 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic	K 355		

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K 355	Continued From page 13 monitoring device/system at a minimum of 30-day intervals. 7.2.2 Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators 7.2.2.1 In addition to 7.2.2, fire extinguishers shall be visually inspected in accordance with 7.2.2.2 if they are located where any of the following conditions exists: (1) High frequency of fires in the past (2) Severe hazards (3) Locations that make fire extinguishers susceptible to mechanical injury or physical damage (4) Exposure to abnormal temperatures or corrosive atmospheres 7.2.4.1 Personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. 7.2.4.3 Where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. 7.2.4.4 Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on	K 355		

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K 355	Continued From page 14 an inspection checklist maintained on file, or by an electronic method. 7.2.4.5 Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. Findings: During a tour of the facility and interview with the Maintenance Director on 12/3/24, the portable fire extinguishers and inspections were observed. 1. At 11:13 a.m., the portable fire extinguisher located in the West water heater room was observed with monthly inspection records for August, September, and October of 2024 missing on the inspection tag. Upon interview, the Maintenance Director confirmed the finding and stated that it was just missed. 2. At 11:28 a.m., the portable fire extinguisher located in the East water heater room was observed with monthly inspection records for August, September, and October of 2024 missing on the inspection tag. Upon interview, the Maintenance Director confirmed the finding and stated that it was just missed.	K 355		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO	K 741	Corrective action for the residents affected: 1. Cigarette butts were removed from the ground in the smoking area and disposed of. And a discussion was had with each of the 2 residents who smoke to reiterate that cigarette butts are to be placed in the receptacle provided.	12/03/2024

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K 741	Continued From page 15 SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoking regulations. This was evidenced by cigarette butts on the ground. This affected the smoking area, and could result in the ignition of fire. Findings: During a tour of the facility, document review, and interview with the Administrator on 12/3/24, the smoking areas were observed. At 10:51 a.m., approximately 50 cigarette butts were observed laying on the ground surrounding the smoking area in the North exterior side of the building located next to the sprinkler riser. Upon interview, the Administrator confirmed the finding and stated that only two residents are allowed to	K 741	2. All residents have the potential to be at risk for the deficient practice. Measures to prevent recurrence: 3. The Maintenance Director will check the area 2x weekly for 6 weeks to ensure cigarette butts are being discarded into the receptacle properly. Monitoring Corrective Action: 4. Results will be reported at QAPI committee meeting on January 16, 2025. After that, maintenance staff will perform regular weekly inspections of the smoking area while maintaining grounds and report to the Maintenance Director to ensure proper disposal is taking place.	01/16/2025 & Ongoing

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K 741	Continued From page 16 smoke and they were disposing incorrectly.	K 741		