STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. BUILDING 01 B. WING _____	07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA HEALTHCARE & WELLNESS CENTRE, LP	415 SOUTH GARFIELD ALHAMBRA, CA 91801

(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 The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findins are in accordance with 42 Codeof Federal Regulations (CFR) 483.73, Requiement for Long Term Care (LTC) Facilities. Representing the California department of Public Health: Federal ID Number: 14041 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities.	E 000	Alhambra Healthcare and Wellness Center submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	
E 030 SS=C	S/S: C Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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 annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the	E 030		

2018 AUG 17 AM 8:00

LOS ANGELES COUNTY DEPT. HEALTH FACILITIES DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/17/18

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.

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E 030	Continued From page 1 following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).	E 030	On July 16, 2018 The Facility Administrator contacted area volunteers to include in the Facility's Emergency Preparedness plan. In case of a prolonged emergency situation the volunteers will provide extra assistance. On July 16, 2018 the Facility Administrator reviewed the Emergency Preparedness Plan and all other areas of the communication plan were fulfilled. Administrator will review the Emergency Preparedness plan every 6 months to ensure compliance. Any negative findings will be communicated to the Quality Assurance Committee monthly for review and further plan of action.	8/17/18

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E 030	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive communication plan that would include volunteers in case there is a prolong emergency and support from non-licensed and licensed staff were needed. The deficient practice could delay care and services to the residents, during an emergency. Finding: On July 13, 2018, at 2:30 p.m., the evaluator conducted a review of the facility's Emergency Preparedness plan in regards to the written communication plan for the staff, residents' physicians, other LTC facilities, and volunteers. The evaluator held an interview with the administrator and it was revealed that at the time of the survey, the communication plan does not include the use of any volunteers in case of an emergency. In case of an emergency, the facility shall develop and make available the communication plan that would include the staff, residents' physicians, other LTC facility, and volunteers in case there is prolong emergency situation that will require extra assistance from licensed or nonlicensed staff.	E 030		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do	E 039	On July 17, 2018 facility administrator scheduled a full scale emergency exercise for Sept 13, 2018. Shakeout scenario planned.	8/17/18

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E 039	Continued From page 3 all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the	E 039	On July 17, 2018 Administrator looked over the Facility Emergency Plan to ensure all testing requirements were met. No other areas were noncompliant. Facility Administrator will review Emergency Preparedness Plan annually to ensure all areas are up to date and compliant. Any negative findings will be communicated to the Quality Assurance Committee monthly for review and further plan of action.	

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E 039	Continued From page 4 following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness policy for emergency preparedness testing. The facility did not have a policy to conduct full scale emergency preparedness exercises using the emergency procedures. The lack of this emergency policy and excercise(s) could delay care and services to the residents, during an emergency. Findings: On July 13, 2018, at 2:15 p.m., a review of the facility's emergency preparedness documentation was conducted. It was noticed that there was no documentation to indicate the facility had conducted any emergency preparedness exercises. The facility had no documentation to show that full-scale exercise, an actual emergency event, nor a second full-scale exercise had been conducted. The evaluator conducted an interview with the administrator regarding the facility's emergency	E 039		

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E 039	Continued From page 5 preparedness documentation, specifically for emergency preparedness testing. The administrator stated that the facility was scheduled to conduct an emergency preparedness full-scale exercise in the near future and she would correct the issue as soon as possible.	E 039		
K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2012 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Representing the Department of Public Health: 14041 The following represents the findings of the Department of Public Health during a Life Safety Code Survey. Highest S/S: F	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: NFPA 101, 2012 Edition 7.10.1.2 Exits.	K 293	On July 11, 2018 Maintenance Supervisor contacted Five Star Fire Protection to relocate and replace exit signs. All exit signs will maintain an obvious and clear fire exit direction to the nearest approved fire exit door at all times.	8/17/18

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K 293	Continued From page 6 7.10.1.2.1* Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. 7.10.1.5 Exit Access. 7.10.1.5.1 Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. 7.10.1.8* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted Based on observation and interview, the facility failed to maintain an obvious and clear fire exit direction to the nearest approved fire exit door, at all times. In case of a fire and/or smoke emergency, a fire exit directional sign is imperative for an efficient exit out of the facility for all of the occupants. This is a repeat deficiency from an official Life Safety Code report, dated 8/8/2016. Findings: On July 11, 2018, at 10:00 a.m., the evaluator conducted a tour of the facility and noted that most of the fire exit signs were distinctive with black arrows. The evaluator inspected the corridor near the	K 293	On July 11, 2018 Maintenance Supervisor did another walk through of all exit signs in the facility and found no other exit signs noncompliant. Maintenance Supervisor will conduct monthly walk through of all exit signs to ensure they are all compliant and visible. All trends and negative findings will be communicated monthly to the Quality Assurance committee for review and further plan of action.	

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K 293	Continued From page 7 dining room and Nurse Station 1. The evaluator observed two exit signs over the resident activity/dining room door and upon closer look, saw the yellow arrow. The word "exit" was in white and the arrows were in a pale yellow. The building supervisor confirmed that the dining room was one of the fire exits out of the immediate area. The evaluator inspected the interior patio and observed approximately 12-residents' room sliding doors facing the interior patio. The evaluator stood in the center of the interior patio area and did not see any signs over the doors that would lead to the fire exit access corridor. One of two doors led to the Magnolia Room with a kitchen set up and then the other door led to the Magnolia Dining Room with one long table. The evaluator held an interview with the building supervisor and he stated he would correct the fire exit signs and arrange for addition of 2-fire exit signs for the interior patio as soon as possible. In case of a fire, smoke, or evacuation emergency the fire exit, fire exit directional signs shall be available, distinctive, and indicate or point to the nearest fire exit or exit access at all times.	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. When the approved automatic fire extinguishing	K 321	On July 12, 2018 Maintenance Supervisor installed a doorknob on the door in the air handler area.	8/17/18

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K 321	Continued From page 8 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 ensure the hazardous area located in the basement are maintained with a smoke resisting partitions at all times. The basement is one smoke compartment with the air handler and condenser held in a separate room and door. This deficient practice could result in the spread of smoke during a fire emergency. Findings: On July 11, 2018, at 8:50 a.m., the evaluator conducted an inspection of the Life Safety Code system. The evaluator inspected the basement	K 321	On July 12, 2018 Maintenance Supervisor checked all doors in the facility to ensure that they all had doorknobs. No other doors were found to have no doorknob. Maintenance Supervisor will check all doors monthly to ensure all doors have doorknobs. All trends and negative findings will be communicated monthly to the Quality Assurance committee for review and further plan of action.	

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K 321	Continued From page 9 area which stores the medical records, building supplies, the air duct system, and the air handler/condenser (in a separate area). The evaluator inspected the area and entered the air handler area via a door. The door had no door handle and left a large hole in the door measuring approximately three inches in diameter. The evaluator held an interview with the building supervisor at the time of the observation, and he stated he would replace the missing doorknob as soon as possible.	K 321		8/17/18
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: NFPA 101, 2012 Edition 8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier	K 372	On July 18, 2018 the Maintenance Supervisor replaced the white substance found in the smoke barrier wall with fire barrier sealant. On July 18, 2018 Maintenance Supervisor checked all the other smoke barrier walls and no other wall was found to be noncompliant. Maintenance Supervisor will check all smoke barrier walls annually to make sure fire barrier walls are compliant. Any negative findings will be communicated to the Quality Assurance Committee for review and further plan of action.	

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K 372	Continued From page 10 walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. NFPA 101, 2012 Edition 8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless	K 372		

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K 372	Continued From page 11 otherwise required by Chapters 11 through 43. Based on observation and interview, the facility failed to maintain a fire resistance rating of at least one-half hour by having penetrations through the smoke barrier wall. Penetrations on smoke barrier walls may compromise the integrity of the smoke compartments, thereby, allowing smoke to travel easily between smoke compartments during a fire emergency. The deficiency affected two of three smoke compartments. Findings: On July 12, 2018, the evaluator conducted an inspection of the smoke barrier wall located over the smoke compartment doors near Room 14. The evaluator requested a ladder to be set up near the smoke compartment double doors. The evaluator observed three electrical conduits penetrating the smoke barrier wall and white substance was used as a sealant. The evaluator conducted an interview with the building supervisor and he stated that he just started to work in the facility and had no knowledge of anyone working in the crawl spaces over the smoke barrier wall. The evaluator observed that this was the only available access to check or inspect the smoke barrier walls. In case of a fire or smoke emergency, the smoke barrier construction shall be maintained in optimal condition and the integrity of the barrier shall be fully intact at all times. All repairs, modification, or penetrations into the smoke compartment barrier walls shall be approved or allowed by the	K 372		

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K 372	Continued From page 12 authority having jurisdiction at all times.	K 372		
K 900 SS=D	Health Care Facilities Code - Other CFR(s): NFPA 101 Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: NFPA 70, 2011 Edition II. 600 Volts, Nominal, or Less 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed	K 900	On July 11, 2018 the Maintenance Supervisor removed the 16 intravenous immediately. On July 11, 2018 Maintenance Supervisor did a walk through of entire facility and found no other electrical panels were affected by deficient practice. On July 12, 2018 Administrator in-serviced maintenance department to keep all electrical panels free of any medical equipment. In case of an emergency immediate access to the electrical panels is required at all times.	8/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. BUILDING 01 B. WING _____	07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA HEALTHCARE & WELLNESS CENTRE, LP	415 SOUTH GARFIELD ALHAMBRA, CA 91801

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K 900	Continued From page 13 Table 110.26(A)(1) Working Spaces, Nominal Voltage to Ground Minimum Clear Distance Condition 1 Condition 2 Condition 3 0-150 914 mm (3 ft) 914 mm (3 ft) 914 mm (3 ft) 151-600 914 mm (3 ft) 1.07 m (3 ft 6 in.) Based on observation and interview, the facility failed to ensure the area directly adjacent to the basement main electrical panel was free of medical equipment storage at all times. This affected the basement area. Findings: On July 11, 2018, at 9:00 a.m., the evaluator conducted an inspection of the basement area. The evaluator observed the staff had stored 16 Intravenous poles up against and adjacent to the electrical panels. The evaluator held an interview with the building supervisor and he stated he would have the staff remove the poles as soon as possible. In case of an emergency, immediate access to the electrical panels are required at all times.	K 900	During daily morning rounds Maintenance Supervisor will make sure all electrical panels are free from any equipment. Any noncompliance will be corrected immediately. Any negative findings will be reported monthly to the Quality Assurance Committee for review and further plan of action.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator	K 916		

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K 916	Continued From page 14 A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: NFPA 99, 2012 Edition, 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed Based on observation and interview, the facility	K 916	On Aug 8, 2018 Maintenance Supervisor contacted James Gollner Services, Inc to install annunicator for the generator at the nursing station. A contract was provided on 8/16/18. Installation will be done within 30 days. On Aug 16, James Gollner Services, Inc checked other components of alarm system and found no other areas to be noncompliant. During the monthly load test Maintenance Supervisor will check that remote annunciator is functioning correctly. Any negative findings will be communicated to the Quality Assurance Committee for review and further plan of action.	8/17/18

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K 916	Continued From page 15 failed to ensure the emergency generator was equipped with an alarm annunciator. The deficient practice had the potential for the staff not to be aware of the alarm condition of the emergency power generator, allowing a potentially dangerous situation to happen that could affect the entire facility. Findings: On July 11, 2018, at 9:15 a.m., the evaluator conducted an inspection of the facility and its generator. The evaluator asked to see the generator's remote annunciator. The evaluator held an interview with the building staff and he stated there was no generator remote annunciator available at the time of the survey. In case of a generator initiation, fault, or malfunction, the generator remote annunciator shall alert the staff at all times.	K 916		

California Department of Public Health

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	CA950000101	A. BUILDING: 01 B. WING _____	07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA HEALTHCARE & WELLNESS CEN	415 SOUTH GARFIELD ALHAMBRA, CA 91801

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B5680	T22 DIV5 CH3 ART6-72601(a) Alterations to Existing Buildings or New Cons (a) Alterations to existing buildings licensed as skilled nursing facilities or new construction shall be in conformance with Chapter 1, Division 17, Part 6, Title 24, California Administrative Code and requirements of the State Fire Marshal. This Statute is not met as evidenced by: Based on observation, interview, and document review, the facility failed to contact the Office of Statewide Health Planning and Development (OSHPD), the authority having jurisdiction (AHJ) for alteration and construction work in healthcare facilities regarding a replacement of back up source of power, the generator. The deficient practice placed the residents at risk to their health and safety if the unauthorized alterations were faulty. Findings: On July 12, 2018, at 11:30 a.m., the evaluator conducted an inspection of the Life Safety Code system. The evaluator was going over the emergency back-up generator monthly test documentation and noted that on June 22, 2018, the generator hour meter reading was .8 hours. However, the generator hour meter reading was 292.7 hours on May 31, 2018. The building supervisor was interviewed on the discrepancy of the reading and he stated that the generator overheated and did not start on June 22, 2018. The building supervisor contacted the generator service company who removed the existing generator and installed a temporary generator.	B5680	During weekly testing on June 22, 2018 facility generator did not turn on. Maintenance Supervisor contacted vendor Sweinhart Electric Company. Within 2 hours vendor had back-up generator on site. Back up generator tested weekly and monthly per NFC Code. Documentation available onsite. Maintenance Supervisor will continue to perform weekly testing and monthly load test of the generator. Any negative findings will be communicated to the Quality Assurance Committee monthly for review and further plan of action.	8/17/18

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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B5680	Continued From page 1 At the time of the exit, on July 12, 2018, at 3:00 p.m., the evaluator asked the administrator if she contacted the AHJ regarding the generator's failure and the installation of a temporary generator. The administrator stated it was not necessary because the old generator was removed and the replacement generator was replaced in no more than one hour. The facility did not notify OSHPD to ensure the temporary generator was reviewed and approved.	B5680		