STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555809	A. BUILDING **01** B. WING _____	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINT'S SUBACUTE & TRANSITIONAL CARE	**1652 MONO AVENUE** **SAN LEANDRO, CA 94578**

(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: 31201 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: 31201 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 62	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan	E 004		5/31/22

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

Electronically Signed | 06/12/2022

6/28/22: POC approved by Brian Fenton, SSM-I

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E 004	Continued From page 1 that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain the written emergency preparedness plan (EPP). This was evidenced by the failure to review and update the EPP at least annually. This affected 62 of 62 residents and could result in a delay of response to an emergency. Findings:	E 004	TAG: E004, SS=D Develop EP Plan, Review and Update Annually E004 CFR(s): 483.73(a) Immediate Corrective Action: Administrator reviewed and updated the Emergency preparedness binder including the most recent policies and procedures. In addition, management names and phone contacts were updated.	

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E 004	Continued From page 2 During document review and interview with the Administrator on 5/25/22, the EPP was reviewed. At 12:22 p.m., there was no review/update signature page in the EPP. The document did not indicate the last time the EPP had been reviewed or updated. Upon interview, the Administrator confirmed the finding.	E 004	Date Complete: 5/31/2022 Corrective Action(s): Name and Contact Policy created stating names and contacts must be updated in policy manuals 1 day after date of hire. Date Complete: 5/31/2022 Responsible Person: Administrator Monitoring: The Annual Update and Revision of Policies will take place on 5/31 of every year	
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not	E 039		6/11/22

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E 039	Continued From page 3 accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based	E 039		

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E 039	Continued From page 4 functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise	E 039		

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E 039	Continued From page 5 following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or	E 039		

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E 039	Continued From page 6 and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section	E 039		

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E 039	Continued From page 7 is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 8 community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion,	E 039		

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E 039	Continued From page 9 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039		

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E 039	Continued From page 10 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the 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. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the 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	E 039		

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E 039	Continued From page 11 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to develop and maintain an Emergency Preparedness (EP) training and testing program. This was evidenced by the failure to provide documents to show that they participated in a community-based disaster drill. This affected 62 of 62 residents and could result in an ineffective Emergency Preparedness (EP) plan. Findings: During document review and interview with the Administrator on 5/25/22, the EP plan was reviewed. At 12:29 p.m., the facility failed to provide a full scale, community-based exercise at the time of survey. Upon interview, the Administrator stated that he will have to look into it for he just started working at the facility on 12/2021. The facility was given the opportunity to e-mail the missing documentation on 5/25/22 by 5 pm. On 5/26/22, at 8 a.m., no e-mail was received.	E 039	TAG: E039 SS=D EP Testing Requirements E039 CFR(s): 483.73(d)(2) Immediate Corrective Action: Administrator registered facility to participate in a full-scale exercise that is community-based. This will occur on October 20, 2022. June 11, 2022 Corrective Action(s): Upon Annual review of EPP on May 31 of each year, Administrator is to review and coordinate the renewal of the Full-Scale Community Based Exercise Monitor Administrator will prepare and follow guidelines included in the □California Shakeout□ instructions between June 12, 2022 and October 20, 2022 of each month. These measures will be covered and updated with staff department heads in a	

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E 039	Continued From page 12	E 039	Quality Assurance meeting on the 5th, of each month. Additionally, each month during All Staff Meetings on the last Friday of each month, the Full-Scale Community Based Exercise will be discussed and in serviced to every member of the facilities staff.	
K 000	INITIAL COMMENTS Surveyor: 31201 K3 BUILDING: 02 (North Building) K6 PLAN APPROVAL: 1980 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: TWO STORIES, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 70 Resident Census: 42 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. K3 BUILDING: 02 (Transitional Care Unit	K 000		

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	555809	A. BUILDING **01** B. WING _____	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINT'S SUBACUTE & TRANSITIONAL CARE	**1652 MONO AVENUE** **SAN LEANDRO, CA 94578**

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K 000	Continued From page 13 Building) K6 PLAN APPROVAL: 1980 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Census: 20 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 31201 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded.	K 342		6/10/22

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K 342	Continued From page 14 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the fire alarm system. This was evidenced by a manual pull station and fire alarm control panel that was obstructed and not accessible. This could lead to the delay of notification in the event of an emergency and affected 15 of 62 residents in the North Building and Transitional Care Unit Building. 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 Fire Detection, Alarm, and Communications Systems. 9.6.1* General. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. 9.6.2.7* Each manual fire alarm box on a system shall be accessible, unobstructed, and visible. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 17.14.5 Manual fire alarm boxes shall be installed so that they are conspicuous, unobstructed, and accessible.	K 342	K342 POC for findings #1 - The copier machine was relocated to the side of the nurse station to free access in any emergency issue like fire - The maintenance will ensure nothing will be obstructed to the fire panel. - Maintenance will monitor regularly during daily rounds in the facility - Issues will be discussed in QA meeting K342 POC for findings #2 - The maintenance supervisor removed the cart where pull station located for free access in case of emergency. - Maintenance supervisor will make sure the cart is no longer blocking the pull station	

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K 342	Continued From page 15 Findings: During a tour of the facility and interview with the Maintenance Staff on 5/25/22, the manual pull stations were observed. 1. At 10:28 a.m., on the second floor of the North Building, the fire alarm control panel at the Nursing Station was obstructed by a copier machine stationed directly in front of the fire alarm control panel. Upon interview, the Maintenance Staff confirmed the obstruction of the fire alarm control panel. 2. At 11:06 a.m., in the Transitional Care Unit Building, the manual pull station along the corridor near the Dining/Recreation room was obstructed by a rolling cart. The rolling cart was placed in front of the pull station. Upon interview, the Maintenance Staff confirmed the finding.	K 342		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	K 354		6/10/22

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K 354	Continued From page 16 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain the sprinkler system out-of-service policy. This was evidenced by the absence of specific fire watch 10-hour time information. This could delay the facilities fire response time and fire watch notification. This affected 62 of 62 residents in the North Building and Transitional Care Unit Building. Findings: During document review and interview with the Maintenance Staff and the Administrator on 5/25/22, the documentation for the fire watch policy was requested and reviewed. At 12:19 p.m., the fire watch policy was reviewed. The fire watch policy failed to include the required initiating time procedures for when the sprinkler system is out of service, such as when the sprinkler system is shut down for more than 10 hours in a 24-hour period. Upon interview, the Maintenance Staff and the Administrator confirmed the finding.	K 354	- on June 9th 2022, the Administrator and Maintenance Supervisor reviewed and revised the Fire Watch Policy to include required initiating time procedures for when the sprinkler system is out of service - Fire Watch Policy attached. - Staff in-service about fire watch policy 6.10.22 - QA committee will review Fire Watch Policy once a year.	
K 355 SS=D	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	K 355		6/10/22

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K 355	Continued From page 17 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation, the facility failed to maintain the fire extinguishers. This was evidenced by missing monthly inspections for one fire extinguisher and by one fire extinguisher missing an inspection tag. This affected five of 62 residents in the Transitional Care Unit Building and the North Building, first floor (non resident area). This could result in a malfunction of the portable fire extinguisher. 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 NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguisher, 2010 Edition 7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. 7.2.2 Procedures. Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place	K 355	- The fire extinguisher will be inspected monthly during monthly inspection rounds in all three buildings. - Called the vendor for tag that was missed to put on the extinguisher.	

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K 355	Continued From page 18 (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 7.2.4 Inspection Record Keeping. 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 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. 7.3* Maintenance. 7.3.1 Frequency. 7.3.1.1 All Fire Extinguishers. 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic	K 355		

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K 355	Continued From page 19 notification. 7.3.1.1.2 Fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Findings: During a tour of the facility and interview with the Maintenance Staff on 5/25/22, the fire extinguishers were observed. 1. At 10:06 a.m., in the Transitional Care Unit Building, the fire extinguisher in the Water Heater/Furnace room was observed. There was no inspection during the months of February to May of 2022. Upon interview, the Maintenance Staff confirmed the finding. 2. At 10:42 a.m., on the first floor of the North Building, the inspection tag on a fire extinguisher in the Central Supply Room was missing. Upon interview, the Maintenance Staff confirmed the finding and stated their vendor forgot to attach the inspection tag.	K 355		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		6/10/22

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K 511	Continued From page 20 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain their wiring and electrical equipment. This was evidenced by a light fixture that had no cover. This affected the North Building, first floor (non resident area) and could result in an increased risk of fire and electrical shock. NFPA 101, Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electric Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, National Electrical Code, 1999 Edition 370-25 In completed installations, each box shall have a cover, faceplate, or fixture canopy. 410-12 Outlet Boxes to Be Covered. In a completed installation each outlet box shall be provided with a cover unless covered by means of a fixture canopy, lampholder, receptacle, or similar device. Findings: During a tour of the facility and interview with the Maintenance Staff on 5/25/22, the electrical wiring and equipment was observed. At 10:13 a.m., the light fixture in the Supply closet was observed without a cover. The light fixture	K 511	- The light fixtures in the supply closet was covered. - Maintenance supervisor will check daily and inspect for safety. - Maintenance will ensure that all lights fixed and covered. - Administrator will randomly check during rounds and maintenance supervisor and report to the facility QA	

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K 511	Continued From page 21 was designed to have a cover. Upon interview, the Maintenance Staff confirmed the finding.	K 511		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to ensure that all staff were familiar with procedures during fire drills. This was evidenced by the failure to provide documentation for two of twelve fire drills at least quarterly on each shift. This affected 62 of 62 residents in the North Building and Transitional Care Unit Building. This could result in potential harm, should staff members be untrained and unaware of their roles and responsibilities during a fire. NFPA 101, Life Safety Code, 2012 Edition 19.7* Operating Features. 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care	K 712	- Fire drill documents are requested to the Vendor and received - see attachement - Documentation regarding fire drill - maintenance will monitor record and file - maintenance supervisor will ensure all documents are complete and log - all log will be maintained by the Maintenance supervisor and report to the facility QA	6/10/22

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K 712	Continued From page 22 occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. 19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1. 19.7.1.3 A copy of the plan required by 19.7.1.1 shall be readily available at all times in the telephone operator ' s location or at the security center. 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. 19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and	K 712		

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K 712	Continued From page 23 devices 19.7.2 Procedure in case of fire. 19.7.2.1* Protection of Patients. 19.7.2.1.1 For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. 19.7.2.1.2 The basic response required of staff shall include the following: (1) Removal of all occupants directly involved with the fire emergency (2) Transmission of an appropriate fire alarm signal to warn other building occupants and summon staff (3) Confinement of the effects of the fire by closing doors to isolate the fire area (4) Relocation of patients as detailed in the health care occupancy ' s fire safety plan 19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following: (1) Use of alarms (2) Transmission of alarms to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire 19.7.2.3 Staff Response. 19.7.2.3.1 All health care occupancy personnel	K 712		

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K 712	Continued From page 24 shall be instructed in the use of and response to fire alarms. 19.7.2.3.2 All health care occupancy personnel shall be instructed in the use of the code phrase to ensure transmission of an alarm under any of the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system 19.7.2.3.3 Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Findings: During document review and interview with Staff on 5/25/22, the fire drill documents were reviewed. At 12:10 p.m., the facility failed to provide documentation for two of twelve fire drills at least quarterly on each shift. The facility failed to provide the PM and NOC shift fire drills during the third quarter (July/August/September) of 2021. Upon interview, the Maintenance Staff and Administrator confirmed the finding. The facility was given the opportunity to e-mail the missing documentation on 5/25/22 by 5 pm. On 5/26/22, at 8 a.m., no e-mail was received.	K 712		
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:	K 741		6/10/22

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K 741	Continued From page 25 (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 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: Surveyor: 31201 Based on observation and interview, the facility failed to maintain a non-designated smoking area. This was evidenced by cigarette butts being disposed on the ground. This could result in the increased risk of fire. This affected 15 of 62 residents in the Transitional Care Unit Building. Findings: During a tour of the facility and interview with the	K 741	- We removed the chair and we will put a sign NO SMOKING in this facility. - Maintenance will make daily inspection to make sure people are aware our facility is a non-smoking - inservice provided to all staff that this facility not allowing smoking - Maintenance supervisor will ensure and bring up to QA	

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	555809	A. BUILDING **01** B. WING _____	**05/25/2022**

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K 741	Continued From page 26 Maintenance Staff on 5/25/22, the non-designated smoking area was observed, and staff interviewed. At 9:59 a.m., there were approximately six cigarette butts observed disposed on ground near the exterior to Resident Room 8. Upon interview, the Maintenance Staff confirmed the finding and stated that the area was not their designated smoking area.	K 741		
K 908 SS=E	Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 31201 Based on document review and interview, the facility failed to maintain the compressed gas system piping. This was evidenced by missing annual inspection/testing records. This affected 42 of 62 residents in the North Building. This could result in a malfunction of the flammable gas system piping. NFPA 99, Health Care Facilities Code, 2012 Edition 5.1.3.3.1.9 Central supply systems for oxygen with a total capacity connected and in storage of	K 908	- Maintenance requested an Annual Report inspection for the bulk liquid oxygen received. - Maintenance supervisor will ensure all documents are complete - This issue will be discussed with the Quality Assurance meeting by Administrator and Maintenance supervisor - Airgas record attached.	6/10/22

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K 908	Continued From page 27 566,335 L (20,000 ft3) or more outside of the facility at standard temperature and pressure (STP) shall comply with NFPA 55, Compressed Gases and Cryogenic Fluids Code. NFPA 55, Compressed Gases and Cryogenic Fluids Code, 2010 Edition 7.6.5 Maintenance of Piping Systems. 7.6.5.1 Maintenance of flammable gas system piping and components shall be performed annually by a qualified representative of the equipment owner. Findings: During document review and interview with the Maintenance Staff on 5/25/22, the inspection and testing records for the gas and vacuum piped systems was requested. At 12:01 p.m., the facility failed to provide a current annual records for the bulk liquid oxygen. The last annual was conducted on 2019. Upon interview, the Maintenance Staff confirmed that they do not have a current annual and the last annual was in 2019,	K 908		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced	K 919		6/10/22

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K 919	Continued From page 28 by: Surveyor: 31201 Based on observation and interview, the facility failed to maintain the electrical system and its components. This was evidenced by an obstructed electrical panel. This affected 19 of 62 residents in the North Building and could result in an increased risk of an electrical fire. NFPA 101 Life Safety Code, 2012 edition 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70 National Electrical Code, 2011 edition 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 919	- The copier machine was moved and relocated to the side of the Nurse Station counter for free access in case of emergency. - The facility will ensure nothing is obstructed to electrical panel. - Maintenance supervisor will ensure to monitor regular during daily round. - Issues will be discussed with the facility QA meeting	

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K 919	Continued From page 29 (2) Width of Working Space. The width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90 degree opening of equipment doors or hinged panels. Findings: During a tour of the facility and interview with the Maintenance Staff on 4/25/22, the electrical system and its components were observed. At 10:28 a.m., on the second floor, the electrical panel in the Nursing Sation was observed. The electrical panel was obstructed by a copier machine stationed directly in front of the electrical panel. Upon interview, the Maintenance Staff confirmed the finding.	K 919		