POC ACCEPTABLE 7/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555832	A. BUILDING _____ B. WING 16279	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA BALDWIN STOCKER HOME	527 S VALINDA AVENUE WEST COVINA, CA 91790

(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 findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility was not in substantial compliance with 42 CFR 483.73, Requirement for LTC Facilities. Representing the Department of Public Health: Evaluator ID #16279, REHS, HFE I Evaluator ID #43230, REHS, HFE I	E 000	This Plan of Correction (POC) constitutes the facility's credible allegation of compliance. " Clara Baldwin Stocker Home, hereinafter, "CBSH" makes its best effort to operate in full compliance with both Federal and State Laws. Nothing included in this POC is an admission otherwise. CBSH has submitted this POC in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that CBSH may contest the merits and /or form of any of the deficiency findings alleged below.	
E 041 SS=F	Highest Severity & Scope: F Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1)	E 041	**E 041 HOSPITAL CAH and LTC EMERGENCY POWER** ***How corrective actions will be accomplished*** The Facility Emergency Power Policy including the Fire Watch Policy was revised and updated by the Administrator on 5/13/2021 to include the name of gas stations and addresses and the procedure to maintain an onsite fuel source to power emergency generators.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lou Diorio — TITLE: Administrator — (X6) DATE: 6/14/21

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.

Not Accepted
Item

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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD	E 041	The Administrator gave In-service training to the Maintenance Supervisor on 5/13/2021 on the revised and updated Policy and Procedure on Emergency Power Policy / Fire Watch Policy. ***How the facility will identify*** The Administrator and the Maintenance Supervisor reviewed the Policy and Procedure on Emergency Preparedness to see what other areas are affected by the same deficient practice. So far, everything else is in place. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** The Facility will maintain 55 gallons of diesel fuel on the premises at all times. In the event the fuel is depleted the Maintenance Supervisor or Designee will obtain additional diesel from the "76" gas Station located at 105 S. Vincent Avenue, West Covina, CA or the alternate "Chevron" located at 206 N. Vincent. Maintenance Supervisor will maintain a log book to indicate the amount of fuel on hand, receipts of fuel purchases, receipts of refill of generator tank. MS will follow the procedure on the revised and updated Policy and Procedure.	

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E 041	Continued From page 2 or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041	***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system*** The Maintenance Supervisor will report the Diesel Fuel Maintenance to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.*** 6/15/2021	

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E 041	Continued From page 3 Based on interview and record review, the facility failed to implement it's emergency preparedness policy with regard to maintaining the emergency power system. The facility's emergency generator policy indicated that the facility would maintain the emergency generator in proper working order, in case of an emergency. However, the policy did not indicate how the fuel would be maintained to keep the generator running. The lack of maintaining the emergency generator could affect the care and services and/or cause harm to the occupants, during an actual emergency. Findings: On May 12, 2021, at 10:55 am, an interview was conducted with the maintenance supervisor regarding the facility's emergency generator. During this interview, the maintenance supervisor stated that if the generator's fuel started to run low, he would get the 5-gallon container (for gas), go to the nearest gas station down the street, purchase the fuel, and refill the generator's tank. At 1:05 pm, a review of the facility's emergency preparedness documentation was conducted. It was noted that the facility's emergency power policy did not indicate how the generator's fuel would be maintained, if the fuel was running low. On May 12, 2021, at 3:30 pm, an interview was conducted with the administrator and the maintenance supervisor regarding maintaining the generator's fuel level, if it started running low. It was mentioned that the facility did not have any documentation to showed that the facility would	E 041		

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E 041	Continued From page 4 go to the nearest gas station, purchase the fuel to refill the generator's tank. At the end of the interview, the administrator stated she would revise the emergency preparedness policy to indicate the procedure.	E 041		

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K 000	INITIAL COMMENTS This facility was surveyed under 42 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following reflects the findings of the California Department of Public Health during the Life Safety Code Recertification Survey. Representing the Department of Public Health: Evaluator ID #16279, REHS, HFE I Evaluator ID #43230, REHS, HFE I Resident census: 19 Bed capacity: 48 Highest Severity & Scope: F	K 000	This Plan of Correction (POC) constitutes the facility's credible allegation of compliance. " Clara Baldwin Stocker Home, hereinafter, "CBSH" makes its best effort to operate in full compliance with both Federal and State Laws. Nothing included in this POC is an admission otherwise. CBSH has submitted this POC in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that CBSH may contest the merits and /or form of any of the deficiency findings alleged below.	
K 293 SS=F	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: Based on observation, interview and record review, the facility failed to provide documentation	K 293	**K 293 EXIT SIGNAGE** ***Corrective actions*** The Administrator gave an In-service Training to Maintenance Department on Monthly Checking of the Exit Signages on 5/13/2021. Administrator created a Log to be used and maintained by the Maintenance Supervisor (MS). All batteries of all Exit Lighting Fixtures in the building were tested on 5/13/2021 by the MS and were logged in the Maintenance Book entitled Exit Signage Monthly Battery Check .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lori Mirzayo — TITLE: Administrator — (X6) DATE: 6/14/21

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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K 293	Continued From page 1 that the facility's battery-operated exit lighting fixtures were tested and maintained on a monthly basis. The periodic testing of the battery-operated exit lighting fixtures will ensure that they will be functioning properly, in the event of a fire emergency. Findings: On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, it was observed that there were 13 exit lighting fixtures throughout the facility. At 1:05 pm, a review of the facility's fire inspection reports and documentation was conducted. During this review, it was noticed that there was no documentation to show that the exit lighting fixtures were tested and maintained on a monthly basis. According to NFPA 101, 2012 Edition, Life Safety Code Handbook, 7.10.9 Testing and Maintenance 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 and exits 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. At 3:30 pm, an interview was conducted with the administrator and maintenance supervisor regarding the exit lighting fixtures. During this interview, the maintenance supervisor was	K 293	***How the facility will identify*** The Administrator and the Maintenance Supervisor visited all the Exit Signages in the facility on 5/13/21, these were all tested and logged in the Exit Signage Monthly Battery Check. ***What measures will be put into place or what systemic changes*** A Battery Check for Exit lighting Fixtures will be conducted by the Maintenance Supervisor or Designee on a monthly basis and record the date on which the test was done in the log. Testing and Maintenance Exit Signs shall be inspected for operation of the illumination sources and periodically monitored every month. ***How the facility plans to monitor its performance*** The Maintenance Supervisor will report the Exit Signages Monthly Battery Check to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	

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K 293	Continued From page 2 informed that the exit lighting fixtures should be inspected, tested and maintained on a monthly basis. At the end of the interview, the maintenance supervisor stated that he would test the exit lighting fixtures and record it on a monthly log. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 293		
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a Class A, B, or C flame spread rating finish of walls by having penetrations at three areas, thereby compromising the fire rated surfaces. In the event of a fire, the separation of these areas would not be achieved because	K 331	**K 331 INTERIOR WALL AND CEILING FINISH** ***Corrective actions*** The three (3) inch penetrations under the countertop inside Station 2 Employee Lounge were sealed with an approved fire retardant sealant on 5/12/2021 by the Maintenance Supervisor. The two 1 and ½ inch penetrations inside Station 1's Medication Room were sealed with an approved fire retardant sealant on 5/12/2021 by the Maintenance Supervisor. The 1 inch penetration in the Radio Room was sealed with an approved fire retardant sealant on 5/12/2021 by the Maintenance Supervisor.	

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K 331	Continued From page 3 these penetrations would allow smoke and/or fire to travel from one area to another. Findings: On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following was observed: 1. At 10:03 am, there were two 3-inch penetrations which extended through one wall (with 1-inch water pipes going through each penetration) under the countertop, inside Station 2's employee lounge. 2. At 10:35 a.m., there were two 1-and-1/2-inch penetrations which extended through two walls (with four computer cables going through), inside Station 1's medication room. 3. At 10:42 am, there was a 1-inch penetration which extended through one wall (with four computer cables going through), inside the "radio" closet, near Station 1. During this LSC tour, the maintenance supervisor stated that he understood that these penetrations must be sealed to prevent the possibility of fire and/or smoke from spreading. At the end of the interview, the maintenance supervisor added that he would seal these penetrations with an approved fire retardant sealant, immediately. The deficient practice affected two of five smoke	K 331	***How the facility will identify*** During his daily rounds the Maintenance Supervisor will make visual inspections on the Interior Wall and Ceilings and will seal every identified penetrations using an approved Fire Retardant Seal. ***What measures will be put into place*** All Staff are instructed to report to Administrator and to the Maintenance Supervisor any identified penetration in the Interior Wall and Celings to prevent the possibility of fire and/or smoke from spreading. The Maintenance Department will continue Visual Inspections daily for any penetration in the interior walls and ceiling and will immediately seal with an Approved Fire Retardant Seal when identified. ***How the facility plans to monitor*** The Maintenance Supervisor will report Summary of Sealed Penetrations to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	

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K 331	Continued From page 4 compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 331		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the fire alarm system goes out of service for more than 4 hours in a 24-hour period. In the event the fire alarm system goes out of service, a fire watch policy would assist with the appropriate emergency procedures to be implemented. Findings: On May 12, 2021, at 1:05 pm, a review of the facility's fire watch policy and procedure was conducted. The policy stated that the facility would notify the fire department. It was noticed that this policy did not state that the facility would notify the authority having jurisdiction (AHJ) when the fire alarm system is out of service for more	K 346	**K 346 FIRE ALARM SYSTEM – OUT OF SERVICE** ***Corrective actions*** The Fire Watch Policy was updated to include detailed procedures and the proper notification of the Department of Health when a Fire Watch exceeds 4 hours on 5/12/2021 by the Administrator. ***How the facility will identify*** A copy of the Updated Policy is now included in the Fire Watch Policy and Procedure Binder. ***What measures will be put into place*** During Monthly Mandatory In-service Meeting of All Staff, the Administrator or Designee will include a brief discussion on Fire Watch including proper notification of the Department of Health when a Fire Watch exceeds 4 hours.	

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K 346	Continued From page 5 than 4 hours in a 24-hour period. At 3:30 pm, an interview was conducted with the administrator and the maintenance supervisor regarding this fire watch policy and procedure. It was pointed out that there were no detailed procedures, regarding the fire watch being implemented after the fire alarm system goes out of service for more than 4 hours in a 24-hour period, and to notify the AHJ. The administrator stated that the fire watch policy would be revised. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 346	***How the facility plans to monitor*** The Maintenance Supervisor will report Summary of Any Fire Alarm Watch to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351	**K 351 SPRINKLER SYSTEM - INSTALLATION** ***Corrective actions*** The 10 Candy Packages stored in the Social Service Department's Closet 5 inches from the deflector were immediately removed on 5/12/2021 by the Maintenance Supervisor. The three packages of clean towels in the linen Closet on the top shelf at 6 inches from the deflector were immediately removed on 5/12/2021 by the Maintenance Supervisor.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 6 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure and maintain 18-inch clearances below the sprinkler deflectors in storage areas throughout the facility. Unobstructed areas below the sprinkler deflectors will ensure an effective response of the fire sprinklers to provide water discharge in a horizontal plane and will function as designed, in case of fire emergencies. Findings: On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following was observed: 1. At 10:15 am, there was 10 candy packages (of various sizes) stored on the top shelf, inside the social services office closet. These packages were 5 inches from the deflector. 2. At 10:20 am, there were three packages of clean towels (measuring 10 inches by 14 inches by 14 inches each) stored on the top shelf, inside the clean linen closet (by Room 20). These packages were 6 inches from the deflector. 3. At 10:45 am, there was one cardboard box	K 351	A cardboard box stored on the top shelf inside the Central Supply Closet which was 8 inches from the deflector was immediately removed on 5/12/2021 by the Maintenance Supervisor. The 4 packages of Styrofoam cups in the dietary storage room on the top shelf which were 12 inches from the deflector were immediately removed on 5/12/2021 by the Maintenance Supervisor. The ten cardboard boxes stored on the top shelf at 7 inches from the deflector of the PPE Storage Closet were immediately removed on 5/12/2021 by the Maintenance Supervisor. An In-service was given by the Administrator to Department Heads and Central Supply on 5/14/2021 on Standards for Installation of Sprinkler Systems. ***How the facility will identify*** In the late afternoon of 5/12/2021 all Department Heads inspected their own units for items stored closer to 18-inch clearances below the sprinkler deflector and removed them all after which the Administrator and Maintenance Supervisor found no more storage is affected by the deficient practice.	

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	555832	A. BUILDING A1 - CLARA BALDWIN STOCKER HOME B. WING _____	05/12/2021

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K 351	Continued From page 7 (measuring 10 inches by 16 inches by 18 inches) stored on the top shelf, inside the central supply closet (by Room 12). This box was 8 inches from the deflector. 4. At 10:55 am, there were four packages of Styrofoam cups (measuring 4 inches by 30 inches) stored on the top shelf, inside the dietary storage room (across from the kitchen). These packages were 12 inches from the deflector. 5. At 10:57 am, there were ten cardboard boxes (measuring 8 inches by 8 inches by 10 inches) stored on the top shelf, inside the PPE storage closet. These boxes were 7 inches from the deflector. During the LSC tour, the maintenance supervisor was informed that there should be an 18-inch clearance between the deflectors and the nearest objects. The maintenance supervisor stated these items would be removed, immediately. At 1:40 pm, a review of the facility's fire prevention check list indicated that sprinkler heads should be unobstructed with an 18-inch clearance required for all areas of storage. The deficient practice affected four of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 351	***What measures will be put into place*** Maintenance Supervisor will make daily Visual Checks for any items stored within the 18-inch clearance below the Sprinkler Deflector and will remove when found. All Department Heads will comply with the Standards for Installation of Sprinkler System. ***How the facility plans to monitor*** The Maintenance Supervisor will report Summary of Noncompliance with the Standards of Sprinkler System to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101	K 354		

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K 354	Continued From page 8 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) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the automatic sprinkler system goes out of service for more than 10 hours in a 24-hour period. In the event the automatic sprinkler system goes out of service, a fire watch policy would assist with the appropriate emergency procedures to be implemented. Findings: On May 12, 2021, at 1:05 pm, a review of the facility's fire watch policy and procedure was conducted. The policy stated that the facility would notify the fire department. It was noticed that this policy did not state that the facility would notify the authority having jurisdiction (AHJ) when the automatic sprinkler system goes out of service for more than 10 hours in a 24 hour	K 354	**K 354 SPRINKLER SYSTEM – OUT OF SERVICE** ***Corrective actions*** The Fire Watch Policy was updated by the Administrator on 5/12/2021 to include notification to the Fire Department having jurisdiction when the sprinkler system goes out of service for more than 10 hours in a 24-hour period. ***How the facility will identify*** A copy of the updated Policy is now included in the Fire Watch Policy and Procedure Binder. ***What measures will be put into place*** During the Monthly Mandatory In-service Meeting of All Staff, the Administrator or Designee will include a brief discussion on Automatic Sprinkler System including proper notification of the Fire Department when the sprinkler system goes out of service for more than 10 hours in a 24-hour period.	

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K 354	Continued From page 9 period (as indicated in NFPA 25, Standard for the Inspection, Testing and Maintenance of the Water-Based Fire Protection Systems). At 3:30 pm, an interview was conducted with the administrator and the maintenance supervisor regarding this fire watch policy and procedure. It was pointed out that there were no detailed procedures, regarding the fire watch being implemented after the automatic sprinkler system goes out of service for more than 10 hours in a 24-hour period, and to notify the AHJ. The administrator stated that the fire watch policy would be revised. The deficient practice affected five of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 354	***How the facility plans to monitor*** The Maintenance Supervisor will report Summary of Any Out- of- Service of Sprinkler System to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced	K 912	**K 912 ELECTRICAL SYSTEMS - RECEPTACLES** ***Corrective actions*** Room 6's Power Receptacle was removed by Maintenance Supervisor on 5/12/2021. ***How the facility will identify*** Out of 26 sinks in 26 resident bathrooms throughout the facility. No other receptacle was found having affected by the same deficient practice.	

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K 912	Continued From page 10 by: Based on observation and interview, the facility failed to ensure that the electrical power outlets, near resident bathrooms sinks, were ground-fault circuit interrupters (GFCI) protection. In the event that water accidentally entered one of twenty-six electrical power outlets, the residents or staff could sustain an electric shock hazard. GFCIs prevent the possibility of serious harm to residents and staff from any electric shock hazards. Findings: On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, it was observed that there were 26 sinks in 26 resident bathrooms throughout the facility. At 10:50 am, upon entering Room 6, it was observed that there was a bathroom sink in the residents' room, next to the door. Closer observation showed that there was an electrical power receptacle, 10 inches above the sink. This electrical power receptacle was not GFCI. (GFCIs are wall-mounted electrical receptacles with devices that instantly disconnect an electric circuit to prevent the possibility of serious harm from an electric shock.). During the LSC tour, an interview was conducted with the maintenance supervisor regarding the electrical power receptacle above the residents' bathroom sinks. It was pointed out that the electrical power receptacle was not a GFCI, in	K 912	***What measures will be put into place*** Maintenance Supervisor and Designee will make daily visual rounds to see any noncompliant electrical receptacle in residents' rooms and consequently remove them. ***How the facility plans to monitor*** The Maintenance Supervisor will report Summary of Any out- of- compliant electrical receptacles to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	

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K 912	Continued From page 11 Room 6, and could potentially harm a resident, staff or visitor. The maintenance supervisor stated he would correct this electrical power receptacle, immediately. The deficient practice affected one of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 912		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920	**K 920 ELECTRICAL EQUIPMENT- POWER CORDS AND EXTENSIONS** ***Corrective actions*** All electrical equipments in the Medical Records that were plugged into adapters and secondary power strips were removed by the Maintenance Supervisor immediately on 5/12/2021. ***How the facility will identify*** No other electrical equipments found having affected by the same deficient practice. ***What measures will be put into place*** Maintenance Supervisor and Designee will make daily visual rounds to see any noncompliant electrical receptacle in residents' rooms and consequently	

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K 920	Continued From page 12 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to plug electrical equipment directly into electrical outlets without the use of domestic electrical extension cords. The use of domestic electrical extension cords could create the possibility of an electrical overload and/or possible fire. In addition, electrical extension cords are not to be substituted for fixed electrical wiring of a structure. Findings: On May 12, 2021, between 8:30 am and 11:25 am, the evaluators and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 9:50 am, upon entering the medical records office, the following was observed: 1. a microwave oven was plugged into one power strip, that was plugged into a second power strip, which was plugged into an electrical wall outlet, 2. a computer, a monitor and a printer were plugged into a power strip, that was plugged into a 6-prong adaptor, which was plugged into an electrical wall outlet, and 3. a radio and an electric fan were plugged into a domestic extension cord, that was plugged into a power strip, which was plugged into an electrical wall outlet.	K 920	remove them. All electrical equipment are only plugged directly into the electrical outlet without the use of domestic electrical extension cords. Extension cords are not used as a substitute for fixed wiring of a structure. ***How the facility plans to monitor*** The Maintenance Supervisor will report Summary of Any out- of- compliant electrical equipment to the QAPI Committee during monthly meeting for resolution and recommendation for three (3) months or until resolved. ***Include dates when corrective action will be completed*** 6/15/2021	

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K 920	Continued From page 13 During this LSC tour, an interview was conducted with the maintenance supervisor regarding these electrical problems. It was mentioned that the use of power strips plugged into other power strips or the use of domestic electrical extension cords, and power strips plugged into adaptors were an unapproved practice and could lead to a fire. At the end of the interview, the maintenance supervisor stated he would correct these problems, immediately. The deficient practice affected one of five smoke compartments. On May 12, 2021, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 920		