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

PRINTED: 01/20/2022
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055855 | A. BUILDING 02<br>B. WING _____ | 01/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARDEN POST ACUTE REHAB | 3400 ALTA ARDEN EXPRESSWAY<br>SACRAMENTO, CA 95825 |

| (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<br><br>Surveyor: 43379<br><br>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.<br><br>Representing the California Department of Public Health: 43379<br><br>The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. | E 000 | RECEIVED<br>By LSC at 11:47 am, Feb 09, 2022 | |
| E 018 SS=D | Census = 103<br>Procedures for Tracking of Staff and Patients<br>CFR(s): 483.73(b)(2)<br><br>§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the | E 018 | E018<br>1. The facility will track the location of on duty staff utilizing the tracking sheet, sign in sheet and schedule. Each department managers will know the location of each employee in their dept.<br>2. No residents were affected by this deficient practice.<br>3. The Administrator in-serviced department managers on 2/3/22 informing them of this responsibility. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Das | TITLE: Administrator | (X6) DATE: 2/9/22

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.

2/9/22 Accepted by Cynthia Luc

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| E 018 | Continued From page 1<br>policies and procedures must address the following:]<br><br>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.<br><br>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.<br><br>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.<br>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.<br>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. | E 018 | 4. The Administrator will notify the QAPI committee of any issues or trends on a quarterly basis.<br>5. This will be accomplished by 2/11/22. | |

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| E 018 | Continued From page 2<br><br>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.<br><br>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide the policy and procedure for tracking of on-duty staff during an emergency. This affected 103 of 103 residents, and could result in an ineffective (EP) plan.<br><br>Finding(s):<br><br>During document review and interview with the Director of Environmental Services on 1/18/22, the EP policies and procedures were requested and reviewed. | E 018 | | |

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| E 018 | Continued From page 3<br>At 12:20 p.m., there was no policy and procedure for tracking of on-duty staff during an emergency documented as part of the facility's EP. Upon interview, the Director of Environmental Services confirmed the finding. | E 018 | E030<br>1. The emergency plan was updated with the list of current staff and contact information on 1/31/22.<br>2. No residents were affected by this deficient practice.<br>3. The Administrator will in-service the receptionist to make changes or additions as needed to maintain a current list.<br>4. The Administrator will notify the QAPI committee of any issues or trends on a quarterly basis.<br>5. This was accomplished on 2/7/22. | |
| E 030 SS=D | Names and Contact Information<br>CFR(s): 483.73(c)(1)<br><br>§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).<br><br>[(c) The [facility 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 every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]<br><br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [facilities].<br>(v) Volunteers.<br><br>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement. | E 030 | | |

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| E 030 | Continued From page 4<br>(iii) Patients' physicians<br>(iv) Other [hospitals and CAHs].<br>(v) Volunteers.<br><br>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Next of kin, guardian, or custodian.<br>(iv) Other RNHCIs.<br>(v) Volunteers.<br><br>*[For ASCs at §416.45(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For Hospices at §418.113(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Hospice employees.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Other hospices.<br><br>*[For HHAs at §484.102(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following: | E 030 | | |

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| E 030 | Continued From page 5<br>(I) Staff.<br>(II) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For OPOs at §486.360(c):] The communication plan must include all of the following:<br>(2) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Volunteers.<br>(iv) Other OPOs.<br>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) Plan. This was evidenced by failure to provide a communication plan that included current contact information for all staff. This could result in delayed notification to staff in the event of an emergency, and affected 103 of 103 residents.<br><br>Finding(s):<br><br>During document review and interview with the Director of Environmental Services on 1/18/22, the EP communication plan was requested and reviewed.<br><br>At 12:22 p.m., a review of the facility's EP plan revealed that the facility's communication plan failed to include the names and contact information for all current staff. Upon interview, the Director of Environmental Services confirmed | E 030 | | |

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| E 030 | Continued From page 6<br>the finding. | E 030 | | |
| E 031<br>SS=D | Emergency Officials Contact Information<br>CFR(s): 483.73(c)(2)<br><br>§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).<br><br>[(c) The [facility] 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 every 2 years [annually for LTC facilities]. The communication plan must include all of the following:<br><br>(2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br><br>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) The State Licensing and Certification Agency.<br>(iii) The Office of the State Long-Term Care Ombudsman.<br>(iv) Other sources of assistance.<br><br>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance. | E 031 | E031<br>1. The ombudsman was added to the emergency plan for federal state and local emergency preparedness on 2/3/22.<br>2. No residents were affected by this deficient practice.<br>3. The regional will in-service the Administrator of need of ombudsman to be included in the emergency plan.<br>4. The Administrator will notify the QAPI committee of any issues or trends on a quarterly basis.<br>5. This was accomplished on 2/3/22. | |

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| | 055865 | A. BUILDING 02<br>B. WING _____ | 01/18/2022 |

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| E 031 | Continued From page 7<br>(iii) The State Licensing and Certification Agency.<br>(iv) The State Protection and Advocacy Agency.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) Plan. This was evidenced by the failure to provide a communication plan that included current contact information for all required state emergency officials. This could result in the lack of notification to state officials in the event of an emergency, and affected 103 of 103 residents.<br><br>Finding(s):<br><br>During document review and interview with the Director of Environmental Services on 1/18/22, the EP communication plan was requested and reviewed.<br><br>At 12:24 p.m., a review of the facility's EP plan revealed that the Office of the State Long-Term Ombudsman and the local State Survey Agency contact information were missing from the EP Plan. Upon interview, the Director of Environmental Services confirmed the finding and stated that it was an oversight. | E 031 | | |
| E 032 SS=D | Primary/Alternate Means for Communication<br>CFR(s): 483.73(c)(3)<br><br>§403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). | E 032 | E032<br>1. The hand radio was removed from the emergency plan as an | |

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| E 032 | Continued From page 8<br><br>[(c) The [facility] 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 every 2 years [annually for LTC facilities]. The communication plan must include all of the following:<br><br>(3) Primary and alternate means for communicating with the following:<br>(i) [Facility] staff.<br>(ii) Federal, State, tribal, regional, and local emergency management agencies.<br><br>*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide an updated communications plan. This affected 103 of 103 residents, and could result in ineffective emergency planning.<br><br>Finding(s):<br><br>During document review and interview with the Director of Environmental Services on 1/18/2022, the EP communication plan was requested and reviewed.<br><br>At 12:30 p.m., a review of the communication plan revealed that an amateur HAM radio was itemized as an alternate means of | E 032 | alternate means of communication on 2/3/22.<br>2. No residents were affected by this deficient practice.<br>3. The regional will in-service the Administrator to list current forms of communications used.<br>4. The Administrator will notify the QAPI committee of any issues or trends on a quarterly basis.<br>5. This was accomplished on 2/3/22. | |

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| E 032 | Continued From page 9<br>communication. Upon interview, the the Director of Environmental Services stated that the facility does not use an amateur HAM radio as a secondary means of communication. The Administrator confirmed that the language was left over from the original template, and was not modified to reflect the facilities current alternate means of communication. | E 032 | | |
| K 000 | INITIAL COMMENTS<br><br>Surveyor: 43379<br>K3 BUILDING: 01<br>K6 PLAN APPROVAL: 4/23/2018<br>K7 SURVEY UNDER: 2012 EXISTING<br><br>STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED.<br><br>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.<br><br>Representing the California Department of Public Health: 43379<br><br>The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.<br><br>Census = 103 | K 000 | | |
| K 232 SS=D | Aisle, Corridor, or Ramp Width<br>CFR(s): NFPA 101 | K 232 | | |

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| K 232 | Continued From page 10<br><br>Aisle, Corridor or Ramp Width<br>2012 EXISTING<br>The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.<br>19.2.3.4, 19.2.3.5<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on observation and interview, the facility failed to maintain the corridors free of obstructions . This was evidenced by wheeled equipment obstructing the corridor. This affected two of nine smoke compartments and could result in delayed egress in the event of an emergency.<br><br>NFPA 101 Life Safety Code, 2012 edition<br><br>19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:<br><br>(1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.<br><br>(2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. | K 232 | K232<br>1. One of the wheelchairs was moved to ensure there was enough space in the hallway and items were only on one side of the hallway on 1/18/22.<br>2. The Maintenance Director did rounds in the facility on 1/19/22 to ensure there was only one side of the hallway that had wheelchairs or other items.<br>3. DON or designee will in-service staff to make sure that only one side of the corridor had wheelchairs or other items.<br>4. The Maintenance Director will monitor monthly and review any concerns with the QAPI committee on a quarterly basis for recommendations and or follow up.<br>5. This will be accomplished by 2/15/22. | |

PRINTED: 01/20/2022
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OMB NO. 0938-0391

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|---|---|---|---|
| | 056855 | A. BUILDING 02 B. WING | 01/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARDEN POST ACUTE REHAB | 3400 ALTA ARDEN EXPRESSWAY SACRAMENTO, CA 95825 |

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| K 232 | Continued From page 11<br>(3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.<br><br>(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:<br><br>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).<br>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled<br>equipment during a fire or similar emergency.<br>(c)*The wheeled equipment is limited to the following:<br><br>i. Equipment in use and carts in use<br>ii. Medical emergency equipment not in use<br>iii. Patient lift and transport equipment<br><br>Findings:<br><br>During a tour of the facility and interview with the Director of Environmental Services on 1/18/22, the corridors were observed.<br><br>1. At 9:30 a.m., two wheel chairs were observed on opposite sides of the corridor next to the conference room, reducing the eight foot corridor width to approximately 32 inches. Upon interview, the Director of Environmental Services confirmed the finding and stated that it was an oversight.<br><br>2. At 9:57 a.m., two wheel chairs were observed on opposite sides of the corridor next to Resident Room 212, reducing the eight foot corridor width to approximately 23 inches. Upon interview, the | K 232 | | |

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| K 232 | Continued From page 12<br>Director of Environmental Services confirmed the finding and stated that it was an oversight. | K 232 | | |
| K 291 SS=D | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on observation and interview, the facility failed to maintain the emergency lights. This was evidenced by an emergency light that failed to remain illuminated when tested. This affected one of nine smoke compartments and could result in delayed egress in the event of an emergency.<br><br>Findings:<br><br>During a tour of the facility and interview with the Maintenance Director on 1/18/22, the emergency lights were observed and tested.<br><br>At 10:22 a.m., the emergency light in the Boiler Room failed to remain illuminated when tested. Upon interview, the Maintenance Director confirmed the finding and stated that the batteries needed to be replaced. | K 291 | K291<br>1. The emergency light was replaced on 1/18/22 by the Maintenance Director.<br>2. The Maintenance Director did rounds and reviewed all emergency lights to ensure all were in working order on 1/18/22. There were no other emergency lights affected.<br>3. The Administrator or designee will conduct an in-service with the Maintenance Director regarding the importance of making sure all emergency lights are in working order.<br>The Maintenance Director or designee will review the emergency lighting on a weekly basis to validate they are in functioning order.<br>4. The Maintenance Director will report findings to the QAPI committee on a quarterly basis for further recommendations and follow up.<br>5. This will be completed by 2/15/22. | |
| K 363 SS=E | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core | K 363 | | |

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| K 363 | Continued From page 13<br>wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by corridor doors that failed to latch when tested and were obstructed from closing. | K 363 | K363<br>1. The Maintenance Director will repair the door of the MDS office so it will properly latch by 2/15/22.<br>The Maintenance Director removed the wedge under the copy machine room door on 1/18/22.<br>The Maintenance Director will repair the door of the Beauty Shop so it would properly latch by 2/15/22.<br>The bed in room 212 was moved so it did not obstruct the door from closing on 1/18/22.<br>The Maintenance Director will repair the door of the Activity Department so it would properly latch by 2/15/22.<br>The Maintenance Director removed the wedge under the Utility Room door on 1/18/22.<br>The Maintenance Director removed the wedge under the folding room door on 1/18/22 and will repair the door so it would properly latch by 2/15/22.<br>The maintenance Director removed the wedge under the employee break room door on 1/18/22. | |

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| | 056865 | A. BUILDING 02<br>B. WING | 01/18/2022 |

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| K 363 | Continued From page 14<br>This could result in the passage of smoke in the event of a fire, and affected four of nine smoke compartments.<br><br>NFPA 101, Life Safety Code, 2012 Edition.<br><br>19.3.6.3.10* Doors shall not be held open by devices other than those that release when the door is pushed or pulled.<br><br>Findings:<br><br>During a tour of the facility and interview with the Director of Environmental Services on 1/18/22, the corridor doors were observed.<br><br>1. At 9:08 a.m., the corridor door with a self-closing device to the Material Data Set (MDS) Office failed to latch when allowed to self-close. The door was tested three times and failed to latch on all three occasions. Upon interview, the Director of Environmental Services confirmed the finding and stated that the self-closing device needed to be adjusted to allow sufficient closing force to close and latch the corridor door.<br><br>2. At 9:13 a.m., the corridor door to the Copy Machine room was obstructed from closing by a rubber wedge. Upon interview, the Director of Environmental Services confirmed the finding.<br><br>3. At 9:28 a.m., the corridor door with a self-closing device to the Beauty Shop failed to latch when allowed to self-close. The door was tested three times and failed to latch on all three occasions. Upon interview, the Director of Environmental Services confirmed the finding and stated that the self-closing device needed to be | K 363 | 2. The Maintenance Director checked the doors in the facility to ensure all other were self closing and latched on 2/19/22.<br>The Maintenance Director checked all doors in the facility to ensure there were no wedges under the doors to prevent them from closing on 1/19/22.<br>3. The Administrator will conducted an in-service with staff by 2/15/22 to ensure all were aware not to use wedge to prop open the doors.<br>The Administrator will conduct an in-service with the maintenance director by 2/15/22 to ensure he is checking the door for self closure.<br>4. The Administrator will report trends and/or concerns to the QAPI Committee for further recommendations and or follow up. | |

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| K 363 | Continued From page 15<br>adjusted to allow sufficient closing force to close and latch the corridor door.<br><br>4. At 9:47 a.m., the corridor door to Resident Room 212 was obstructed from closing by the foot of Bed B, which created a gap of approximately 32 inches. Upon interview, the Director of Environmental Services confirmed the finding.<br><br>5. At 10:11 a.m., the corridor door with a self-closing device to the Activities Department failed to latch when allowed to self-close. The door was tested three times and failed to latch on all three occasions. Upon interview, the Director of Environmental Services confirmed the finding and stated that the self-closing device needed to be adjusted to allow sufficient closing force to close and latch the corridor door.<br><br>6. At 10:31 a.m., the corridor door to the Utility Closet was obstructed from closing by a rubber wedge. Upon interview, the Director of Environmental Services confirmed the finding.<br><br>7. At 10:33 a.m., the corridor door to the folding room was obstructed from closing by a rubber wedge and the door failed to latch when allowed to self-close. The door was tested three times and failed to latch on all three occasions. Upon interview, the Director of Environmental Services confirmed the finding and stated that the self-closing device needed to be adjusted to allow sufficient closing force to close and latch the corridor door.<br><br>8. At 10:41 a.m., the corridor door to the employee break area was obstructed from closing by a rubber wedge. Upon interview, the | K 363 | | |

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| K 383 | Continued From page 16<br>Director of Environmental Services confirmed the finding. | K 363 | | |
| K 741 SS=D | Smoking Regulations<br>CFR(s): NFPA 101<br><br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(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.<br>(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.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(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.<br>18.7.4, 19.7.4<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on observation and interview the facility failed to adhere to the smoking policy. This was evidenced by extinguished cigarette buds found | K 741 | K741<br>1. The Maintenance Director removed the plastic lining in the smoking receptacle on 1/18/22.<br>The Maintenance Director cleaned up the cigarette butts from the outside employee area on 1/18/22.<br>2. The Maintenance Director conducted rounds to ensure there were no other plastic lined smoking receptacles and cigarette butts in the outside areas on 1/18/22.<br>3. The Administrator or designee will conduct in-service with staff regarding using the receptacle to extinguish their cigarette when they have finished smoking by 2/15/22.<br>The Maintenance Director will in-service the housekeepers to ensure that the receptacles for smoking are not lined with plastic liners by 2/15/22.<br>The Maintenance Director will monitor for compliance on a weekly basis and report any concerns to the Administrator.<br>4. The Maintenance Director will report any issues or concerns to the QAPI committee for further recommendations or follow up. | |

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| K 741 | Continued From page 17<br>in a plastic lined trash container and extinguished cigarette buds found on the floor. This affected the smoking areas, and could result in a fire.<br><br>Findings:<br><br>During a tour of the facility and interview with the Director of Environmental Services on 1/18/22, the designated smoking areas were observed.<br><br>1. At 10:04 a.m., two dozen extinguished cigarette buds were observed in a plastic lined receptacle in the resident's designated smoking area. Upon interview, the Director of Environmental Services confirmed the finding and stated that he was not aware that his staff was placing the plastic lining in the smoking receptacles.<br><br>2. At 10:27 a.m., the employee smoking area in the back patio was observed with 59 extinguished cigarette buds littered on the ground and across the foliage. Upon interview, the Director of Environmental Services confirmed the finding and stated that he was not aware of why the employees were littering when designated receptacles and ashtrays were provided. | K 741 | | |
| K 918 SS=D | Electrical Systems - Essential Electric Syste CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. | K 918 | K918<br>1. The Maintenance Director removed the boxes form the boiler room on 1/18/22.<br>2. The Maintenance Director reviewed the boiler room to ensure there were no other items in the boiler room on 1/18/22. | |

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| K 918 | Continued From page 18<br>Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43379<br>Based on observation and interview, the facility failed to maintain the Emergency Power Supply System (EPSS). This was evidenced by two cardboard boxes found near the EPSS. This affected one of nine smoke compartments, and could result in a fire and malfunction of the EPSS.<br><br>NFPA 101, Life Safety Code, 2012 Edition<br>19.5 Building Services.<br>19.5.1 Utilities. | K 918 | 3. The Administrator or designee will conduct an In-service with the Maintenance Director to ensure that no items are placed or stored in the boiler room by 2/15/22.<br>The Administrator will monitor for compliance on a weekly basis.<br>4. The Administrator will report any issues or trends to the QAPI committee for further recommendations. | |

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| K 918 | Continued From page 19<br>19.5.1.1 Utilities shall comply with the provisions of Section 9.1.<br><br>9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.<br><br>9.1.4 Stored Electrical Energy Systems. Stored electrical energy systems shall be installed, tested, and maintained in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems.<br><br>NFPA 110, Standard for Emergency and Standby Power Systems, 2012 Edition<br><br>7.11.1 The room in which the EPS equipment is located shall not be used for other purposes that are not directly related to the EPS. Parts, tools, and manuals for routine maintenance and repair shall be permitted to be stored in the EPS room.<br><br>NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems, 2010 Edition<br><br>7.4.1 The room in which the EPS equipment is located shall not be used for storage purposes. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition.<br><br>Findings:<br><br>During a tour of the facility and interview with the Director of Environmental Services on 1/18/22, the EPSS was placed was observed. | K 918 | | |

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|---|---|---|---|---|
| K 918 | Continued From page 20<br><br>At 10:35 a.m., two cardboard boxes were observed in the boiler room approximately two feet away from the EPSS. The boxes contained a utility sink and a turbine vent. Upon interview, the Director of Environmental Services confirmed the finding and stated that the boxes were not stored in the boiler room and had been placed there since he was in the middle of a project. | K 918 | | |
| K 920 SS=D | Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>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.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by: | K 920 | K920<br>1. The Maintenance Director removed the extension cord and Christmas lights on 1/18/22.<br>2. The Maintenance Director made rounds throughout the facility to ensure there were no other extension cords in the power strips on 1/18/22.<br>3. The Administrator will conduct an in-service with the Maintenance Director regarding the use of extension cords by 2/15/22. The Maintenance Director will make rounds on a weekly basis to ensure extension cords are not used as a substitute for fixed wiring.<br>4. The Maintenance Director will report findings on a quarterly basis for further recommendations and or follow up. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055855 | A. BUILDING 02<br>B. WING _____ | 01/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARDEN POST ACUTE REHAB | 3400 ALTA ARDEN EXPRESSWAY<br>SACRAMENTO, CA 95825 |

| (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 920 | Continued From page 21<br>Surveyor: 43379<br>Based on observation and interview, the facility failed to maintain the electrical equipment and wiring. This was evidenced by the non-compliant use of an extension cord. This affected one of nine smoke compartments, and could result in an electrical fire.<br><br>NFPA 101, Life Safety Code, 2012 Edition<br>19.5 Building Services.<br>19.5.1 Utilities.<br>19.5.1.1 Utilities shall comply with the provisions of Section 9.1.<br><br>Chapter 9 Building Service and Fire Protection Equipment<br>9.1 Utilities.<br>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.<br><br>NFPA 70, National Electrical Code, 2011 Edition<br>400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:<br><br>(1) As a substitute for the fixed wiring of a structure<br><br>Finding(s):<br><br>During a facility tour and interview with the Director of Environmental Services on 1/18/22, the electrical equipment and wiring were observed.<br><br>At 9:07 a.m., an extension cord was observed in | K 920 | | |

PRINTED: 01/20/2022
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055855 | A. BUILDING 02<br>B. WING _____ | 01/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARDEN POST ACUTE REHAB | 3400 ALTA ARDEN EXPRESSWAY<br>SACRAMENTO, CA 95825 |

| (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 920 | Continued From page 22<br>the Material Data Set (MDS) office connected to a surge protector running out of the north window connected to Christmas lights. Upon interview, the Director of Environmental Services confirmed the finding. | K 920 |  | |

## Communication Plan

Our communication plan supports *rapid* and *accurate* communication both internally and externally. This section describes the elements of a basic communication plan incorporated into this EOP.

Relative to internal communications, the facility maintains a contact list of all staff, including telephone numbers and email addresses (if available). This contact information may be used whenever it is necessary to notify staff of a threat or emergency that may impact or involve them. We have a regular schedule to update staff on critical information related to the emergency. See Appendix N – Staff Recall and Survey for details on the physical location of contact lists.

Once an incident is recognized that may require activation of the EOP, the person who first recognizes the incident should immediately notify their supervisor or the senior manager on site.

Our internal communication equipment includes:

- ☒ Overhead Page
- ☒ Cell phones with texting
- ☒ Message board
- ☒ Public Relations Liaison (also known as Public Information Officer)
- ☒ Runner
- ☐ Other

It is also important to communicate with relevant external partners to: 1) gather information relevant to the incident, and 2) share information regarding the facility's status, activities and needs. Our facility will report incidents as required to jurisdictional authorities, e.g., report a fire to the local fire department. We may also share relevant situational information with external partners consistent with local policies and procedures. See Appendix M – NHICS Forms for NHICS 258: External Contact list (also called Facility Resource Directory). Our external communication equipment includes:

- ☒ Land lines
- ☒ Cell phones with texting
- ☒ Internet
- ☐ Other

Resident and Family Communication – Our facility provides information to all residents and family members regarding our EOP as part of our orientation and on-going communications. In the event of an emergency, family members may be notified and briefed on the status of