STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. BUILDING **02** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPA POST ACUTE	**705 TRANCAS ST.** **NAPA, CA 94558**

(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: 32973 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: 32973 The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities Census: 117	E 000		
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in	E 015		12/12/22

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

Electronically Signed | 01/13/2023

1/17/2023: POC accepted per Brian Fenton, SSM-1

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E 015	Continued From page 1 place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on document review and interview, the facility failed to maintain Emergency	E 015	How corrective action will be accomplished	

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E 015	Continued From page 2 Preparedness Plan (EPP) Policy and Procedure. This was evidenced by the failure to include all required provisions for subsistence needs. This affected 117 of 117 residents and could result in an ineffective EPP for sheltering in-place. Findings: During document review and interview with Administrative Staff (AS) on 11/30/22, the EPP, was requested and reviewed. At 3:20 p.m., the approved Policy and Procedure provided for Subsistence Needs, failed to address sewage and waste disposal. The submitted plan did not provide directives on how the facility would manage sewage and waste disposal in an emergency disaster when sheltering in-place. Upon interview, AS1 confirmed the finding.	E 015	The facility policy and procedures have been updated to reflect information on disposal of waste and disposal for substance need. How the facility will identify other residents having potential to be affected: No resident has been affected by the deficient practice as there has not been a disaster in the facility. What measures will be put into place to ensure the deficient practice does not reoccur: The policy and procedure manual will be reviewed with all the stakeholders annually. This will be compared to LSC regulations to ensure that all LSC are being met. How the facility plans to monitor its performance, so solutions are sustained: The QA team will review any new AFLs dealing with LSC to ensure that all LSC needs are being met.	
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), §485.542(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, REHs	E 039		12/29/22

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E 039	Continued From page 3 at §485.542, 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 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	E 039		

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E 039	Continued From page 4 [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 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	E 039		

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E 039	Continued From page 5 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 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	E 039		

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E 039	Continued From page 6 (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 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,	E 039		

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E 039	Continued From page 7 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 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,	E 039		

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E 039	Continued From page 8 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 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	E 039		

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E 039	Continued From page 9 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, 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,	E 039		

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E 039	Continued From page 10 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 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	E 039		

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E 039	Continued From page 11 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 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: 32973 Based on document review and interview, the facility failed to maintain Emergency Preparedness Plan (EPP) testing. This was evidenced by the failure to perform an annual full-scale community-based exercise and/or provide rationale for non-performance along with a second individual facility-based exercise during the past 12 months. This affected 117 of 117 residents and could result in a delayed response to a full-scale, community-wide emergency. Findings: During document review and interview with Administrative Staff (AS) on 11/30/22, the EPP drills, were requested and reviewed. At 3:13 p.m., no documentation was submitted by	E 039	How corrective action will be accomplished The facility has contracted with Surburban propane and gas to ensure that a community-based disaster drill has been completed scheduled for 12/29/2022. How the facility will identify other residents having potential to be affected: No resident has been affected by the deficient practice as there has not been a disaster in the facility. What measures will be put into place to ensure the deficient practice does not reoccur:	

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E 039	Continued From page 12 the facility for a current full-scale community-based drill, and/or rationale for non-compliance, and a second individual facility-based exercise including After-Action Report during the past 12 months. Upon interview, AS1 confirmed the findings after reviewing the testing records, and stated that the vendor who performs the drills was not able to conduct it due to the COVID pandemic.	E 039	The facility has received a calendar from the new contracted company that is being reviewed to ensure compliance with all required drills. How the facility plans to monitor its performance, so solutions are sustained: The calendar will be reviewed monthly to ensure that all monthly and annual drills are being accomplished timely.	
E 041 SS=D	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), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] 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), §485.542(e)(1), §485.625(e)(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	E 041		12/13/22

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E 041	Continued From page 13 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), §485.542(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),§485.542(e)(2) 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), REHs at §485.542(g), and 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 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	E 041		

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E 041	Continued From page 14 _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: Surveyor: 32973 Based on document review and interview, the facility failed to maintain Emergency Preparedness Plan (EPP) Policy and Procedure. This was evidenced by the failure to provide a policy for maintaining the operation of the facility's emergency generator and on-site fuel source	E 041	How corrective action will be accomplished A contract has been signed with suburban propane and gas to provide emergency fuel within 24 hours to ensure that adequate fuel is provided in the case of	

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E 041	Continued From page 15 during an emergency unless it evacuated. This affected 117 of 117 residents and could result in a delayed response to an emergency power outage. Findings: During document review and interview with Administrative Staff (AS) on 11/30/22, the EPP, was requested and reviewed. At 3:18 p.m., the facility's EPP did not provide a policy and procedure that addressed how it would keep the 150-kilowatt generator and on-site diesel fuel supply operational during an emergency unless it evacuated. Upon interview, AS2 confirmed the finding after review of the EPP, and stated that they would include an emergency operational plan for the generator in the facility's plan.	E 041	an emergency. How the facility will identify other residents having potential to be affected No resident has been affected by the deficient practice as there has not been a disaster in the facility. What measures will be put into place to ensure the deficient practice does not reoccur: A contract has been signed with suburban propane and gas to provide emergency fuel within 24 hours to ensure that adequate fuel is provided in the case of an emergency. How the facility plans to monitor its performance, so solutions are sustained: The administrator will provide the contract for reviewed to the QAPI team for review and recommendation.	
K 000	INITIAL COMMENTS Surveyor: 32973 K3 BUILDING: 01 K6 PLAN APPROVAL: 1969 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual	K 000		

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K 000	Continued From page 16 Life Safety Code re-certification 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: 32973 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 117	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		12/13/22

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K 321	Continued From page 17 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the hazardous areas. This was evidenced by not maintaining the minimum opening protection. This affected 23 of 117 residents and could result in a delay in containing smoke and/or fire to a hazardous area. Findings: During a facility tour and interview with staff on 11/30/22, the hazardous area enclosures, were observed. At 1:18 p.m., the Central Supply Room, was observed. The room was greater than 50 square feet (approximately 200 square feet) and contained multiple storage supplies. The corridor door was equipped with a self-closing device. The door was obstructed from fully closing and latching due to a malfunctioning self-closing device. Upon interview, Staff 2 confirmed the finding.	K 321	How corrective action will be accomplished The corridor door has been fixe to ensure proper latching of the doors. How the facility will identify other residents having potential to be affected: No other residents have been affected by the practice. What measures will be put into place to ensure the deficient practice does not reoccur: The maintenance team will do monthly life safety checks to ensure that all doors latch. How the facility plans to monitor its performance, so solutions are sustained: The maintenance manager will bring the monthly checks to QA for review and recommendation.	
K 363 SS=D	Corridor - Doors	K 363		12/13/22

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K 363	Continued From page 18 CFR(s): NFPA 101 Corridor - Doors 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 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363		

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K 363	Continued From page 19 etc. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by doors that failed to positive latch with testing and a door with an open penetration. This affected 40 of 117 residents and could result in the inability to contain smoke and/or fire to a room and smoke compartment. Findings: During a facility tour and interview with staff on 11/30/22, the corridor doors, were observed. 1. At 12:40 p.m., the corridor door to the Conference Room, was observed. A malfunctioning self-closing device prevented the door from fully closing and latching. Upon interview, Staff 2 confirmed the finding. At 1:21 p.m., the corridor door to the Staff Development Room, had an approximately one-quarter inch diameter open penetration above the door handle. Upon interview, Staff 2 confirmed the finding.	K 363	How corrective action will be accomplished The corridor door has been fixe to ensure proper latching of the doors. How the facility will identify other residents having potential to be affected: No other residents have been affected by the practice. What measures will be put into place to ensure the deficient practice does not reoccur: The maintenance team will do monthly life safety checks to ensure that all doors latch. How the facility plans to monitor its performance, so solutions are sustained: The maintenance manager will bring the monthly checks to QA for review and recommendation.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372		12/13/22

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K 372	Continued From page 20 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed to maintain the fire/smoke barrier walls. This was evidenced by an unsealed penetration. This affected 64 of 117 residents and could result in the spread of smoke/and or fire to other areas of the facility, exposing residents to a full facility evacuation. NFPA 101, Life Safety Code, 2012 Edition. 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1/2-hour fire resistance rating, unless otherwise permitted by one of the following: (1)This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a)Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b)Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent	K 372	How corrective action will be accomplished The smoke barrier has been approved using fire rating protectant. How the facility will identify other residents having potential to be affected: The maintenance director reviewed smoke barriers to ensure that no other openings have occurred. No other breaks have been affected. What measures will be put into place to ensure the deficient practice does not reoccur: The maintenance team will do monthly life safety checks to ensure that all smoke barriers are intact. How the facility plans to monitor its performance, so solutions are sustained: The maintenance manager will bring the monthly checks to QA for review and recommendation.	

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K 372	Continued From page 21 to the smoke barrier. 8.5 Smoke Barriers. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. Findings: During a facility tour and interview with staff on 11/30/22, the fire/smoke barrier walls, were observed. At 12:54 p.m., the fire/smoke barrier wall located inside the attic above the 90-minute Fire Resistant Rated (FRR) corridor doors by Resident Room 11, had an approximately 5 inches diameter unsealed penetration that traveled completely through the wall. Upon interview, Staff 2 confirmed the finding after viewing the wall.	K 372		
K 712 SS=E	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	K 712		12/13/22

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K 712	Continued From page 22 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: 32973 Based on document review and interview, the facility failed to maintain required fire drills. This was evidenced by the failure to conduct drills quarterly on each shift. This affected 117 of 117 residents and could result in staff being untrained and unaware of shift-specific roles and responsibilities during an emergency. Findings: During document review and interview with staff on 11/30/22, the fire drill records, were requested. At 1:43 p.m., no documentation was available for a P.M. shift drill, third quarter (July, August, September) 2022. At 1:44 p.m., no documentation was available for a Night shift drill, third quarter (July, August, September) 2022. At 1:45 p.m., no documentation was available for a P.M. shift drill, fourth quarter (October, November, December) 2021-2022. At 1:46 p.m., no documentation was available for a Night shift drill, fourth quarter (October, November, December) 2021-2022. Upon interview, Staff 2 confirmed the findings after record review, and stated that the vendors were not going into the facility due to COVID.	K 712	How corrective action will be accomplished All fire drills have been accomplished this quarter. How the facility will identify other residents having potential to be affected: No other resident has been effected by the deficient practice. What measures will be put into place to ensure the deficient practice does not reoccur: The facility has switch contract companies to Fire Safety to ensure that the drill are being accomplished monthly and on each shift.	

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K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on observation and interview, the facility failed maintain the safe use of electrical appliances. This was evidenced by the failure to adhere to the manufacturer's directions on a portable space heater. This affected 32 of 117 residents and could result in a fire hazard. Findings: During a facility tour and interview with staff on 11/30/22, the electrical appliances, were observed. At 12:36 p.m., a portable space heater located inside the Social Services Office, was observed plugged into a wall outlet with the back of the heater directly in contact with a wooden desk. According to the manufacturer's instructions on a caution label on the portable space heater, the heater should be least three feet away from furniture. Upon interview, Staff 1 confirmed the finding.	K 781	How corrective action will be accomplished All space heaters have been removed How the facility will identify other residents having potential to be affected: No residents have been affected by the deficient practice. What measures will be put into place to ensure the deficient practice does not reoccur: All space heaters have been removed from the facility	12/13/22
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		12/13/22

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K 918	Continued From page 24 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. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 32973 Based on document review and interview, the facility failed to maintain the Emergency Power Supply System (EPSS). This was evidenced by the failure to conduct the required monthly battery	K 918	How corrective action will be accomplished Generator battery has been tested.	

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NAPA POST ACUTE	**705 TRANCAS ST.** **NAPA, CA 94558**

(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 918	Continued From page 25 testing. This affected 117 of 117 resident and could result in a generator malfunction in the event of a power outage. NFPA 101 Life Safety Code, 2012 edition 19.5 Building Services. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 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. NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 The permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. Findings: During document review and interview with staff	K 918	How the facility will identify other residents having potential to be affected: No residents have been effected by the deficient practice. What measures will be put into place to ensure the deficient practice does not reoccur: Contract has been reviewed with Ready one to ensure that all checks have been accomplished How the facility plans to monitor its performance, so solutions are sustained: Maintenance director will ensure that the calendar is followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 26 on 11/30/22, monthly maintenance records, were reviewed. At 2:04 p.m., documentation titled, "Monthly generator Log" dated 2021-2022, did not include the required monthly battery testing for 2 of 2 lead-acid generator batteries during the last 12 months. Upon interview, Staff 2 confirmed the finding.	K 918		