STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055494	A. BUILDING 1A, 1B B. WING _____	02/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS MEADOWS POST-ACUTE	1633 CYPRESS LANE PARADISE, CA 95969

(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: 37135 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: 37135 Census: 88	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based	E 039	Disclaimer Clause: Preparation and/ or execution of this plan of correction does not constitute admission and/or agreement with the facts alleged or conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

LABORATO [redacted] GNATURE TITLE Administrator (X6) DATE Mar. 12, 2018

Any deficie [redacted] which the institution may be excused from correcting providing it is determined that other safeg [redacted] ons.) 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.

3/13/18 — Approveed by Cynthia Lee

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E 039	Continued From page 1 full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to complete the required disaster	E 039	Response for E 039: The after action report for Dec. 12, 2018 was completed on Mar. 6, 2018. The Maintenance Services Director (MSD) inspected disaster drills on record to ensure completion and compliance. Inspection completed with full compliance on Mar. 6, 2018. Additionally, the MSD is a current participant in the Butte County Emergency Preparedness Coalition. The MSD and staff were inserviced on Mar. 6, 2018 re: timely conduction and documentation of disaster drills. The MSD shall submit drill audits upon completion to Administrator for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI Committee and evaluated re: implementation and effectiveness. Completion Date: Mar. 12, 2018	

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E 039	Continued From page 2 drills. This was evidenced by the absence of one of two disaster drills. This affected seven of seven smoke compartments and could result in a delayed response to a during an actual disaster due to lack of training. Findings: During document review and interview with the Maintenance Director 2/26/18, records of emergency preparedness training drills were requested. 1. At 10:30 a.m., records provided indicated that the facility completed one facility based drill on 2/6/18. Upon interview, the Maintenance Director confirmed the finding and stated that they did have a power outage on 12/12/17, but did not complete an after action report.	E 039		
K 000	INITIAL COMMENTS Surveyor: 37135 K3 BUILDING: Main Building (1633 Cypress Lane) K6 PLAN APPROVAL: 11/1/67 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. 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 -	K 000		

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K 000	Continued From page 3 Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 37135 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 88 Surveyor: 37135 K3 BUILDING: Cottage Building (6900 Clark Road) K6 PLAN APPROVAL: 1/1/60 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: PARTIAL TWO STORY W/PARTIAL BASEMENT, CONSTRUCTION TYPE V, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 37135 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 0	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101	K 161		

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K 161	Continued From page 4 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor	K 161	Response to K 161: The Maintenance Services Department (MSD) sealed the penetrations for Items 1&2 on Feb. 27, 2018. The MSD director and staff conducted facility inspection to ensure that all penetrations were sealed. Inspection completed with compliance on Feb. 28, 2018. The MSD and staff were in-serviced on Mar. 6, 2018 re: maintenance of building construction and sealing of penetrations and a log was created to track and demonstrate compliance. The MSD shall submit logs to Administrator upon completion for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion date: March 12, 2018	

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K 161	Continued From page 5 plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by unsealed penetrations in the ceiling. This affected one of seven smoke compartments and could result in the spread of fire and smoke in the event of a fire. Findings: During a tour of the facility and interview with the Maintenance Director on 2/26/18, the walls and ceilings were observed. 1. At 11:56 a.m., the Business Office was observed. There was an approximate 1/2 inch diameter penetration with two blue cords and one gray cord going through the ceiling area near the northeast wall. Upon interview, the Maintenance Director confirmed the finding. 2. At 12:00 p.m., the Phone Panel Room was observed. There was an approximate 1/2 inch diameter penetration with two blue cords going through the ceiling area near the south wall. Upon interview, the Maintenance Director confirmed the finding.	K 161		
K 293 SS=E	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.	K 293		

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K 293	Continued From page 6 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: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the battery operated exit signs. This was evidenced by battery operated exit signs throughout the facility that were not tested monthly and annually. This affected seven of seven smoke compartments and could result in the malfunction of the battery operated exit signs during an emergency. NFPA 101, Life Safety Code, 2012 Edition. 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. 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. 7.10.9.2 Testing. Exit 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. 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.	K 293	Response to K 293: The Wing A&B battery operated exit signs (BOES) were tested as compliant on March 6, 2017. The Maintenance Services Director (MSD) and staff conducted facility inspections to ensure that all BOES were functional and operational. Inspection completed with full compliance on March 7, 2018. The MSD department and staff were in-serviced on Mar. 6, 2018 re: testing BOES and a log was initiated to track and demonstrate compliance. The MSD shall submit documentation to Administrator upon completion for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion Date: March 12, 2018	

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K 293	Continued From page 7 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. (4) A visual inspection shall be performed at intervals not exceeding 30 days. (5) Functional testing shall be conducted annually for a minimum of 1 1/2 hours.	K 293		

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K 293	Continued From page 8 (6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11?2-hour test. (7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1 1/2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. Findings: During document review, observation, and interview with the Maintenance Director on 2/26/18, the battery operated exit signs records were requested. 1. At 10:45 a.m., there were no records provided that indicated the battery operated exit signs throughout the facility were tested for 30 seconds monthly and 90 minutes annually. Upon interview, Maintenance Director confirmed the	K 293		

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K 293	Continued From page 9 finding. At 11:33 a.m., the battery operated exit sign at the entry of Wing A was observed. At 11:48 a.m., the battery operated exit sign at the entry of Wing B was observed.	K 293		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review and interview, the facility failed to maintain the smoke detector devices. This was evidenced by 40 of 40 single station battery operated smoke alarm that were not tested on a weekly basis as required per the manufacturer. This affected five of seven smoke compartments and could result in the delayed notification in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.2.10.1.1 Where required by another section of this Code, single-station and multiple-station smoke alarms shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code, unless otherwise provided in 9.6.2.10.1.2, 9.6.2.10.1.3, or 9.6.2.10.1.4.	K 347		

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K 347	Continued From page 10 NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. 10.3.2 System components shall be installed, tested, and maintained in accordance with the manufacturer's published instructions and this Code. 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Findings: During document review and interview with the Maintenance Director on 2/26/18, the smoke alarm device records were requested. 1. At 10:08 a.m., records provided indicated that 40 of 40 single station battery operated smoke alarms were not tested weekly from March 2017 through November 2017. Upon interview, the Maintenance Director confirmed the finding.	K 347	Response to K 347: The facility identified the missing documumentation issue in December 2017 and referred the item to our QAPI committee. This identification and proof of identification was shared and provided to the Life Safety Code representative on Feb. 26, 2018. The Maintenance Services Director (MSD) and staff inspected deparmental documentation and intiated testing to ensure compliance. Inspection completed and facility compliance with testing since Dec. 7, 2018. The MSD department and staff were inserviced on Mar. 6, 2018 to leave all facility documentation intact upon change of employment and to not abscond with facility documentation. The MSD/Administrator shall audit said documentation upon personnel turnover for compliance. The Administrator or designee shall review audits to ensure compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion date March 12, 2018.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		

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K 353	Continued From page 11 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review, observation, and interview, the facility failed to maintain the automatic sprinkler system and it components. This was evidenced by a quarterly inspection/test report that were noted with deficiencies, the absence of 10 of 12 monthly inspections, and one sprinkler head that did not have the required 18 inch clearance. This affected seven of seven smoke compartments and could result in the malfunction of the sprinkler system in the event of a fire. NFPA 101, Life Safety Code. 2012 Edition. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height	K 353	Response to K 353: page 15: 1) sprinkler system vendor report: Vendor replaced janitor closet head on Mar. 9, 2018; facility staff removed obstructions to FDR on Feb. 26, 2018; obstruction to kitchen wall clearance correction initiated on March 9, 2018. 2) Facility intitiated QAPI to address missing documention and to ensure compliance from Dec. 2017 forward (See K 347). 3) Facility staff removed the gym obstruction on Feb. 26, 2018. page 17: 1) Sprinkler system vendor report: Vendor replaced items 1-8 on March 9, 2018. Facility initiated QAPI to address missing documentation and to ensure compliance from Dec. 2017 forward. (see K347) The Maintenace Services Director (MSD) and staff were inspected the facility to ensure compliance with maintenance and testing of the sprinkler system. Inspection completed with full compliance on March 9, 2018. The MSD department were inserviced on March 6-9, 2018 re: completion and compliance with vendor reports, facility obstructions, and maintenance of the sprinkler system. The MSD shall forward completed vendor report audits and facility inspection audits to Administrator for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion date: March 12, 2018	

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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 353	Continued From page 12 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA-25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 13, Standard for the Installation of Sprinkler System. 2010 Edition 8.6.6* Clearance to Storage (Standard Pendent and Upright Spray Sprinklers). 8.6.6.1 The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 2011 Edition. 4.1.4* Corrections and Repairs. 4.1.4.1 The property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by this standard. 4.1.4.2* Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. 4.3 Records 4.3.1* Records shall be made inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. 5.2.4 Gauges 5.2.4.1* Gauges on a wet pipe sprinkler shall be	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055494	A. BUILDING 1A, 1B B. WING _____	02/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 13 inspected monthly to ensure that they are in good condition and the normal water supply pressure is being maintained. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification 13.4.1.1* Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained. (2) The valve is free of physical damage. (3) All valves are in the appropriate open or closed position. (4) The retarding chamber or alarm drains are not leaking. 13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. Findings: During documentation review, a tour of the facility, and interview with the Maintenance Director on 2/26/18, the sprinkler system was observed and records were requested.	K 353		

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 353	Continued From page 14 1. At 10:12 a.m., a document titled, " Inspection, Testing, and Maintenance," was provided. The document indicated that the sprinkler system was inspected/tested on 1/15/18 by Sprinkler System Vendor 1. On page 3 of 3 of the documents, it indicated that the following three deficiencies were found: 1-Janitor closet head corroded, 2-Keep FDC clear of obstructions, and 3-Kitchen wall required clearance from sprinkler head. There was no documentation provided that indicated the repairs were made. Upon interview, the Maintenance Director confirmed the finding and stated they were working with vendor to make repairs. 2. At 11:23 a.m., records indicated that monthly visual inspections for the alarm and system riser check valves and pressure gauge for the following months were not completed: March, April, May, June, July, August, September, October, November, and December of 2017. Upon interview, the Maintenance Director confirmed the finding. 3. At 12:25 p.m., the sprinkler head located in the Gym Closet was observed. There were two leg braces stored at approximately five inches from the deflector. Upon interview, the Maintenance Director confirmed the finding. Surveyor: 37135 Based on document review, and interview, the facility failed to maintain the automatic sprinkler system and it components. This was evidenced by a quarterly inspection/test report that were noted with deficiencies, and the absence of 10 of 12 monthly inspections. This affected two of two smoke compartments and could result in the malfunction of the sprinkler system in the event of	K 353		

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K 353	Continued From page 15 a fire. NFPA 101, Life Safety Code. 2012 Edition. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 2011 Edition. 4.1.4* Corrections and Repairs. 4.1.4.1 The property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by this standard. 4.1.4.2* Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. 4.3 Records 4.3.1* Records shall be made inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 5.2.4 Gauges 5.2.4.1* Gauges on a wet pipe sprinkler shall be inspected monthly to ensure that they are in good condition and the normal water supply pressure is being maintained. 13.3.2.1.1 Valves secured with locks or	K 353		

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K 353	Continued From page 16 supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification 13.4.1.1* Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained. (2) The valve is free of physical damage. (3) All valves are in the appropriate open or closed position. (4) The retarding chamber or alarm drains are not leaking. 13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. Findings: During documentation review, and interview with the Maintenance Director on 2/26/18, the sprinkler system was observed and records were requested. 1. At 10:10 a.m., a document titled, "Inspection, Testing, and Maintenance," was provided. The document indicated that the sprinkler system was inspected/tested on 1/15/18 by Sprinkler System	K 353		

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K 353	Continued From page 17 Vendor 1. On page 3 of 3 of the documents, it indicated that the following eight deficiencies were found: 1-Rm 112 one bent deflector and four painted heads, 2-Rm 110 two painted heads and bathroom one painted head, 3-Guest Lounge paint on one head, 4-Entry by reception one corroded head, 5-Rm 101 two painted heads and bathroom one painted head, 6-Shower room one corroded and one painted head, 7-Hallway outside of 104 one painted head, and 8-NE corner basement missing one ring hanger. There was no documentation provided that indicated the repairs were made. Upon interview, the Maintenance Director confirmed the finding and stated they were working with vendor to make repairs. 2. At 11:23 a.m., records indicated that monthly visual inspections for the alarm and system riser check valves and pressure gauge for the following months were not completed: March, April, May, June, July, August, September, October, November, and December of 2017. Upon interview, the Maintenance Director confirmed the finding.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.	K 355		

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K 355	Continued From page 18 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by two extinguishers that were freestanding and unsecured. This affected one of two smoke compartments and could result in the the extinguishers being damaged and in return malfunction if/when operation is needed. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Extinguishers, 2010 Edition. 6.1.3.4* Portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means: (1) Securely on a hanger intended for the extinguisher (2) In the bracket supplied by the extinguisher manufacturer (3) In a listed bracket approved for such purpose (4) In cabinets or wall recesses Findings: During a tour of the facility and interview with the	K 355	Response to K 355: The Maintenance Services Director (MSD) and staff secured the two extinguishers on March 6, 2018. The MSD and staff inspected all fire extinguishers on Feb. 18, 2018 and on March 6, 2018 to ensure extinguishers were secured on their hangers. Inspection completed with full compliance on March 6, 2018. The MSD department and staff were in-serviced on March 6, 2018 re: maintenance of portable fire extinguishers via secure hangers. The MSD shall conduct compliance audits as necessary and at least monthly for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion date: March 12, 2018	

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K 355	Continued From page 19 Maintenance Director on 2/26/18, the portable fire extinguishers were observed. 1. At 12:42 p.m., there was an ABC type extinguisher sitting on the Nurse Station counter. The extinguisher was freestanding and unsecured. 2. At 12:43 p.m., there was an ABC type extinguisher sitting on the drawers located across the Nurse Station. The extinguisher was freestanding and unsecured. These findings were confirmed by the Maintenance Director.	K 355		
K 363 SS=D	Corridor - Doors 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	K 363		

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K 363	Continued From page 20 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, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by one corridor door that did not latch when tested and two corridor doors that were obstructed from closing. This affected three of seven smoke compartments and could result in the inability to contain smoke and/or fire to a room. NFPA 101, Life Safety Code, 2012 Edition. 19.3.6.3.10* Doors shall not be held open be devices other then those that release when the door is pushed or pulled. Findings: During a tour of the facility and interview with the Maintenance Director on 2/26/18, the corridor doors were observed.	K 363	Response to K 363: The clean utility room door latch was adjusted. Room 22 door obstruction was removed. Room 40 obstruction was removed. All corrections made on Feb. 28, 2018. The Maintenance Services Director and staff inspected all corridor doorways to ensure maintenance and proper closure. Inspection completed with full compliance on Feb. 27, 2018. The MSD department and staff were inserviced on March 2, 6-9, 2018 re: maintenance of corridor doors. An audit was initiated on Mar. 6, 2018 to demonstrate compliance. The MSD shall conduct compliance audits as necessary and at least quarterly for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion date: March 12, 2018	

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K 363	Continued From page 21 1. At 11:38 a.m., the corridor door to the Clean Utility Room located next to Resident Room 4 did not latch when tested. The door was equipped with a self-closing device. 2. At 12:07 p.m., the corridor door to the Resident Room 22 was obstructed from closing by the bedside curtain of Bed A. 3. At 12:29 p.m., the corridor door to the Resident Room 40 was obstructed from closing by a wooden arm chair that was station in front of the door. These findings were confirmed by the Maintenance Director.	K 363		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on document review, and interview, the facility failed to maintain the smoke and fire dampers. This was evidenced by the absence of fire/smoke damper testing documentation. This affected two of two smoke compartments, and	K 521		

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K 521	Continued From page 22 could result in the spread of fire and/or smoke in the event of a fire. NFPA 101 Life Safety Code, 2012 Edition 19.5.2 Heating, Ventilating, and Air-Conditioning. 19.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications, unless otherwise modified by 19.5.2.2. 9.2 Heating, Ventilating, and Air-Conditioning. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 90A Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 Edition 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. 19.3.4 Documentation. All inspections and testing shall be documented, indicating the location of	K 521	Response to K 521: Facility completed damper inpsection on Mar.9, 2018 for 6900 Clark Road, (cottage). The Maintenace Services Director (MSD) and staff inpsected the damper report for the main building (1633 Cypress Lane) to ensure compliance. Inspection report dated Sept. 21, 2016 reviewed with full compliance on Feb. 26, 2018. The MSD department and staff were in-serviced on March 6, 2018 re: maintenance of damper inspection records. The MSD shall conduct compliance audits as necessary and at least quarterly for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness.	

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K 521	Continued From page 23 the fire damper, date(s) of inspection, name of inspector, and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. 19.4.2 All tests shall be completed in a safe manner by personnel wearing personal protective equipment. 19.4.3 Full unobstructed access to the fire or combination fire/ smoke damper shall be verified and corrected as required. 19.4.4 If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. 19.4.5 The operational test of the damper shall verify that there is no damper interference due to rusted, bent, misaligned, or damaged frame or blades, or defective hinges or other moving parts. 19.4.6 The damper frame shall not be penetrated by any foreign objects that would affect fire damper operations. 19.4.7 The damper shall not be blocked from closure in any way. 19.4.8 The fusible link shall be reinstalled after testing is complete. 19.4.8.1 If the link is damaged or painted, it shall be replaced with a link of the same size, temperature, and load rating. 19.4.9 All inspections and testing shall be documented, indicating the location of the fire damper or combination fire/ smoke damper, date of inspection, name of inspector, and deficiencies discovered.	K 521		

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K 521	Continued From page 24 19.4.9.1 The documentation shall have a space to indicate when and how the deficiencies were corrected. 19.4.10 All documentation shall be maintained and made available for review by the AHJ. Findings: During document review and interview with the Maintenance Director on 2/26/18, the fire/smoke damper testing records were requested. 1. At 11:25 a.m., there were no records provided that indicated a 4 year fire/smoke damper inspection and testing was completed. Upon interview, the Maintenance Director confirmed the finding.	K 521		
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 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: 37135 Based on document review and interview, the facility failed to ensure that fire drills were held quarterly on each shift. This was evidenced by	K 712		

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K 712	Continued From page 25 two of four AM, PM, and NOC shift drills that were not completed. This affected seven of seven smoke compartments and could result in staff being unprepared in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices. Findings: During document review and interview with the Maintenance Director on 2/26/18, the quarterly fire drill records were requested. 1. At 10:00 a.m., records provided indicated that the AM, PM, and NOC shift quarterly fire drills for the second and third quarter of 2017 were not completed. Upon interview, the Maintenance Director confirmed the finding and stated they could not locate the drill reports.	K 712	Response to K 712: The facility identified the missing documentation issue and referred the item to the QAPI committee. This information and proof of identification of issue was shared and provided to the Life Safety Code evaluator on Feb. 26, 2018. The Maintenance Services Director (MSD) and staff inspected departmental documentation from 4th quarter 2017 through Feb. 2018 to ensure compliance. Inspection completed with full compliance on Feb. 26, 2018. The MSD and staff were inserviced on March 6, 2018 to leave all facility documentation intact upon change of employment. The MSD / Administrator shall audit documentation upon personnel turnover for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the QAPI committee and evaluated re: implementation and effectiveness.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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	K 918		

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	055494	A. BUILDING 1A, 1B B. WING _____	02/26/2018

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K 918	Continued From page 26 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: 37135 Based on observation and interview, the facility failed to maintain the emergency power system. This was evidenced by the absence of 41 of 52 weekly inspections and seven of twelve 30 minute monthly full load tests on the 77 kilowatt (KW) diesel generator. This affected seven of seven smoke compartments and could result in the failure of the generator in the event of a power outage.	K 918	Response to K 918: The facility identified the missing documentation and refererred the item to our QAPI committee. This information and proof of identification was shared with the evaluator on Feb. 26, 2018. The Maintenance Service Director (MSD) and staff inspected departmental documentation from 4th quarter 2017-Feb. 2018 to ensure compliance. Inspection completed with full compliance on Feb. 26, 2018. Generator testing records have been in compliance since Dec. 2017. The MSD department and staff were in-serviced on March 6, 2018 to leave all facility documentation intact upon change of employment. The MSD / Administrator shall audit documentation upon personnel turnover for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be forwarded to the the QAPI committee and evaluated re: implementation and effectiveness. Completion date: March 12, 2018.	

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K 918	Continued From page 27 NFPA 99, Health Care Facilities Code, 2012 Edition. 6.4.4.1.1.3 Maintenance shall be preformed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. 8.3 Maintenance and Operational Testing. 8.3.4 A permanent record of the EPSS inspections, tests, exercises, operations and repairs shall be maintained and readily available. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. Findings: During document review and interview with the Maintenance Director on 2/26/18, the records for the 77 KW diesel generator were requested. 1. At 9:55 a.m., the records provided indicated that the weekly inspections from March 2017 through November 2017 were not completed. 2. At 9:56 a.m., the records indicated that the	K 918		

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K 918	Continued From page 28 monthly 30 minute load test from May 2017 through November 2017 were not completed. Upon interview, the Maintenance Director confirmed the findings and stated they had a change in maintenance staff and could not locate the records. Surveyor: 37135 Based on observation and interview, the facility failed to maintain the emergency power system. This was evidenced by the absence of weekly inspections and monthly full load tests on the 40 kilowatt (KW) diesel generator. This affected two of two smoke compartments and could result in the failure of the generator in the event of a power outage. NFPA 99, Health Care Facilities Code, 2012 Edition. 6.4.4.1.1.3 Maintenance shall be preformed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 8. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. 8.3 Maintenance and Operational Testing. 8.3.4 A permanent record of the EPSS inspections, tests, exercises, operations and repairs shall be maintained and readily available. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the	K 918		

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K 918	Continued From page 29 manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. Findings: During document review and interview with the Maintenance Director on 2/26/18, the records for the 40 KW diesel generator were requested. 1. At 9:50 a.m., the facility was not able to provide 51 weekly inspection records at the time of survey. 2. At 9:51 a.m., the facility was not able to provide 11 monthly full load test records at the time of survey. Records provided indicated that the only inspection/test completed in the last 12 months was the annual 90 minute load back test, which was completed on 10/24/17. Upon interview, the Maintenance Director confirmed the finding and stated that they could not locate the missing records.	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)	K 919		

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K 919	Continued From page 30 This REQUIREMENT is not met as evidenced by: Surveyor: 37135 Based on observation and interview, the facility failed to maintain the electrical system and its components. This was evidenced by an obstructed electrical panel. This affected one of seven smoke compartments, and could result in an increased risk of an electrical fire. NFPA 101 Life Safety Code, 2012 edition 19.5.1 Utilities. Utilities shall comply with the provisions of section 9.1 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70 National Electrical Code, 2011 edition 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are	K 919		

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K 919	Continued From page 31 enclosed. (2) Width of Working Space. The width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. Findings: During a tour of the facility and interview with the Maintenance Director on 2/26/18, the electrical system and its components were observed. 1. At 11:50 a.m., the electrical panels in the TV Room were observed. The panel labeled AM was obstructed from access and view by three cardboard boxes that were stored directly in front of it. Upon interview, the Maintenance Director confirmed the finding.	K 919	Response to K 919: The obstructions were removed on Feb. 26, 2018. The Maintenance Services Director (MSD) and staff inspected all electrical panal rooms to ensure non-obstruction. Inspection completed with full compliance on Feb. 27, 2018. The MSD department and staff were in-serviced on March 6, 2018 re: initiating an electrical panel room log to track and demonstrate compliance. The MSD shall conduct audits as necessary and at least quarterly for compliance. The Administrator or designee shall review audits to ensure sustained compliance. Results of these audits shall be fowarded to the QAPI committee and evaluated re: implementation and effectiveness. Completion date: March 12, 2018	