STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555390	A. BUILDING **02** B. WING _____	**06/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORONA REGIONAL MEDICAL CENTER D/P SNF	**730 MAGNOLIA AVENUE** **CORONA, CA 92879**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census = 59	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004		7/24/25

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

Electronically Signed | 06/18/2025

6/19/2025: POC accepted per Jose Gonzalez, SSM-1

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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain their Emergency Operations Plan. This was evidenced by the failure to review and update the Emergency Operations Plan at least annually for long term care facilities. The facility may be unprepared in the event of an emergency or disaster. This affected 59 of 59 patients. Findings: During record review and interview with the Director of Subacute and Director of Plant Operations on 6/3/25, the Emergency Operations Plan was requested.	E 004	The director of plant operations revised the emergency operations plan. The emergency management committee approved the revised emergency operations plan and will be presented to Subacute Quality Assurance and Performance Improvement committee for final approval. The Director of plant operations will be revising the emergency operations plan on annual basis (within first quarter of the year).	

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E 004	Continued From page 2 At 11:50 a.m., the facility's Emergency Operation Plan stated that the plan was last reviewed and updated on 11/29/22. During interview, the Director of Plant Operations stated that they thought the plan needed to be reviewed every two years with the hospital review.	E 004		
E 039 SS=E	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 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	E 039		6/30/25

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E 039	Continued From page 3 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based 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	E 039		

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

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E 039	Continued From page 5 and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or 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	E 039		

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E 039	Continued From page 6 statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section 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,	E 039		

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

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

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

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

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E 039	Continued From page 11 Plan. This was evidenced by the failure to meet the emergency preparedness testing requirements of at least twice each year. The facility may be unprepared in the event of an emergency or disaster. This affected 59 of 59 residents. Findings: During record review and interview with the Director of Subacute and Director of Plant Operations on 6/3/25, the Emergency Operations Plan was requested. At 12 p.m., documentation was not provided showing that the facility participated in an annual full-scale community-based exercise that tested the emergency plan. Documentation was also not provided for an additional annual full-scale exercise. During interview, the Director of Plant Operations stated that they needed to find the after-action report for an actual emergency the hospital experienced in the last year. The facility was given until 12 p.m. on 6/4/25 to email documentation, however, an email was not received.	E 039	following documents:On 5/30/2024, incident command was set up internally for a water pipe ruptured in the ceiling of a non-patient care hallway. This is contiguous to a supply room and near the kitchen. Code Triage Internal was called and facility engineers were already on-site mitigating the issue. Water was shut-off to the building at the street. County and state were notified. (Please see the attachment) On 2/19/2025, incident command was set up due to phone outage and inability to receive incoming calls or make outgoing calls. Internal unit to unit and employee mobile phones being utilized to support communication. First information from IT is that is not a switch issue, but more wide-spread and involves AT&T. In addition, Pyxis is on critical override. Intermittent computer down. (Please see the attachment). PLAN: Facility will continue to perform mock disaster drills as scheduled per our Environment of Care (EOC)/Emergency Management (EM)/Life Safety (LS) in accordance with state and county guidelines and participate in tabletop exercises with the county and other agencies. and all documents will be maintained by the disaster coordinator. A scheduled tabletop exercise is planned for October 16th, 2025 in collaboration with local and State agencies, "The great	

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E 039	Continued From page 12	E 039	California shakeout".	
K 000	INITIAL COMMENTS K3 BUILDING: 01 - Original Building K6 PLAN APPROVAL: 1989 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. K3 BUILDING: 02 - Annex Building K6 PLAN APPROVAL: 2023 K7 SURVEY UNDER: 2012 NEW STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 61 (40 in Original Building + 21 in Annex Building) Resident Census: 59 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. The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		6/30/25

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	555390	A. BUILDING **02** B. WING _____	**06/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORONA REGIONAL MEDICAL CENTER D/P SNF	**730 MAGNOLIA AVENUE** **CORONA, CA 92879**

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K 345	Continued From page 13 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke detectors in a reliable operating condition. This was evidenced by a smoke detector that failed to activate the fire alarm system during a functional test. This could result in a delay in notification during a fire emergency. This affected 24 of 59 residents in one of four smoke compartments. Findings: During a facility tour and interview with the Director of Subacute and Chief Executive Officer on 6/3/25, the smoke detectors were tested. At 2:13 p.m., the smoke detector, located in the hallway by Nurse Station 1 and resident rooms 730 and 743 in the main building, failed to actuate an alarm upon spraying the smoke detector three times with smoke detector test spray. During interview, the Director of Subacute stated that they did not know why the smoke detector did not activate.	K 345	Smoke detector located in the hallway by nurse station 1 and resident rooms 730 and 743 was repaired by contracted company (Please see the attachment) MONITORING: 1. The plant operations team headed by the plant operations director or qualified designee will be inspecting all smoke detectors on a semi-annual basis. Monitoring will be conducted during Environment of Care (EOC) rounding on a quarterly basis. Action plans are generated with findings and deadlines for completion. Findings and data trends are reported to the environment of care committee on a quarterly basis for further review and recommendations.	
K 353 SS=E	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,	K 353		6/30/25

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K 353	Continued From page 14 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 _____ 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: Based on observation, record review, and interview, the facility failed to maintain the Automatic Sprinkler System. This was evidenced by the failure to perform monthly inspections of the sprinkler system and its components. This could result in a delay in identifying a problem with the sprinkler system. The facility also failed to maintain the sprinkler heads. This was evidenced by a sprinkler head that was corroded and could result in a malfunction of the sprinkler head. This affected 59 of 59 residents and four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.3 Protection. 19.3.5 Extinguishment Requirements. 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	K 353	The sprinkler located by dining room C was replaced by contracted company. (Please see the attachment) Scheduled recurring preventative maintenance was implemented to occur monthly to visually inspect the sprinklers PM schedule. MONITORING: 1. The plant operations team headed by the Plant Operations Director or qualified designee will be inspecting the sprinklers on a semi annual basis. Added monitoring is a visual inspection to be conducted during Environment of Care (EOC) rounding on a quarterly basis. Action plans are generated with findings and deadlines for completion. Findings and data trends are reported to the environment of care committee on a	

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K 353	Continued From page 15 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. 9.7.8 Record Keeping. Testing and maintenance records required by NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 5.1 General. 5.1.1 Minimum Requirements. 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. 5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1 * Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)* Loading	K 353	quarterly basis for further review and recommendations.	

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K 353	Continued From page 16 (6) Painting unless painted by the sprinkler manufacturer 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation. 5.2.4 Gauges. 5.2.4.1 * Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 13.1 * General. 13.1.1 Minimum Requirements. 13.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. 13.1.1.2 Table 13.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 13.2.8 Records. Records shall be maintained in accordance with Section 4.3. 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.1.2 After any alterations or repairs, an inspection shall be made by the property owner or designated representative to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 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	K 353		

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K 353	Continued From page 17 (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification 13.4 System Valves. 13.4.1 Inspection of Alarm Valves. Alarm valves shall be inspected as described in 13.4.1.1 and 13.4.1.2. 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 Backflow Prevention Assemblies. 13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly. Findings: During a facility tour, record review, and interview with the Director of Subacute, Plant Operations Manager, and Chief Executive Officer on 6/3/25, the Automatic Sprinkler System was observed, and records were requested. 1. At 3:30 p.m., 8 of 12 records were not provided showing the sprinkler system components (e.g. gauges and valves) were visually inspected monthly. During interview, the Plant Operations Manager stated that they only performed quarterly visual inspections. This deficiency was	K 353		

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K 353	Continued From page 18 previously cited during a Life Safety Code Recertification Survey on 2/20/24. 2. At 3:58 p.m., a corroded sprinkler head was observed in Dining Room C located in the main building. During interview, the Director of Subacute stated that they were unaware of the corroded sprinkler head.	K 353		
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 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	K 363		6/30/25

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K 363	Continued From page 19 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: Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by corridor doors that did not latch upon closing. This could delay containment of a fire in the event of a fire emergency. This affected 14 of 59 residents and one of four smoke compartments. Findings: During a facility tour and interview with the Director of Subacute and Chief Executive Officer on 6/3/25, the corridor doors were observed. 1. At 3:48 p.m., the corridor door to the SNF Nurse Manager office did not latch upon self-closing. 2. At 3:50 p.m., the corridor door to the Storage room by resident room 732 did not latch upon self-closing. During interview, the Director of Subacute stated that they were unaware that the doors did not latch.	K 363	The contracted company repaired corridor door to SNF nurse manager office and storage room by resident room 732. (Please see the attachment). MONITORING: 1. The plant operations team headed by the Plant Operations Director or qualified designee will be inspecting the doors on a annual basis. Additional monitoring will be conducted during Environment of Care (EOC) rounding on a quarterly basis. Action plans are generated with findings and deadlines for completion. Findings and data trends are reported to the environment of care committee on a quarterly basis for further review and recommendations.	
K 712 SS=E	Fire Drills	K 712		6/17/25

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K 712	Continued From page 20 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: Based on record review and interview, the facility failed to conduct quarterly fire drills per shift. This was evidenced by missing fire drills. This could result in a delay in response and evacuation during a fire. This affected 59 of 59 residents. Findings: During record review and interview with the Director of Subacute and Plant Operations Manager on 6/3/25, fire drill records were requested. At 1:38 p.m., records were not provided showing a fire drill was conducted for the AM shift for the first quarter (January, February, March) of 2025 and the third quarter (July, August, September) of 2024. In addition, a record was not provided for the PM shift for the fourth quarter (October, November, December) of 2024. During interview, the Plant Operations Manager stated that they follow a fire drill matrix which showed they performed fire drills quarterly per shift but in	K 712	The director of plant operations updated the current fire drill matrix to reflect a separate Subacute fire drills that will occur monthly for each shift (Main Building and Annex). The director of plant operations provided in-service to the plant operation staff for new process with updated fire matrix. (Please see the attachments). MONITORING: 1. The Plant Operations Manager or qualified designee will be inspecting the fire drill record and fire drill process on a quarterly basis. Findings and data collected are reported to the environment of care committee on a quarterly basis for further review and recommendations.	

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K 712	Continued From page 21 various departments throughout the hospital. The Plant Operations Manager and Director of Subacute confirmed that subacute responded to the fire drills, however, it was not recorded in some fire drill reports.	K 712		
K 908 SS=E	Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the Piped Medical Gas and Vacuum System. This was evidenced by the failure to correct discrepancies identified in a report given to the facility during an annual inspection and test of the medical gas system. This affected 59 of 59 residents and four of four smoke compartments. NFPA 99, Heath Care Facilities Code, 2012 Edition 5.1.14* Category 1 Operation and Management. 5.1.14.2.3 Inspection and Testing Operations. 5.1.14.2.3.1 General. The elements in 5.1.14.2.2.2 through 5.1.15 shall be inspected or tested as part of the maintenance program as follows: (1)*Medical air source, as follows: (a) Room temperature	K 908	The contracted company repaired medical gas equipment according to inspection report on 6/13/25. MONITORING: 1. The Plant Operations Manager or qualified designee will be maintaining the preventive maintenance of the piped gas and vacuum system. The Director of Plant Operations will do random record review and inspection of the process at least annually or as needed to check compliance. Findings and data collected are reported to the environment of care committee on a quarterly basis for further review and recommendations.	6/30/25

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K 908	Continued From page 22 (b) Shaft seal condition (c) Filter condition (d) Presence of hydrocarbons (e) Room ventilation (f) Water quality, if so equipped (g) Intake location (h) Carbon monoxide monitor calibration (i) Air purity (j) Dew point (2)*Medical vacuum source - exhaust location (3) WAGD source - exhaust location (4)*Instrument air source - filter condition (5)*Manifold sources (including systems complying with 5.1.3.5.10, 5.1.3.5.11, 5.1.3.5.12, and 5.1.3.5.13), as follows: (a) Ventilation (b) Enclosure labeling (6) Bulk cryogenic liquid source inspected in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code (7) Final line regulation for all positive pressure systems - delivery pressure (8)*Valves - labeling (9)*Alarms and warning systems-lamp and audio operation (10) Alarms and warning systems, as follows: (a) Master alarm signal operation (b) Area alarm signal operation (c) Local alarm signal operation (11)*Station outlets/inlets, as follows: (a) Flow (b) Labeling (c) Latching/delatching (d) Leaks A.5.1.14.2.1 The facility should retain a written or an electronic copy of all findings and any corrections performed. A.5.1.14.2.2.2 In addition to the minimum inspection and testing in 5.1.14, facilities should	K 908		

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K 908	Continued From page 23 consider annually inspecting equipment and procedures and correcting any deficiencies. Findings: During record review and interview with the Plant Operations Manager on 6/3/25, records were requested for the Piped Medical Gas and Vacuum System. On 6/3/25 at 5 p.m., the annual report for piped medical gas and vacuum system was not available, so the Plant Operations Manager stated that they would email the report the next day. On 6/4/25 at 2 p.m., the annual Medial Gas and Vacuum System inspection, testing, and maintenance report was received. The report, dated 5/2/25, indicated fails and discrepancies on page 9 and page 16. The fails and discrepancies included leakage noted with adapter inserted, outlet/inlet loose, zone valve box requires cleaning, and requires caution label. The report did not include a page with corrective actions. During interview, the Plant Operations Manager provided a proposal for repairs and stated that they were waiting on approval to proceed with the repairs.	K 908		
K 918 SS=F	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 capability for the life safety and critical branches.	K 918		6/30/25

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K 918	Continued From page 24 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: Based on observation, record review, and interview, the facility failed to maintain the Emergency Power Supply System (EPSS). This was evidenced by the failure to perform testing of the facility's generators. This could impact the operational reliability of the system. This affected 59 of 59 residents and four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 19.5 Building Services.	K 918	The contracted company to take sample for fuel quality test on 5/15/25. The Director of Plant Operations contacted the company for the result. Both generators will be tested for fuel quality on annual basis. Action plans are generated with findings and deadlines for completion. The Plant Operations Manager or	

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	555390	A. BUILDING **02** B. WING _____	**06/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 25 19.5.1 Utilities. 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 Standby and Power Systems, 2010 Edition 8.3 Maintenance and Operational Testing 8.3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 8.3.2 A routine maintenance and operational testing program shall be initiated immediately after the EPSS has passed acceptance tests or after completion of repairs that impact the operational reliability of the system. 8.3.2.1 The operational test shall be initiated at an ATS and shall include testing of each EPSS component on which maintenance or repair has been performed, including the transfer of each automatic and manual transfer switch to the alternate power source, for a period of not less than 30 minutes under operating temperature. 8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 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	K 918	qualified designee will be maintaining the record of preventive maintenance of the electrical system including the generator fuel quality test. The Director of Plant Operations will do random record review and inspection of the process at least annually or as needed to check compliance. Findings and data collected are reported to the environment of care committee on a quarterly basis for further review and recommendations.	

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K 918	Continued From page 26 the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. Findings: During a facility tour, record review, and interview with the Director of Subacute, Plant Operations Manager, and Chief Executive Officer on 6/3/25, the EPSS was observed, and records were requested. At 3:15 p.m., documentation was not provided showing a fuel quality test was performed at least annually on the 200-Kilowatt (kW) diesel generator for subacute and the 125-kW diesel generator for the annex building. Documentation was provided for the last fuel quality test that was performed on 6/23/22 for the subacute generator. During interview, the Plant Operations Manager stated that a fuel quality test was performed on 5/15/25 and they were waiting to receive the report. The facility was given until 12 p.m. on 6/4/25 to email a copy of the 2025 or 2024 report, however, an email was not received. This deficiency was previously cited during a Life Safety Code Recertification Survey on 2/20/24.	K 918		