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

POC accepted 6/13/25, #28045

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555805	A. BUILDING _____ B. WING _____	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	5001 EAST ANAHEIM STREET EAST LONG BEACH, CA 90804

(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 Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care (LTC) Facilities. Census: 35	E 000		

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

ADMINISTRATOR 06/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	555805	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2025**

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K000	INITIAL COMMENTS K3 BUILDING: 1 K6 PLAN APPROVAL: 01/10/2011 K7 SURVEY UNDER: 2012 Existing STRUCTURE TYPE: ONE STORY, TYPE: V (WOOD), FULLY SPRINKLED 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)(i), 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 (LTC) Facilities. Resident Certified Beds: 41 Census: 35	K000		
K321 SS=D	Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and	K321	BEL VISTA HEALTHCARE CENTER makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. BEL VISTA HEALTHCARE CENTER is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes BEL VISTA HEALTHCARE CENTER's written credible allegation of compliance for the deficiencies noted.	06/12/2025

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	555805	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2025**

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K321	Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the doors of hazardous areas are maintained in a closed position when not in use. Hazardous areas include rooms or spaces larger than 50 square feet (ft 2) used for storage of combustible supplies and equipment. In the event of a fire, containment of smoke and fire would not be achieved with non-latching, non-self-closing doors in hazardous areas. This deficient practice could affect one of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:02 a.m. with the Maintenance Supervisor (MS), the door to the electrical panel room was propped open. The MS acknowledged During a review of the facility policy and procedure(P&P) titled, "Maintenance Service [undated]". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K321	It is the facility's policy to comply with all applicable federal and state regulations regarding hazardous areas enclosure requirements as specified in NFPA 101 Life Safety Code sections 19.3.2.1 and 19.3.5.9. **Corrective Action Taken** :On 5/20/2025, the Maintenance Supervisor immediately removed the door prop and verified proper door closure and latching operation for the electrical panel room door. The door's self-closing mechanism and latching hardware were inspected and confirmed to be functioning properly. A facility-wide inspection of all hazardous area doors was completed on 5/20/2025 to ensure proper operation of self-closing mechanisms and latching hardware. **Identification of Other Areas with Potential to be Affected** :On 5/20/2025, the Maintenance Director conducted a comprehensive facility-wide assessment of all hazardous areas including electrical rooms, storage rooms over 50 square feet, mechanical rooms, and other areas requiring fire-rated separation. This assessment included verification of door closure mechanisms, and latching hardware functionality. 1. Daily rounds to verify doors are unobstructed and properly closing • Monthly documented inspections of all fire-rated door assemblies. • Prohibition of door stops or other devices that prevent proper door closure. 2. Staff education was provided on 5/21/2025 regarding:	

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K321		K321	• The importance of maintaining closed doors in hazardous areas. • Proper operation of fire-rated doors. • Reporting procedures for malfunctioning door hardware. **Monitoring and Quality Assurance** :The Maintenance Director or designee will conduct daily rounds to ensure all hazardous area doors are maintained in the closed position and functioning properly. The Maintenance Director will review compliance data monthly and report findings to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months. Date of Completion: 6/12/2025	
K342 SS=E	Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain access to a pull station (a device that is used to manually trigger the fire alarm within the facility).	K342	BEL VISTA HEALTHCARE CENTER makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. BEL VISTA HEALTHCARE CENTER is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes BEL VISTA HEALTHCARE CENTER's written credible allegation of compliance for the deficiencies noted. **Corrective Action Taken** :On 05/19/2025, the	06/12/2025

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K342	This deficient practice has the potential for staff to be unable to locate or access the pull station which could cause a delay in the sounding of the fire alarm and a subsequent delay in evacuation of the residents inside the facility. This deficient practice could affect two of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 8:59 a.m. with the MS, across from the nurse's station two rolling portable nurse worktables blocked pull station 1. The MS moved the units and stated, "they know not to leave those units in front of the pull station but to store them on the opposite wall". The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:00 a.m. with the MS, a dirty linen cart was left unattended and blocking pull station 2. The MS moved the cart and acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K342	It is the facility's policy to comply with all applicable federal and state regulations regarding fire alarm system initiation requirements as specified in NFPA Life Safety Code sections 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, and 9.6.2.5. Maintenance Supervisor immediately removed the rolling portable nurse worktables and dirty linen cart that were blocking pull stations 1 and 2. The Maintenance Department conducted a facility-wide inspection of all pull stations to ensure clear access and visibility. New "Keep Clear" floor markings were installed in front of all pull stations on 05/20/2025 to designate required clearance zones. **Identification of Other Areas with Potential to be Affected** :On 05/20/2025, the Maintenance Director conducted a comprehensive facility-wide assessment of all fire alarm pull stations to identify any additional access issues or potential obstructions. This assessment included all four smoke compartments and verification of proper pull station placement per NFPA requirements. **Systemic Changes and Measures Implemented:** 1. In-service training was conducted for staff on 05/21/2025 regarding: • Proper placement of equipment and furniture • Importance of maintaining clear access to pull stations **Monitoring and Quality Assurance** :The Director of Maintenance/designee will conduct	

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K342		K342	daily rounds to ensure pull stations remain accessible and unobstructed. The Maintenance Director will conduct weekly comprehensive fire safety inspections, including verification of pull station accessibility, and document findings on a checklist. The Director of Maintenance will compile monthly reports of monitoring results for review by the QAPI committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months. Any identified issues will be addressed immediately with additional staff education and corrective measures as needed. Date of Completion: 06/12/2025	
K353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems shall be 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 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: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems	K353	BEL VISTA HEALTHCARE CENTER makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. BEL VISTA HEALTHCARE CENTER is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes BEL VISTA HEALTHCARE CENTER's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to comply with all applicable federal and state regulations regarding NFPA 25 Standard for the Inspection,	06/12/2025

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K353	2011 Edition 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). This REQUIREMENT is not met as evidence by: Based on observation, interview, and record review, the facility failed to ensure fire sprinklers were continuously maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. The periodic inspection, testing, and maintenance of the automatic sprinkler system is essential in identifying if any problems exist that could affect the activation and effective operation of the sprinkler components for the dispersion of water in an event of a fire. The facility failed to maintain sprinkler deflectors free from dust and debris and in good repair. This deficient practice has the potential to affect the efficacy of the sprinkler system in working as intended. The deficient practice affected three of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:10 a.m. with the MS, in the kitchen the sprinkler deflector on the ceiling of the dry good storeroom had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:32 a.m. with the MS, in the social service storeroom the sprinkler deflector on the ceiling had paint on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:38 a.m. with the MS, in the administrator's office the sprinkler deflector on the ceiling had paint on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:43 a.m.	K353	Testing, and Maintenance of Water-Based Fire Protection Systems, specifically section 5.2.1.1.1 concerning sprinkler maintenance and testing. **Corrective Action Taken** :On 05/19/2025, the Maintenance Director initiated immediate cleaning and restoration of all affected sprinkler heads. A licensed fire protection contractor was engaged to properly clean and inspect all sprinkler deflectors throughout the facility, with special attention to those identified in the survey findings. All painted sprinkler heads were replaced with new, properly rated sprinkler heads. The shower room sprinkler head showing mildew was replaced and the surrounding ceiling area was treated for mold prevention. **Identification of Other Areas with Potential to be Affected** :On 05/20/2025, the Maintenance Director and Fire Safety Officer conducted a comprehensive facility-wide inspection of all sprinkler heads and deflectors in all smoke compartments. This inspection documented the condition of each sprinkler component and identified any additional heads requiring cleaning or replacement. **Systemic Changes and Measures Implemented:** 1. A new monthly sprinkler inspection checklist has been implemented that specifically addresses cleanliness, paint, corrosion, and proper orientation of all sprinkler heads. 2. The preventive maintenance schedule has been updated to include quarterly deep	

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K 353	Continued From page 5 maintenance of the automatic sprinkler system is essential in identifying if any problems exist that could affect the activation and effective operation of the sprinkler components for the dispersion of water in an event of a fire. The facility failed to maintain sprinkler deflectors free from dust and debris and in good repair. This deficient practice has the potential to affect the efficacy of the sprinkler system in working as intended. The deficient practice affected three of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:10 a.m. with the MS, in the kitchen the sprinkler deflector on the ceiling of the dry good storeroom had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:32 a.m. with the MS, in the social service storeroom the sprinkler deflector on the ceiling had paint on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:38 a.m. with the MS, in the administrator's office the sprinkler deflector on the ceiling had paint on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:43 a.m. with the MS, in the CNA storeroom located next to room 5 the sprinkler deflector on the ceiling had paint on it. The MS acknowledged the findings.	K 353		

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K353	with the MS, in the CNA storeroom located next to room 5 the sprinkler deflector on the ceiling had paint on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 9:47 a.m. with the MS, in room 3 the sprinkler deflector on the ceiling above bed B had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 10:00 a.m. with the MS, in room 8 the sprinkler deflector on the ceiling over bed B had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 10:01 a.m. with the MS, in room 9 the sprinkler deflector on the ceiling in the restroom had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 10:12 a.m. with the MS, in the shower room the sprinkler deflector on the ceiling had a buildup of both a green mildew -like substance and dust on it. The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K353	cleaning of all sprinkler heads by qualified maintenance staff. **Monitoring and Quality Assurance** :The Maintenance Director will conduct weekly inspections of randomly selected sprinkler heads throughout the facility for the next 90 days. The Director of Maintenance will oversee all monitoring activities and report findings to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Date of Completion: 06/12/2025	
K511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric	K511	BEL VISTA HEALTHCARE CENTER makes every effort to operate in substantial compliance with Federal and State laws and regulations.	06/12/2025

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	555805	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	**5001 EAST ANAHEIM STREET** **EAST LONG BEACH, CA 90804**

(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 6 During a concurrent observation and interview on 05/19/2025 at 9:47 a.m. with the MS, in room 3 the sprinkler deflector on the ceiling above bed B had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 10:00 a.m. with the MS, in room 8 the sprinkler deflector on the ceiling over bed B had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 10:01 a.m. with the MS, in room 9 the sprinkler deflector on the ceiling in the restroom had a buildup of dust on it. The MS acknowledged the findings. During a concurrent observation and interview on 05/19/2025 at 10:12 a.m. with the MS, in the shower room the sprinkler deflector on the ceiling had a buildup of both a green mildew -like substance and dust on it. The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K 353		
K 511 SS=D	Utilities - Gas and Electric	K 511		

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K511	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: NFPA 101: Life Safety Code, 2012 Edition NFPA 70: National Electrical Code, 2011 Edition 110.26 (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. Based on observation and interview, the facility failed to ensure the Electrical panel was not used for storage. This deficient practice affected one of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:01 a.m. with the MS, in the electrical panel room it was noted the following items were stored three inches from the electrical panel: multiple binders and blank paper stored on a bookcase and a floor polishing machine. The case manager's office area was located within the electrical panel room. The MS stated, "this room is used as the case manager's office and for storage". The MS went on to state "The electrical panel room has been used as an office for years because the building is so small, and space is at a premium". The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service (undated)". The Maintenance Service Policy and	K511	Nothing in this Plan of Correction is an admission otherwise. BEL VISTA HEALTHCARE CENTER is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes BEL VISTA HEALTHCARE CENTER's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to comply with all applicable federal and state regulations regarding electrical safety requirements as specified in NFPA 101 Life Safety Code (2012 Edition) and NFPA 70 National Electrical Code (2011 Edition), specifically regarding maintaining clear working spaces around electrical panels. **Corrective Action Taken** :On 05/20/2025, the Maintenance Supervisor immediately removed all stored items, including binders, paper, and floor polishing machine from the electrical panel room. The Case Manager's office was relocated to an alternative space within the facility. The electrical panel room was secured with appropriate signage indicating "Electrical Room - No Storage Permitted." The Maintenance Supervisor conducted a complete inspection of all electrical panel rooms facility-wide to ensure compliance with NFPA requirements for clear working spaces. **Identification of Other Areas with Potential to**	

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K 511	Continued From page 7 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: NFPA 101: Life Safety Code, 2012 Edition NFPA 70: National Electrical Code, 2011 Edition 110.26 (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. Based on observation and interview, the facility failed to ensure the Electrical panel was not used for storage. This deficient practice affected one of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:01 a.m. with the MS, in the electrical panel room it was noted the following items were stored three inches from the electrical panel: multiple binders and blank paper stored on a bookcase and a floor polishing machine. The case manager's office area was located within the electrical panel room. The MS stated, "this room is used as the case manager's office and for	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K511	Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K511	**be Affected** :The Maintenance Supervisor, in conjunction with the Safety Committee, completed a facility-wide assessment on 05/20/2025 to identify any other electrical panels or utility rooms that could potentially be affected by improper storage or space utilization. This assessment included all four smoke compartments and documentation of current space utilization near all electrical equipment. **Systemic Changes and Measures Implemented:** 1. The facility's Maintenance Service Policy and Procedure has been revised to specifically address electrical room safety requirements, including: • Prohibition of storage within 36 inches of electrical panels • Required monthly inspections of all electrical rooms and panels 2. Implementation of a facility-wide space utilization assessment to ensure appropriate allocation of office and storage areas. **Monitoring and Quality Assurance** :The Maintenance Director will conduct weekly inspections of all electrical rooms for the first month, then monthly thereafter. The Director of Maintenance will conduct independent monthly audits to ensure continued compliance. Results will be documented and reviewed during monthly Safety Committee meetings and quarterly QAPI meetings. The QAPI Committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters. Any identified issues will	

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K 511	Continued From page 8 storage". The MS went on to state "The electrical panel room has been used as an office for years because the building is so small, and space is at a premium". The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K 511		
K 917 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: 6.4.2.2.6.2 Receptacles. The requirements for receptacles shall comply with 6.4.2.2.6.2(A), 6.4.2.2.6.2(B), and 6.4.2.2.6.2(C). (C)* The electrical receptacles or the cover plates for the electrical receptacles supplied from the life safety and critical branches shall have a distinctive color or marking so as to be readily identifiable. Based on observation and interview, the facility failed to ensure all emergency receptacles	K 917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K511		K511	be immediately addressed and corrective actions implemented as needed. The Administrator is responsible for overall compliance with this plan of correction. Date of Completion: 06/12/2025	
K917 SS=D	Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: 6.4.2.2.6.2 Receptacles. The requirements for receptacles shall comply with 6.4.2.2.6.2(A), 6.4.2.2.6.2(B), and 6.4.2.2.6.2(C). (C)* The electrical receptacles or the cover plates for the electrical receptacles supplied from the life safety and critical branches shall have a distinctive color or marking so as to be readily identifiable. Based on observation and interview, the facility failed to ensure all emergency receptacles supplied for life safety and critical branches have distinctive color markings. This deficient practice could affect one of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:03 a.m. with the MS, in the dining room it was noted the electrical receptible located on the wall next to the exit sliding door was missing most of the red coloring from it. The MS stated, "the receptacle is designated as an emergency outlet that is connected to the life safety emergency system and should be red in color". The MS stated, "the reason why the outlet is no longer completely red in color is because the residents' wheelchairs have rubbed off the red color for the receptacles". The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance	K917	BEL VISTA HEALTHCARE CENTER makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. BEL VISTA HEALTHCARE CENTER is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes BEL VISTA HEALTHCARE CENTER's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to comply with all applicable federal and state regulations regarding electrical systems and essential electric system receptacles as specified in NFPA 99 codes 6.4.2.2.6, 6.5.2.2.4.2, and 6.6.2.2.3.2. **Corrective Action Taken** :On 5/20/2025, the Maintenance Director immediately replaced the emergency receptacle located in the dining room next to the exit sliding door with a new red-colored receptacle that clearly identifies it as being connected to the life safety emergency system. Additionally, all emergency receptacles throughout the facility were inspected for proper	06/12/2025

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BEL VISTA HEALTHCARE CENTER	**5001 EAST ANAHEIM STREET** **EAST LONG BEACH, CA 90804**

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K 917	Continued From page 9 supplied for life safety and critical branches have distinctive color markings. This deficient practice could affect one of four smoke compartments. Findings: During a concurrent observation and interview on 05/19/2025 at 9:03 a.m. with the MS, in the dining room it was noted the electrical receptible located on the wall next to the exit sliding door was missing most of the red coloring from it. The MS stated, "the receptacle is designated as an emergency outlet that is connected to the life safety emergency system and should be red in color". The MS stated, "the reason why the outlet is no longer completely red in color is because the residents' wheelchairs have rubbed off the red color for the receptacles". The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K 917		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		

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K917	Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K917	color identification and marking. **Identification of Other Areas with Potential to be Affected** :The Maintenance Director conducted a facility-wide assessment on 5/20/2025 of all emergency receptacles connected to life safety and critical branches to identify any other receptacles with worn or missing distinctive color markings. This assessment included all four smoke compartments of the facility. **Systemic Changes and Measures Implemented:** 1. A preventive maintenance schedule has been implemented requiring monthly inspections of all emergency receptacles for proper color identification. **Monitoring and Quality Assurance** :The Maintenance Director will conduct monthly audits of all emergency receptacles to ensure proper identification markings are maintained. Results will be documented on the Emergency Receptacle Inspection Log. The Director of Maintenance will review these logs monthly and report findings to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for a minimum of three consecutive quarters. Date of Completion: 5/20/2025	
K918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K918	BEL VISTA HEALTHCARE CENTER makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an	06/12/2025

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K 918	Continued From page 10 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: NFPA 99 Health Care Facilities Code 2012 Edition 6.4.2.2.3.5 No functions other than those in 6.4.2.2.3.2, 6.4.2.2.3.3, and 6.4.2.2.3.4 shall be connected to the life safety branch, except as	K 918		

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K918	and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: NFPA 99 Health Care Facilities Code 2012 Edition 6.4.2.2.3.5 No functions other than those in 6.4.2.2.3.2, 6.4.2.2.3.3, and 6.4.2.2.3.4 shall be connected to the life safety branch, except as specifically permitted in 6.4.2.2.3. This REQUIREMENT is not met as evidence by: Based on observation and interview, the facility failed	K918	admission otherwise. BEL VISTA HEALTHCARE CENTER is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes BEL VISTA HEALTHCARE CENTER's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to comply with all applicable federal and state regulations regarding NFPA 99 Health Care Facilities Code 2012 Edition, specifically section 6.4.2.2.3.5 concerning the proper use of Life Safety emergency system electrical outlets. **Corrective Action Taken** :On 05/20/2025, the Maintenance Director immediately removed all phone charging cords from the emergency red outlets in Room 19. The Maintenance Director conducted a facility-wide inspection of all emergency red outlets to ensure no unauthorized equipment was connected. **Identification of Other Areas with Potential to be Affected** :The Maintenance Director completed a comprehensive audit of all emergency power outlets throughout the facility on 05/20/2025 to identify any similar instances of improper use. This included inspection of all four smoke compartments and documentation of all emergency power circuits and their current usage.	

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	555805	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL VISTA HEALTHCARE CENTER	**5001 EAST ANAHEIM STREET** **EAST LONG BEACH, CA 90804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 11 specifically permitted in 6.4.2.2.3. This REQUIREMENT is not met as evidence by: Based on observation and interview, the facility failed to ensure that only allowed electrical equipment is connected to the Life Safety emergency system at all times. In case of a prolonged normal electrical failure, un-essential equipment shall not be continuously connected to the emergency system in order to avoid power overload and sub-sequential failure of the alternative source of power. This deficient practice could affect one of four smoke compartments. Findings During a noted concurrent observation and interview, on 05/19/2025 at 9:51 a.m. with the MS, in room 19 it was noted phone charging cords were plugged into to the emergency red outlets located on the wall behind beds A and B. When asked, the MS stated, "the red outlets in room 19 are connected to the life safety emergency system". The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service {undated}". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K918	to ensure that only allowed electrical equipment is connected to the Life Safety emergency system at all times. In case of a prolonged normal electrical failure, un-essential equipment shall not be continuously connected to the emergency system in order to avoid power overload and sub-sequential failure of the alternative source of power. This deficient practice could affect one of four smoke compartments. Findings During a noted concurrent observation and interview, on 05/19/2025 at 9:51 a.m. with the MS, in room 19 it was noted phone charging cords were plugged into to the emergency red outlets located on the wall behind beds A and B. When asked, the MS stated, "the red outlets in room 19 are connected to the life safety emergency system". The MS acknowledged the findings. During a review of the facility policy and procedure(P&P) titled, "Maintenance Service (undated)". The Maintenance Service Policy and Procedure indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a) maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.	K918	**Systemic Changes and Measures Implemented:** 1. Installed clear signage at all emergency outlets identifying proper usage restrictions. 2. Conducted in-service training for staff on 05/21/2025 regarding emergency power systems and proper outlet usage 3. Added emergency outlet inspection to daily maintenance rounds checklist **Monitoring and Quality Assurance** :The Maintenance Director will conduct daily rounds to ensure compliance with emergency outlet usage requirements. Results will be documented on a standardized audit tool. The Administrator will review audit results monthly. The Maintenance Director will report monitoring results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months. Additional education and monitoring will be implemented as needed based on audit findings. Date of Completion: 06/12/2025	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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