STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MESA GLEN CARE CENTER	638 E COLORADO AVENUE GLENDORA, CA 91740

(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: 96	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 03/20/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING **01 - MESA GLENN CARE CENTER** B. WING _____	**03/05/2025**

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 10/01/1969 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, TYPE III, FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 96 Census: 96	K 000	Preparation and/or execution of this plan of correction does not constitute admissions of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of the deficiencies. This plan of corrections is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and C.F.R. 405.1907.	
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101 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,	K 342	K 342 Fire Alarm System - Initiation Correct Deficient Practice: On 03/7/25 Maintenance Supervisor (MS) called Delta Fire Equipment to get replacement snap bar for the manual pull station. Snap bars to be delivered and replaced on 03/10/25. Identify Others: On 03/10/2025 MS checked all manual pull stations to ensure all other manual pull stations are in proper working order and have the protective plastic "snap" bars. No other deficient practice found.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 04/04/2025

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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K 342	Continued From page 1 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on an observation and interview, the facility failed to maintain one of seven manual fire alarm pull station (a device that will sound the fire alarm when activated manually) in proper working order and as designed with the protective plastic "snap" bars. This failure has the potential for the pull station to mistakenly activate the fire alarm system and send a false alarm to the monitoring company and fire department. This deficient practice affected two of three smoke compartments (A space within a building enclosed by smoke barriers on all sides, having an appropriate resistance to the spread of smoke). Findings: During a concurrent observation and interview on 3/5/2025 at 11:15 a.m. with the Maintenance Supervisor (MS) next to Resident Room 3, the pull station was missing the snap bar (a glass or plastic rod to indicate set in the pull station to indicate it is ready for use and has not be tampered with). The MS stated he believes the patients remove them. During a concurrent observation and interview on 3/5/2025 at 11:34 a.m. with the MS next to Nurse Station South, the pull station was missing the snap bar. The MS stated he believes the patients remove them.	K 342	Systemic Changes: On 03/10/2025 Administrator provided in-service education to Maintenance Supervisor regarding facility policy and procedures titled, "Maintenance Services" & "Fire Safety Inspections," indicating the maintenance department is responsible for maintaining the fire alarm system in good working order and the need for monthly fire safety inspections to be completed and forwarded to the administrator within 48 hours. MS or designee will complete the Mesa Glen Alarm Test Log on a monthly basis to ensure all manual pull stations are in proper working order and have the protective plastic "snap" bars in place. Any negative findings will be reported to administrator and corrected immediately. Monitoring: Findings and trends from Inspection rounds will be brought to Quarterly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/2025.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		

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K 345	Continued From page 2 A fire alarm system is tested and maintained in accordance with an approved program complying 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 interview and record review, the facility failed to maintain the annual fire alarm test records completed within the last 12 months. This deficient practice has the potential for the issues with the fire alarm and monitoring to go unnoticed and unaddressed by the facility which could possibly affect the safety of the residents, staff, visitors to the facility. Findings: During an interview on 3/5/2025, at 10:30 a.m., with the ADM and MS, a request for written documentation of the most recently conducted "Annual Fire Alarm Test" was verbally requested along with a written request. During a concurrent interview and record review on 3/5/2025, at 2:54 p.m., with the MS and Regional Maintenance Director (RMD), the RMD stated they are missing the Annual Fire Alarm Test within the past twelve months.	K 345	K 345 Fire Alarm System - Testing and Maintenance Correct Deficient Practice: On 3/07/25 MS called Delta Fire Equipment to schedule the facility's Annual Fire Alarm Test on 3/10/25. Identify Others: All residents, employees, and visitors are at risk due to this deficient practice. Systemic Changes: On 03/10/2025 Administrator provided in-service education to Maintenance Supervisor regarding facility policy and procedures titled, "Maintenance Services" & "Fire Safety Inspections," indicating the maintenance department is responsible for maintaining the fire alarm system in good working order and the need for Annual Fire Alarm System Test inspections to be completed and forwarded to the administrator within 48 hours. MS or designee will complete the Mesa Glen Annual Fire Alarm Test Log on a annual basis to ensure all parts of the Fire Alarm system are in working order. Any negative findings will be reported to administrator and corrected immediately. Monitoring: Findings and trends from Inspection rounds will be brought to Quarterly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/2025.	
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	K 353		

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K 353	Continued From page 3 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: 1) Based on interview and record review, the facility failed to maintain an annual fire sprinkler service (testing and evaluation of the system designed to extinguish a fire) completed within the last 12 months. This deficient practice has the potential for the issues with the fire sprinkler system to go unnoticed and unaddressed by the facility which could possibly affect the safety of the residents, staff, visitors to the facility. 2) Based on interview, and record review, the facility failed to conduct a 20-year sprinkler test (a test conducted on a sample of the facility's sprinkler heads to ensure that the sprinklers are still functioning properly) for their quick-release sprinkler heads throughout the facility. This deficient practice has the potential for the old, untested sprinkler heads to have a decreased effectivity when discharging water as designed, during a fire emergency, this would affect the safety residents, staff, and visitors at the facility.	K 353	K353 Sprinkler System - Maintenance and Testing Correct Deficient Practice: On 3/07/25 MS Called Delta Fire to schedule Annual Fire Sprinkler Test on 3/07/25. On 3/14/25 Kord Fire Protection to schedule the facility's 20 Year Quick Release Sprinkler Test on 4/03/25. Identify Others: All residents, employees, and visitors are at risk due to this deficient practice. Systemic Changes: On 03/10/2025 Administrator provided in-service education to Maintenance Supervisor regarding facility policy and procedures titled, "Maintenance Services" & "Fire Safety Inspections," indicating the maintenance department is responsible for maintaining the fire alarm system in good working order and the need for Annual and 20 Year Quick Response Sprinkler Test inspections to be completed and forwarded to the administrator within 48 hours. Any negative findings will be reported to administrator and corrected immediately. Monitoring: Findings and trends from Inspection rounds will be brought to Quarterly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/2025.	

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K 353	Continued From page 4 Findings: 1) During an interview on 3/5/2025, at 10:30 a.m., with the ADM and MS, a request for written documentation of the most recently conducted "Annual Sprinkler Service" was verbally requested along with a written request. During a concurrent interview and record review on 3/5/2025, at 2:47 p.m., with the MS and RMD, the RMD stated they are missing the Annual Sprinkler Service within the past twelve months. 2) During an interview on 3/5/2025, at 10:30 a.m., with the ADM and MS, a request for written documentation of the most recently conducted "20 Year Quick Response Sprinkler Service" was verbally requested along with a written request. During a concurrent interview and record review on 3/5/2025, at 2:51 p.m., with the MS and RMD, the RMD stated they are missing the 20 Year Quick Response Sprinkler Service and Test.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to install a portable fire extinguisher (PFE) at the required height range in	K 355	K 355 Portable Fire Extinguishers Correct Deficient Practice: On 3/10/25 MS removed the portable fire extinguisher mounted on the wall inside the kitchen and properly reinstalled it less than 5 feet off the ground. Identify Others: On 03/10/2025 MS did a visual check on all portable fire extinguishers to ensure they were installed at the proper height off the floor to allow easy access when needed. No other deficient practice found.	

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K 355	Continued From page 5 accordance with NFPA 10, 2010 Edition Section 6.1.3, affecting one of three smoke compartments. This deficient practice has the potential to hinder access to the PFE and delay the extinguishing of a fire in the event of an emergency. Findings: During a concurrent observation and interview on 3/5/2025 at 1:30 p.m. with the MS and RMD, the PFE mounted on the wall inside the kitchen by the dry storage area was measured from the top of the PFE to the floor and the RMD stated it was 65.5 inches.	K 355	Systemic Changes: On 03/10/2025 Administrator provided in-service education to MS regarding NFPA 10 titled, "Fire Extinguisher Placement Guide," indicating that "Extinguishers need to be installed at least 4 inches off the ground up to a maximum of 5ft. The exception to this is for extinguishers heavier than 40 lbs, they can only be up to 3 ft 6 inches off the ground and wheeled fire extinguishers don't need to be off the ground since the wheels already keep the cylinder from touching the floor." MS verbalized understanding. MS will complete monthly checks to ensure compliance and ease of access for all portable fire extinguishers in the facility. Any negative findings will be reported to the Administrator and corrected immediately.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363	Monitoring: Findings and trends from Inspection rounds will be brought to Monthly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/25 K 363 Corridor - Doors Correct Deficient Practice: On 03/10/2025 MS replaced malfunctioning latch that was preventing the fire door from latching shut when closed. Identify Others: All fire doors in the facility were inspected on 03/10/2025 by MS to ensure doors latch when closed. No other deficient practice found.	

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K 363	Continued From page 6 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain resident room doors in good repair and free from impediments that prevent the full closure of the door in one of three smoke compartments. This deficient practice has the potential for doors to remain open during a fire or other emergency, affecting the safety of residents, staff, and visitors. This deficient practice had the potential to allow for the spread of fire within the building which poses a risk to the safety to the residents if a fire were to occur inside the facility. Findings: During a concurrent observations and interview on 3/5/2025 at 11:05 a.m. with the MS outside Resident Room 18, the positive latching hardware of the corridor door did not activate to keep the door shut. The MS stated he will replace the	K 363	Systemic Changes: In-service education was provided by Administrator on 03/10/2025 to Maintenance Supervisor regarding facility's policy and procedures titled "Fire Safety Inspections and "Fire and Smoke Barrier Doors," indicating that fire and smoke barrier doors will automatically close when the fire alarm system is activated or power failure occurs. On 03/10/2025 Director of Staff Development provided in-service education to staff regarding facility policy and procedure titled, "Fire and Smoke Barrier Doors" indicating that staff are to report fire and smoke barrier doors that are partially open or that do not close properly in writing to the maintenance supervisor. Staff attending the in-service verbalized understanding. Monitoring: Findings and trends from Inspection rounds will be brought to Quarterly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/25	

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K 363	Continued From page 7 malfunctioning latch.	K 363		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to maintain the documentation for the fire drills conducted during every quarter for every shift. This affected six of twelve drills. This deficient practice has the potential to negatively affect the staff's response to a fire drill, potentially affecting the health and safety of residents, staff, and visitors to the facility. Findings: During an interview on 3/5/2025, at 10:30 a.m., with the ADM and MS, a request for written documentation of the quarterly fire drills conducted in the last twelve months for each shift was verbally requested along with a written request. During a concurrent record review and interview of the Fire Drill Logs for the facility on 3/5/2025, at	K 712	K 712 Fire Drills Correct Deficient Practice: On 3/10/25 Director of Staff Development (DSD) called Southwest Fire Life Safety and Security LLC and scheduled Fire Drills for both the PM Shift and NOC shifts on 03/26/25. Identify Others: DSD reviewed Fire Drills performed within the last 12 months, and no other deficient practice found. Systemic Changes: In-service education was provided by Administrator on 03/10/2025 to DSD and MS regarding facility's policy and procedure titled "Fire and Life Safety Training Drills," indicating that fire and life safety drill are conducted on at least a monthly basis and at least quarterly on each shift. On 3/17/25 DSD Called Southwest Fire Life Safety and Security LLC and created an annual schedule for the facility's fire drills. DSD will be in charge of ensuring these fire drills take place at least quarterly for each shift and will keep the written documentation of the quarterly fire drills conducted. Any deficient practice will be reported to Administrator and corrected immediately. Monitoring: Completed fire drills will be reported monthly to Safety Committee meeting by DSD until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/25	

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K 712	Continued From page 8 3:03 p.m., the sign-in sheet for four out of twelve fire drills were missing: first quarter NOC shift, second quarter PM shift, third quarter PM and NOC shifts. The Administrator stated they will keep looking for the missing fire drills.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an annual fire door assembly test completed within the last 12 months in accordance with NFPA 80 2010 Edition Section 5.2. This deficient practice has the potential for the issues with the fire doors to go unnoticed and unaddressed by the facility which could possibly affect the safety of the residents, staff, visitors to the facility. Findings: During an interview on 3/5/2025, at 10:30 a.m.,	K 761	K 761 Maintenance, Inspection & Testing - Doors Correct Deficient Practice: On 3/10/25 MS called Delta Fire Equipment, Inc. and scheduled the facility's Annual Automatic Closing Assemblies for the fire doors. The Annual Automatic Closing Assemblies for the fire doors is scheduled on 3/10/25. Systemic Changes: On 03/10/2025 Administrator provided in-service education to MS regarding NFPA 80, Fire Doors and Other Opening Protectives 5.2 Inspections. "5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ." MS verbalized understanding. MS and Administrator will create a yearly life and Safety Checklist with all services needed for the facility to stay in compliance. MS will ensure that all services are performed on a timely basis. At the begining of every month MS will review checklist and schedule the needed services. For three months or until compliance is sustained MS will report all Life and Safety services scheduled and performed in the building to Safety Committee, if any services were missed the MS will immediately notify the Administrator and correct the deficient practice.	

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MESA GLEN CARE CENTER	**638 E COLORADO AVENUE GLENDORA, CA 91740**

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K 761	Continued From page 9 with the ADM and MS, a request for written documentation of the most recently conducted "Annual Fire Door Assemblies Test" was verbally requested along with a written request. During a review of the facility's records, the reports did not indicate that the fire door assemblies had an annual test. During a concurrent interview and record review on 3/5/2025, at 3:11 p.m., with the MS and RMD, the RMD stated they are missing the Annual Fire Door Assemblies Test within the past twelve months.	K 761	Monitoring: Findings and trends from Life and Safety Checklist will be brought to Monthly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/25	
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. 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	K 918	K 918 Electrical Systems - Essential Electric Systems Correct Deficient Practice: On 03/10/2025 MS Scheduled Bay City Electric to perform a four-hour continuous exercise under load condition on 04/08/2025 Identify Others: The deficient practice has the potential to affect all residents, staff and visitors in the event of a power failure. Systemic Changes: In-service education was provided by Administrator on 03/10/2025 to MS regarding NFPA 110 and Life Safety Code requirements to ensure facility's generator is being tested appropriately. MS and Administrator will create a yearly calendar for testing the generator. MS will perform the generator tests and complete the Mesa Glen Generator Testing Log on an as needed basis to ensure facility's generator is functioning appropriately.	

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K 918	Continued From page 10 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 interview and record review, the facility failed to provide documentation that the facility's emergency generator had a four-hour continuous exercise within the past 36 months. In the event of a power loss, this failure has the potential for emergency generator to fail or not properly operate as intended which can negatively affect the health and safety of residents, staff, and visitors in the facility. This deficient practice affected three of three smoke compartments. Findings: During an interview on 3/5/2025, at 10:30 a.m., with the Administrator and MS, a request for written documentation of the most recently conducted "four hour generator load test" was verbally requested along with a written request. During a review of the facility's generator service reports, the reports did not indicate that the generator had a four-hour continuous exercise/test. During an interview on 3/5/2025 at 3:15 p.m. with	K 918	Monitoring: Findings and trends from Inspection rounds will be brought to Quarterly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/25	

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K 918	Continued From page 11 the MS and RMD, the surveyor requested for documented evidence that the facility's generator was continuously tested for at least four hours within the past 36 months. The RMD stated that they could not find evidence of a four hour generator load test.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly use surge protectors and prevent the use of outlet extenders (a device that	K 920	K 920 Electrical Equipment - Power Cords and Extension Cords Correct Deficient Practice: MS removed unapproved surge protectors from the Social Service Director's office and the Director of Staff Development's Office. Identify Others: Maintenance Supervisor did a visual check of the facility for any other unapproved electrical equipment being used. No other deficient practice found. Systemic Changes: In-service education was provided by Administrator on 03/10/2025 to Department Heads regarding only using approved electrical power strips and the danger of daisy chaining appliances. Director of Staff Maintenance Supervisor will create a log to check the facility on a weekly basis to ensure only approved electrical extension cords and power strips are being used for 3 months or until compliance is sustained. Maintenance Supervisor will also check electrical extension cords and power strips monthly and complete Maintenance Inspection Report. Any negative findings will be reported to Administrator and corrected immediately.	

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K 920	Continued From page 12 plugs into an outlet and turns the one outlet into multiple usable outlets) in one of three smoke compartments. This deficient practice has the potential to create an electrical overload (when too much electricity passes through an electrical device) and/or possible fire, affecting the safety residents, staff, and visitors at the facility. Findings: During a concurrent observation and interview on 3/5/2025, at 12:29 p.m., with the MS, inside the DSD's office, a surge protector was observed to be plugged into a surge protector. The MS stated they should not be connected to one another. During a concurrent observation and interview on 3/5/2025, at 12:52 p.m., with the MS, inside the Social Services office, a surge protector was observed to be plugged into a surge protector. The MS stated he will take care of the issue.	K 920	Monitoring: Maintenance Supervisor will present weekly and monthly logs to facility's Safety Committee Meeting on a monthly basis for analysis of trends until compliance is achieved. Safety Committee will provide further recommendations when needed. Completion Date: 3/28/25	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum	K 923		

K923 Gas Equipment-Cylinder and COntainer Storage

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K 923	Continued From page 13 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to segregate full oxygen cylinders from empty oxygen cylinders in one of three smoke compartments. This deficient practice had the potential to confuse staff as to which oxygen cylinders are full and which oxygen cylinders are empty in the event of an emergency, which could pose a risk to resident's safety. Findings: During a concurrent observation and interview on 3/5/25 at 1:09 p.m. with the MS and RMD by the oxygen storage closet near Resident Room 2, there were three empty oxygen cylinders stored	K 923	K923 Gas Equipment- Cylinder and Container Storage Correct Deficient Practice: On 3/07/25 Central Supply separated and arranged the oxygen tanks accordingly. Identify Others: All residents, employees, and visitors are at risk due to this deficient practice. Systemic Changes: On 03/10/2025 Administrator provided in-service education to Maintenance Supervisor and Central Supply regarding the proper storage of oxygen tanks. Admin to check oxygen storage room weekly. Any negative findings will be reported to administrator and corrected immediately. Monitoring: Findings and trends from Inspection rounds will be brought to Quarterly Safety Committee meeting by MS until Safety Committee has determined compliance has been sustained. Facility's Safety Committee will provide further recommendations as necessary. Completion Date: 3/28/2025.  Christian Urbina,NHA Administrator	

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K 923	Continued From page 14 with full oxygen cylinders. The RMD stated they need to be separated.	K 923		