STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335379	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGO PARK NURSING HOME	**111 26 CORONA AVENUE** **FLUSHING, NY 11368**

(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 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 4, 2021 following New York Department of Health, Health Facility Survey and Field Operations survey on April 9, 2021. At this Comparative Federal Monitoring Survey, Rego Park Nursing Home was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Rego Park Nursing Home is a six story building that was built in 1974. It is composed of Type II (222) and is partially sprinklered on domestic water. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. Emergency backup power to the building was supplied by a 125 Kw diesel generator outside the facility that is tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases and emergency facility lighting. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the	K 000		

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

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K 000	Continued From page 1 means of egress in areas of construction, repair, alterations or additions. The facility has 200 certified beds. At the time of the survey the census was 140. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a	K 222	**Plan of Correction for affected areas** 1) Maintenance staff permanently removed the fabric stop sign attached with Velcro across the Main Dining Room exit access door. 2) The Maintenance staff permanently removed the fabric stop sign attached with Velcro across the 1st Floor Stair B exit door. 3) The Maintenance staff permanently removed the delayed egress locking mechanism from the 1st floor Stair B exit door. 4) The Maintenance staff permanently removed the “Stop” sign from the 3rd Floor Stair B exit door. 5) The Maintenance staff permanently removed the “Stop” sign from the 3rd Floor Stair A exit door. 6) The Maintenance staff permanently removed the “Stop” sign from the 6th Floor Stair B exit door. 7) The Maintenance staff permanently removed the “Stop” sign from the 6th Floor Stair A exit door.	05/11/21

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K 222	Continued From page 2 complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18 .2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide signs at exits with delayed egress locking devices that indicated the procedure for the operation of the delayed release function, and all required exit	K 222	**Plan of Correction to identify other areas potentially affected** The Maintenance staff completed a survey of all exit access and stair doors for any obstructions or signage that would potentially confuse or prohibit residents instant use of the facility designed exit. None were found. **Plan of Correction for system measures to prevent reoccurrence** The Engineer or Designee will monitor all exits during environment of care rounds and report the findings to the Safety Committee for a period of six (6) months. **Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	05/11/21

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K 222	Continued From page 3 passageways are readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.1, 19.2.2, 19.2.2.2.4, 7.1.10.1, 7.1.10.2, 7.10.1.2.1, 7.2.1, 7.2.1.6 and 7.10.1.2.1. The deficient practice could affect 125 of 125 residents, as well as an indeterminable number of staff and visitors. Findings include: Observation on May 4, 2021 at approximately 10:05 AM revealed dining room exit access door had fabric "stop" sign across the door, attached with velcro to the door frame that blocked the door prohibiting residents instant use of the facility designated exit in the case of fire or other emergency. Observation on May 4, 2021 at approximately 10:56 AM revealed first floor stair way B exit door had fabric "stop" sign across the door, attached with velcro to the door frame that blocked the door prohibiting residents instant use of the facility designated exit in the case of fire or other emergency. Observation on May 4, 2021 at approximately 10:57 AM revealed first floor stair way B exit door did not have a sign on the door with a contrasting background indicating how to operate the delayed egress locking mechanism. Observation on May 4, 2021 at approximately 11:18 AM revealed third floor B exit door had "stop" sign on the door potentially confusing or	K 222		

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K 222	Continued From page 4 prohibiting residents instant use of the facility designated exit in the case of fire or other emergency. Observation on May 4, 2021 at approximately 11:22 AM revealed third floor A exit door had "stop" sign on the door potentially confusing or prohibiting residents instant use of the facility designated exit in the case of fire or other emergency. Observation on May 4, 2021 at approximately 11:26 AM revealed sixth floor B exit door had "stop" sign on the door potentially confusing or prohibiting residents instant use of the facility designated exit in the case of fire or other emergency. Observation on May 4, 2021 at approximately 11:32 AM revealed sixth floor A exit door had "stop" sign on the door potentially confusing or prohibiting residents instant use of the facility designated exit in the case of fire or other emergency. The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	K 281	**Plan of Correction for affected areas** 1) The facility permanently installed a light fixture with dual lamps under the canopy at the 1st Floor Rehab exit discharge above the door.	08/24/21

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K 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide emergency illumination that would operate automatically along the means of egress and the required illuminance with two lamps energized during emergencies in accordance with NFPA 101, 2012 Edition, Section 19.2.8, 7.8, 7.8.1.1, 7.8.1.2,7.8.1.4 and 7.9.2.1 . The deficient practice could affect 60 of 200 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on May 4, 2021 at approximately 9:55 AM revealed first floor rehab exit door the lighting was obstructed by a canopy, there was no continuous lighting along the path of egress to safety. Observation on May 4, 2021 at approximately 10:24 AM high voltage room contained the automatic transfer switch revealed all lighting, including the emergency lights could be powered off. There was no continuous lighting along the path of egress to safety when the switch was in the off position. Observation on May 4, 2021 at approximately 10:57 AM revealed first floor stairway B exit door there was no continuous lighting along the path of egress to safety. The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.	K 281	2) The facility permanently installed a light fixture with dual lamps at the 1st Floor Stair B exit discharge above the door. 3) The facility permanently removed the light switch in the Main electrical room. The lights will remain on at all times. The facility also maintains an Emergency Battery Pack light in the room. **Plan of Correction to identify other areas potentially affected** The Maintenance staff conduct a survey of all exit discharge. Based on the survey the facility permanently installed a light fixture with dual lamps at the 1st Floor Stair C exit discharge above the door. **Plan of Correction for system measures to prevent reoccurrence** The Engineer or Designee will monitor all lighting during environment of care rounds and report the findings to the Safety Committee for a period of six (6) months. **Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	08/24/21

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K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to visually inspect and maintain fire suppression manual release in accordance with the requirements NFPA 101, 2012 Edition, Section 19.3.2.5.1, 9.2.3, NFPA 96, 2011 Edition, Sections 10.5, 12.1.2.4 and 12.1.2.5. The deficient practice could affect 30 of 200 residents, as well as an indeterminable number	K 324	**Plan of Correction for affected areas** 1) The Maintenance staff immediately removed the garbage cart and the telephone charger that obstructed the ANSUL manual release mechanism. The Maintenance staff permanently relocated the electrical outlet from below the ANSUL manual release mechanism. 2) 2) The deep-fat fryer was permanently separated from the adjacent cooking equipment in excess of 16". **Plan of Correction to identify other areas potentially affected** The deep-fat fryer was permanently separated from the adjacent cooking equipment in excess of 16". **Plan of Correction for system measures to prevent reoccurrence** All staff will be in-serviced to keep the ANSUL manual release mechanism free of obstructions for immediate use. The Dietary Director will be responsible for the in-service training for all staff. The Engineer or Designee will conduct environment of care rounds and report the findings to the Safety Committee for a period of six (6) months.	05/11/21

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K 324	Continued From page 7 of staff and visitors. Findings include: Observation on May 4, 2021 at approximately 10:11 AM in kitchen revealed that the ANSUL manual release was obstructed by a garbage cart on the floor and a telephone charger connected to an electrical socket three inches below the release mechanism, it was not readily accessible and immediately available. Observation on May 4, 2021 at approximately 10:15 AM in kitchen revealed deep-fat fryer was not located sixteen inches form surface flames of adjacent cooking equipment and there was no steel or tempered glass baffle plate eight inches high installed. The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.	K 324	**Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	05/11/21
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351	Plan of Correction for affected areas 1) The Maintenance staff permanently relocated the light fixture. 2) 2) The facility will permanently install a sprinkler pendant in the identified area behind the dryer.	08/24/21

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K 351	Continued From page 8 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, this facility did not provide complete sprinkler coverage as required by CMS regulation § 483.90(a) Physical environment. The facility failed to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5 and 9.7, NFPA 13, 2012 Edition, Section 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2, 8.6.3.3 and Table 8.6.5.1.2. The lack of sprinkler coverage and obstructed sprinkler could delay or prevent the extinguishment of a fire in this area. The deficient practice could affect 20 of 200 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on May 4, 2021 at approximately 9:50 AM in first floor rehab bathroom revealed sprinkler was obstructed by a light fixture located three inches deep and two inches to the side of sprinkler head. Observation on May 4, 2021 at approximately 1:32 PM in laundry room revealed that the area behind the dryer was not provided with sprinkler coverage.	K 351	**Plan of Correction to identify other areas potentially affected** The maintenance staff checked all sprinklers for obstructions and/or lack of coverage. None were found. **Plan of Correction for system measures to prevent reoccurrence** The Engineer or Designee will conduct environment of care rounds and report the findings to the Safety Committee for a period of six (6) months. **Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	08/24/21

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K 351	Continued From page 9 The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.	K 351		
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, 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 and interview, the facility failed to maintain the sprinkler system, ensuring the ceiling level was smoke resisting, sprinklers free from loading (obstruction) and sprinkler box not having the correct number of replacement sprinklers in accordance with NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12, 9.7 and 9.7.5, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.1.1, 5.2.1.1.2, 5.4.1.4. The deficient practice of failing to provide a complete smoke resisting ceiling at	K 353	**Plan of Correction for affected areas** 1) The facility permanently completed the ceiling assembly and sealed the plumbing pipe to prevent hot gases and smoke past the sprinkler into the space above in the Therapy Storage Closet. 2) The facility permanently completed the ceiling assembly to prevent hot gases and smoke past the sprinkler into the space above in the Kitchen. 3) The Maintenance staff removed the yellow foam and obstruction on the identified sprinkler head in the Freezer. 4) The Facility ordered the required spare sprinklers for each type of sprinkler pendant used in the facility and will store them in the approved cabinet. 5) The facility permanently completed the ceiling assembly to prevent hot gases and smoke past the sprinkler into the space above in the identified Storage Room.	**05/11/21**

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K 353	Continued From page 10 the level of the installed sprinklers, sprinklers free from loading would not ensure prompt and proper operation of the sprinklers. The deficient practice could affect 50 of 200 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on May 4, 2021 at approximately 9:52 AM in therapy storage closet revealed one foot by two foot section of ceiling tile missing and penetrations by plumbing piping not properly fire stopped allowing hot gasses and smoke past the sprinkler into the space above. Observation on May 4, 2021 at approximately 10:09 AM in kitchen revealed one foot by one foot section of ceiling tile missing allowing hot gases and smoke past the sprinkler into the space above. Observation on May 4, 2021 at approximately 10:10 AM in walk in freezer revealed sprinkler loaded with yellow foam and obstructed. Observation on May 4, 2021 at approximately 10:26 AM in the sprinkler room the facility sprinkler box did not have the correct number of six spare sprinklers for each type used in the facility. Observation on May 4, 2021 at approximately 10:39 AM in storage room revealed six sections of four foot by two foot of ceiling tile missing allowing hot gases and smoke past the sprinklers into the space above.	K 353	**Plan of Correction to identify other areas potentially affected** The maintenance staff checked all sprinklers for foreign material All sprinkler heads were free of foreign material. The maintenance staff checked all ceiling integrity throughout the facility. No openings were found that would allow hot gases or smoke past the sprinkler into the space above. **Plan of Correction for system measures to prevent reoccurrence** The Engineer or Designee will conduct environment of care rounds and report the findings to the Safety Committee for a period of six (6) months. **Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	**05/11/21**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 11 Observation on May 4, 2021 at approximately 1:32 PM in laundry room revealed one foot by one foot of ceiling tile missing allowing hot gases and smoke past the sprinkler into the space above. The findings were verified by the Maintenance Director and Housekeeping Supervisor at the times of the observation.	K 353		
K 355 SS=F	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 and interview, the facility failed to visually inspect fire extinguishers monthly, not obstructed and ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition, Sections 5.5.5.3, 6.1.3.1 6.1.3.3.1, 7.2, 7.2.1.2, 7.2.2, 7.2.4.3 and 7.2.4.4. The deficient practice could affect 160 of 200 residents, as well as an indeterminable number of staff and visitors. Findings include: Observation on May 4, 2021 at approximately 9:55 AM in therapy room revealed that the fire extinguisher was not inspected monthly. The	K 355	**Plan of Correction for affected areas** The Maintenance staff immediately reinspected all fire extinguishers in the facility and marked each tag as inspected. The Maintenance staff immediately removed the garbage cart that obstructed the “K” fire extinguisher. The Maintenance staff immediately removed the medication cart that obstructed the fire extinguisher in the basement corridor outside the sprinkler room. **Plan of Correction to identify other areas potentially affected** Maintenance staff were in-serviced that all fire extinguishers inspection tags will be signed for each monthly inspection along with the Records & Logs inspection sheets. **Plan of Correction for system measures to prevent reoccurrence** The established Preventive Maintenance & Scheduling will be followed reflecting the monthly and annual testing of the fire extinguishers.	08/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335379	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2021**

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K 355	Continued From page 12 inspection tag was blank and did not indicate that monthly inspection (date and initials) was completed. Interview on May 4, 2021 at approximately 9:56 AM Maintenance Director revealed that the fire extinguisher was inspected monthly, records of inspections was available although the inspection tag on all fire extinguishers was blank and did not indicate the monthly inspection was completed. Observation on May 4, 2021 at approximately 10:11 AM in kitchen revealed that the K type fire extinguisher was obstructed by a garbage cart it was not readily identifiable, accessible and immediately available. Observation on May 4, 2021 at approximately 10:24 AM in the basement corridor outside sprinkler room revealed that the fire extinguisher was obstructed by a medication cart it was not readily identifiable, accessible and immediately available. The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.	K 355	All staff will be in-serviced to keep all fire extinguishers free of obstructions for immediate use. The Engineer of Designee will be responsible for the in-service training for all staff. The Engineer or Designee will monitor all testing and report the findings to the Safety Committee for a period of six (6) months. **Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	08/12/21
K 700 SS=F	Operating Features - Other CFR(s): NFPA 101 Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	K 700	**Plan of Correction for affected areas** The Director of Housekeeping immediately stopped the practice of drying rags and mop heads in a dryer in the facility.	05/11/21

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K 700	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to safely process mop heads and rags that have chemicals or grease in accordance with NFPA 101, 2012 Edition, Section 19.1.1.3.1. This deficient practice could lead to the spontaneous combustion of laundry and would affect occupants of the facility by putting them at risk of serious harm if a fire occurred. The deficient practice could affect 125 of 125 residents, as well as an indeterminable number of staff and visitors. Findings include: Interview on May 4, 2021 at approximately 10:44 AM in laundry room revealed the laundry staff wash housekeeping rags and mop heads and dry them in a dryer. Observation on May 4, 2021 at approximately 10:45 AM in laundry room revealed Diamond CRT safety bleach was utilized in the cleaning process and safety data sheet hazard identified NFPA Rating Fire Scale 3, oxidizing substance that may cause fire or explosion. According to the National Fire Protection Association, many fires occur each year in laundries as a result of improper processing of chemical and grease laden rags. Some of those that are not air dried, have been known to build up heat and spontaneously combust as a result of the chemical reaction.	K 700	**Plan of Correction to identify other areas potentially affected** The practice of using the dryer for all material used with chemicals that could cause a fire or explosion and/or spontaneously combust was permanently stopped. The facility hired a vendor to clean and dry all rags and mop heads outside the facility. **Plan of Correction for system measures to prevent reoccurrence** The Director of Housekeeping will monitor all materials throughout the facility are being sent out during environment of care rounds and report the findings to the Safety Committee for a period of six (6) months. **Plan of Correction for monitoring corrective actions** The Director of Housekeeping will review environment of care rounds for any cases of non-compliance. The Facilities Manager or Designee will report the result of these audits to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	05/11/21
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918	**Plan of Correction for affected areas** The facility has contracted with our Emergency Generator contractor to permanently install a remote Emergency shut off outside the generator encasement.	**8/18/21**

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K 918	Continued From page 14 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 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 and interview the facility did not ensure a remote stop for the generator	K 918	**Plan of Correction to identify other areas potentially affected** The facility will have permanently installed the remote Emergency shut off outside the generator encasement. **Plan of Correction for system measures to prevent reoccurrence** The Engineer or Designee will report when the emergency generator remote shutoff was installed to the Safety Committee. **Plan of Correction for monitoring corrective actions** The Engineer or Designee will review environmental rounds for any case of non-compliance. The Facilities Manager or Designee will report to the Safety committee on a quarterly basis, as well as correction plan if warranted. **Responsibility:** Administrator	**08/18/21**

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K 918	Continued From page 15 was provided in accordance with the requirements of NFPA 101, 2012 Edition, Section 9.1.3.1, NFPA 110, 2010 Edition, Section 9.1.3.1, 5.6.5.6. This deficient practice does not to prevent inadvertent or unintentional operation. The deficient practice could affect 125 of 125 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on May 4, 2021 at approximately 2:20 PM during the facility tour identified the facility generator was outside and encased. Inside the generator encasement was the emergency shut off. Further observation revealed that there was no remote emergency shut off outside the generator encasement. The findings were verified by the Maintenance Director and Housekeeping Supervisor at the time of the observation.	K 918		