Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001061	07/28/2025
Name of Provider or Supplier	**Street Address, City, State**	
Pacific Eye Institute	555 N 13th Avenue, Upland, CA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 416.54, Condition for Coverage for Ambulatory Surgical Centers (ASCs). Representing the California Department of Public Health: 40597 Census: 2
E0026	Roles Under a Waiver Declared by Secretary CFR(s): 416.54(b)(6) 403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 460.84(b)(9), 482.15(b)(8), 483.73(b)(8), 483.475(b)(8), 485.542(b)(7), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at 403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of

	Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the emergency preparedness policies and procedures. This was evidenced by the failure to provide a policy and procedure that would describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. This could result in a delay to continue care and services during an emergency. This affected the patients, staff members, and visitors. Findings: During a review of record and interview with the Office Manager 2 and Office Manager 3 on 7/28/25, the emergency preparedness policies and procedures were reviewed. At 11:41 a.m., the facility failed to provide an 1135 waiver policy and procedure. The emergency action plan (EAP) dated 2024 indicated that the evacuation operations team would reschedule appointments during an emergency. The EAP did not provide a policy to continue services at an alternative care site. Upon interview, the Office Manager 3 stated that she used a similar waiver at a different facility, but the 1135 waiver policy and procedure was not readily available.
E0039	EP Testing Requirements CFR(s): 416.54(d)(2) 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 460.84(d)(2), 482.15(d)(2), 483.73(d)(2), 483.475(d)(2), 484.102(d)(2), 485.68(d)(2), 485.542(d)(2), 485.625(d)(2), 485.727(d)(2), 485.920(d)(2), 491.12(d)(2), 494.62(d)(2). *[For ASCs at 416.54, CORFs at 485.68, REHs at 485.542, OPO, "Organizations" under 485.727, CMHCs at 485.920, RHCs/FQHCs at 491.12, and ESRD Facilities at 494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises

to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at 441.184(d), Hospitals at 482.15(d), CAHs at 485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at 460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires

activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at 483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at 483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at 484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise

following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at 486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at 403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to maintain the emergency preparedness testing program. This was evidenced by the failure to provide an after-action report for an annual community based, full-scale exercise, and by the failure to provide documentation for a secondary exercise within the last 12 months. This could result in a delay to provide care and services during an emergency. This affected patients, staff members, and visitors.

Findings:

During a review of record and interview with the Office Manager 2 and Office Manager 3 on 7/28/25, the emergency preparedness testing was requested.

1. At 11:45 a.m., the facility failed to provide documentation that would indicate a community-based, full-scale exercise was completed within the last 12 months. During an interview, the Office Manager 3 stated that they collaborated with the County, and a critique of the test exercise would be provided. Additional time was given to the facility to provide records of the exercise by 10 a.m. the following day 7

	/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH). 2. At 11:46 a.m., the facility failed to provide documentation that would indicate a secondary test exercise was completed within the last 12 months. During an interview, the Office Manager 3 stated that she will look for the documents in her office. Additional time was given to the facility to submit the requested records by 10 a.m. the following day 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH).
K0000	K3 BUILDING: 01 K6 PLAN APPROVAL: 3/9/87 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: TWO STORY WITH CLINICAL OFFICES ON FIRST FLOOR, CONSTRUCTION TYPE V (111), NON-SPRINKLERED. The following reflects the findings of the California Department of Public Health, during a recertification Life Safety Code survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 416.44(b)(c)(f), 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 416.44 for Ambulatory Surgical Centers (ASCs).
K0293	Exit Signage CFR(s): NFPA 101 Exit Signage Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 20.2.10, 21.2.10, 7.10 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the battery powered exit signs. This was evidenced by the failure to provide functional testing of the exit signs once a month and annually. This could result in a delay to evacuate the occupants to an area of refuge during an emergency. This affected two of two patients, staff members, and visitors in two of two smoke compartments.

NFPA 101 Life Safety Code, 2012 Edition

21.2.10 Marking of Means of Egress. Means of egress shall have signs in accordance with Section 7.10.

7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3.

7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.

7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:

(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).

(2) *The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.

(3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.

(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).

(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

Findings:

During record review and interview with the Office Manager 2 and Facilities Manager on 7/28/25, the exit signs records were requested.

1. At 2:54 p.m., the facility failed to provide testing of the exit signs once a month for not less than 30 seconds. The facility was equipped with 12 exit signs. During an interview, the Facilities Manager stated that the All-In-One Facility Management (AFM) completes their testing on Thursdays. Additional time was given to the facility to provide the requested records by 10 a.m. on 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH).

	2. At 2:55 p.m., the facility failed to provide testing of the exit signs at least annually for a minimum of 1 1/2 hours. During an interview, the Facilities Manager stated that he will provide records by 10 a.m. on 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH).
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance 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 STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire alarm system. This was evidenced by the failure to provide a vendor report indicating that the fire alarm system was inspected and tested annually, by the failure to provide visual inspections at least every six months, and by the failure to provide annual and semiannual testing of the sealed lead acid batteries. This could result in a malfunction of the fire alarm system during an emergency. This affected two of two patients, staff members, and visitors in two of two smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 21.3.4 Detection, Alarm, and Communications Systems. 21.3.4.1 General. Ambulatory health care facilities shall beprovided with fire alarm systems in accordance with Section9.6, except as modified by 21.3.4.2 through 21.3.4.4. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition 14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Table 14.3.1 Visual Inspection Frequencies: Semi Annual

1. Control equipment

3. Batteries

4. Transient suppressors

5. Fire alarm control unit trouble signals

7. In-building fire emergency voice/alarm communication equipment

8. Remote annunciators

9. Initiating devices

12. Interface equipment

13. Alarm notification appliances

15. Supervising station alarm systems - transmitters

16. Special procedures

17. Supervising station alarm systems - receivers

18. Public emergency system reporting system transmission equipment

19. Mass notification system, supervised

14.3.4 The visual inspection shall be made to ensure that there are no changes that affect equipment performance.

14.4.2.2* Systems and associated equipment shall be tested according to Table 14.4.2.2.

5. Batteries-general tests: Prior to conducting any battery testing, the person conducting the test shall ensure that all system software stored in volatile memory is protected from loss.

(a) Visual inspection: Batteries shall be inspected for corrosion or leakage. Tightness of connections shall be checked and ensured. If necessary, battery terminals or connections shall be cleaned and coated. Electrolyte level in lead-acid batteries shall be visually inspected.

(e) Load voltage test: With the battery charger disconnected, the terminal voltage shall be measured while supplying the maximum load required by its application. The voltage level shall not fall below the levels specified for the specific type of battery. If the voltage falls below the level specified, corrective action shall be taken, and the batteries shall be retested.

Table 14.4.5 Testing Frequencies

(d) Sealed lead-acid type

	(1) Charger test - Annually (2) Discharge test - Annually (3) Load voltage test - Semiannually Findings: During record review, and interview with the Office Manager 1, Office Manager 2, and Facilities Manager on 7/28/25, the fire alarm system records were requested. 1. At 11:10 a.m., the facility failed to provide the annual inspection and testing of the fire alarm system. Upon interview, the Facilities Manager stated that the vendor report will be available by end of day today. Additional time was given to the facility to provide a copy of the annual report by 10 a.m. on 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH). This is a repeat deficiency that was cited on the Life Safety Code survey dated 4/20 /17. 2. At 12:20 p.m., the facility failed to provide two of two semi-annual inspections of the fire alarm system and its components. During an interview, the Office Manager stated that she will look for the record. The Facilities Manager stated that All-In-One Facilities Maintenance (AFM) completes weekly visual inspections every Thursdays, and he will provide the records. Additional time was given to the facility to provide record of the semiannual visual inspections by 10 a.m. on 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH). 3.At 2:07 p.m., the facility failed to provide records of the annual and semiannual testing of the seal lead acid battery. The battery was located in thefire alarm control panel on the first floor. During an interview, the Office Manager 2 stated that she will check with the Facilities Manager. At 2:49 p.m., the Facilities Manager stated that he will provide the annual and semiannual testing of the battery. Additional time was given to the facility to provide battery testing by 10 a.m. on 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH).
K0355	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. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10

This STANDARD is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by missing an annual inspection, missing monthly visual inspections, and by missing a tamper seal on the top handle. This could result in a malfunction of the extinguisher to operate at the time of a fire. This affected two of two patients, staff members, and visitors in two of two smoke compartments.

NFPA 101, Life Safety Code, 2012 Edition

21.3.5.3 Portable fire extinguishers shall be provided in ambulatory health care facilities in accordance with 9.7.4.1.

9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition

7.2 Inspection.

7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device / system at a minimum of 30-day intervals.

7.2.2 Procedures. Periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items:

(1) Location in designated place

(2) No obstruction to access or visibility

(3) Pressure gauge reading or indicator in the operable range or position

(4) Fullness determined by weight or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks

7.2.2.2 Where required by 7.2.2., the following inspection procedure shall be in addition to those addressed in 7.2.2:

1. Verifying that operating instructions on nameplates are legible and face outward.

2. Checking for broken or missing safety seals and tamper indicators.

3. Examination for obvious physical damage, corrosion, leakage, or clogged nozzle.

7.2.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be

	taken. 7.2.4.3 Where a least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspections shall be recorded. 7.3* Maintenance. 7.3.1 Frequency. 7.3.1.1 All Fire Extinguisher 7.3.1.1.1 Fire extinguishers shall be subject to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. 7.3.1.1.2 Fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Table 7.3.1.1.2 -Dry Chemical, cartridge-and cylinder-operated, with mild steel shells: 1 year interval Findings: During a tour of the facility, record review, and interview with the Office Manager 2, Office Manager 3, and Facilities Manager on 7/28/25, the portable fire extinguishers were observed, and records were requested and reviewed. 1. At 2:50 p.m., the fire extinguisher in the southwest stairwell was observed. The inspection tag indicated that it was last serviced annually in March 2022. During an interview, the Facilities Manager stated that the vendor should have serviced it annually during November 2024. 2. At 2:59 p.m., the fire extinguisher in the pre-operation area was observed. The pull pin tamper seal was missing. During an interview, the Office Manager 2 stated that she was not aware of it. 3. At 3:17 p.m., the fire extinguishers in the pre-operation, nurse station, and lobby were missing the monthly inspection in December 2024. During an interview, the Facilities Manager stated that the All-In-One Facilities Management (AFM) completes monthly inspections on Thursdays.
K0521	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2 This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to maintain the heating, ventilation, and air-conditioning (HVAC) system. This was evidenced by the missing inspection and testing of the fire dampers every four years. This could result in the spread of fire to other areas during an emergency. This affected two of two patients, staff members, and visitors in two of two smoke compartments.

NFPA 101, Life Safety Code, Edition 2012

21.5 Building Services.
21.5.2 Heating, Ventilating, and Air-Conditioning.
21.5.2.1 Heating, ventilating, and air-conditioning shall complywith the provisions of Section 9.2 and shall be in accordancewith the manufacturers specifications, unless otherwisemodified by 21.5.2.2.

9.2 Heating, Ventilating, and Air-Conditioning.

9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 Edition

5.4 Fire Dampers, Smoke Dampers, and Ceiling Dampers.

5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.

NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition

19.3 Operational Test.

19.3.1 Fire Dampers. After the installation of a damper is completed, an operational test shall be conducted.

19.3.1.1 The damper shall fully close from the open position.

19.3.1.4 The operational test shall verify that there are no obstructions to the operation of the damper.

19.3.3 Inspection. Following completion of the test, a visual inspection shall be made of the assembly to ensure no obstructions have been introduced.

19.3.4 Documentation. All inspections and testing shall be documented, indicating the

	location of the fire damper, date(s) of inspection, name of inspector, and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. 19.4 * Periodic Inspection and Testing. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. 19.4.4 If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place is so equipped. 19.4.5 The operational test of the damper shall verify that there is no damper interference due to rusted, bent, misaligned, or damage frame or blades, or defective hinges or other moving parts. 19.4.8 The fusible link shall be reinstalled after testing is complete. 19.4.8.1 If the link is damaged or painted, it shall be replaced with a link of the same size, temperature, and load rating. 19.4.10 All documentation shall be maintained and made available for review by the AHJ. Findings: During a review of record and interview with the Office Manager 2, Office Manager 3, and Facilities Manager on 7/28/25, the fire damper records were requested and reviewed. At 3:15 p.m., the facility failed to provide the inspection and testing records of the fire dampers at least every four years. The facility provided a document titled, "Renewal Agreement for HVAC System" that was dated 7/16/25. The agreement failed to indicate the fire dampers were inspected and tested. During an interview, the Facilities Manager stated that he will contact the vendor to see if they have additional documentation. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH).
K0761	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. 21.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)

This STANDARD is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to maintain the fire rated doors. This was evidenced by missing annual inspection and testing of the fire door assemblies, fire rated doors having gaps that were greater than 1/8 of an inch, and fire rated doors that failed to self-close and latch. This could result in the spread of smoke and fire to other areas during an emergency. This affected two of two patients, staff members, and visitors in two of two smoke compartments.

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21.3.7 Subdivision of Building Space.
21.3.7.1 Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following requirements:
(1) Walls shall have not less than a 1-hour fire resistance rating and shall extend from the floor slab below to the floor or roof slab above.
(2) Doors shall be constructed of not less than 13?4 in.(44 mm) thick, solid-bonded wood core or the equivalent and shall be equipped with positive latches.
(3) Doors shall be self-closing and shall be kept in the closedposition, except when in use.
(4) Any windows in the barriers shall be of fixed fire window assemblies in accordance with Section 8.3.

8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code.

NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition

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.

5.2.2 * A record of all inspections and testing shall be signed by the inspector and kept for inspection by the AHJ.

5.2.3 Functional Testing.

5.2.3.1 Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing.

5.2.3.2 Before testing, a visual inspection shall be performed to identify any damaged or missing parts that can create a hazard during testing or affect operation or resetting.

5.2.4 Swinging Doors with Builders Hardware or Fire Door Hardware.

5.2.4.1 Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.

5.2.4.2 As a minimum, the following items shall be verified:

(1)No open holes or breaks exist in surfaces of either the door or frame.

(2)Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.

(3)The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.

(4)No parts are missing or broken.

(5)Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.

(6)The self-closing device is operational; that is, the active door completely closes when operated from the full open position.

(7)If a coordinator is installed, the inactive leaf closes before the active leaf.

(8)Latching hardware operates and secures the door when it is in the closed position.

(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.

(10)No field modifications to the door assembly have been performed that void the label.

(11)Gasketing and edge seals, where required, are inspected to verify their presence and integrity.

6.3.1.7* Clearances.

6.3.1.7.1 The clearances between the top and vertical edges of the door and the frame, and the meeting edges of doors swinging in pairs, shall be 1/8 inch +/- for steel doors and shall not exceed 1/8 inch +/- for wood doors.

Findings:

During a tour of the facility, record review, and interview with the Office Manager 2, Office Manager 3, and Facilities Manager (FM) on 7/28/25, the fire rated doors were observed, and records were requested and reviewed.

1. At 2:56 p.m., the fire rated door that open into Operating Room 2 was observed.

	The door failed to close and self-latch after two attempts. The latching mechanism did not engage with the striker plate. During an interview, the FM stated that he was not aware of it. During the previous Life Safety Code survey on 4/20/17, the facility was cited for doors in the operating rooms that failed to self-latch. 2. At 2:57 p.m., the facility failed to provide the annual inspection and testing records of the fire rated door assemblies.During an interview, the FM stated thatAll-In-One Facility Managment may have the last inspection. 3. At 2:58 p.m., the fire rated doors that open into Operating Rooms 1 and 2 were observed. The clearance between the top and vertical edges of the doors exceeded the allowable 1/8-inch gap. When the doors were closed, a visible gap measuring approximately 1/2-inch was observed. During a concurrent interview, the Office Manager 2, Office Manager 3, and FM confirmed the finding.
K0918	Essential Electrical Systems Generator or Alternate Source 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 four 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 and readily identifiable. 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 STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the stored electrical energy emergency and standby power systems (SEPSS). This was evidenced by missing weekly inspections of the cells within the battery system, and by the failure to provide a load testing of the UPS at least annually. This could result in a malfunction of the Uninterruptible Power Systems (UPS) during a loss of utility power. This affected two of two patients, staff members, and visitors in two of two smoke compartments.

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21.5 Building Services.

21.5.1 Utilities.

21.5.1.1 Utilities shall comply with the provisions of Section 9.1.

9.1.4 Stored Electrical Energy Systems. Stored electrical energysystems shall be installed, tested, and maintained in accordancewith NFPA 111, Standard on Stored Electrical EnergyEmergency and Standby Power Systems.

NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems, 2010 Edition

7.6.5 Baseline Measurement. A permanently installed method of monitoring LA batteries shall be permitted based on ohmic measurements. Ohmic measurements shall be taken of every cell within the battery system approximately 2 weeks following the full load test described in 7.6.2.3, or 2 weeks following the most recent discharge thereafter. Measurements shall be taken on a fully charged battery while float charging. The data shall be recorded to establish a baseline against which all future measurements will be compared.

8.4 Operational Inspection and Testing.

8.4.1* Level 1 equipment shall be inspected monthly and tested in accordance with the manufacturers recommendations. (See Figure A.8.4.2.)

8.4.2* Inspection of the equipment shall include the following:

(1) The battery and associated charger/control equipment shall be checked to verify that they are in a clean and satisfactory condition and that no exceptional environmental or other conditions exist that could damage or affect performance.

(2) Battery electrolyte levels shall be checked, where applicable, and refilled as necessary.

(3) Terminals and intercell connectors shall be cleaned and regreased, if necessary, and cell tops shall be cleaned.

(4) Individual cell voltages shall be checked and recorded where practical.

(5) The specific gravity of pilot cells shall be checked and recorded, where applicable.

(6) The conditions of the plates and sediment of free-electrolyte, LA batteries in transparent containers shall be noted.

(7) All indicator lamps, meters, and controls shall be checked to verify that they are operating correctly.

(8) The load value shall be checked to ensure that it is within the equipment rating.

8.4.3 Load Testing.

8.4.3.1 A load test shall be performed as required by 8.4.1. The output voltage, battery voltage, and duration of the test shall be recorded at the beginning and at the end of the test for each battery set.

8.4.3.2 When a method of ohmic measurements is used to monitor LA batteries, the results shall be maintained and checked for deviance from the baseline established at the time of the battery system installation acceptance in 7.6.5. If data are within the acceptable range as determined by the battery manufacturer, annual load testing shall not be required. If data indicate deviation outside an acceptable range determined by the battery manufacturer, the SEPSS shall be checked at full load for the full duration for its class. A fully rated load bank shall be used in lieu of an actual load provided it is sized to be equal to the ECE rating.

8.4.3.3 When a history of ohmic measurements is not used or maintained, the SEPSS shall be checked annually at full load for 60 percent of its class. A fully rated load bank shall be permitted inlieu of an actual load provided it is sized to be equal to the ECE rating.

8.4.4 The SEPSS shall be checked annually at full load for 60 percent of its class.

8.4.5 A written record of all checks and tests in 8.4.2 shall be maintained and shall be accessible to the authority having jurisdiction. (See Figure A.8.4.2.)

8.4.6 The routine maintenance and operational testing program shall be performed by qualified personnel.

Findings:

During a tour of the facility, record review, and interview with the Office Manager 2 and Facilities Manager on 7/28/25, the SEPSS was observed, and records were reviewed.

1. At 12:30 p.m., the facility failed to provide 20 of 52 weekly inspections of the 12 lead acid (LA) batteries connected to the UPS. A document titled, "2025 Weekly UPS Assessment Log" indicated that the UPS batteries were inspected from 1/6/25 through 7/28/25. The weekly inspection from 8/1/24 through 12/31/24 were not provided. During an interview, the Office Manager 2 stated that the 2024 weekly inspection logs were not available for review.

During the prior Life Safety Code survey on 4/20/17, the facility was cited for missing weekly inspections of the LA batteries.

	2. At 2:58 p.m., the facility failed to provide load testing of the UPS at least annually. During a concurrent interview, the Office Manager 2 stated that she could not locate any other UPS records. During a Life Safety Code survey on 4/20/17, the facility was cited for missing a maintenance and testing program.
K0926	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the medical gas equipment. This was evidenced by the failure to provide an inspection of the medical gas piped system at least annually, and by the failure to provide continuing education of oxygen storage and handling. This could result in a delay to continue care during an emergency. This affected two of two patients, staff members, and visitors in two of two smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition 5.1.15* Category 1 Maintenance. Facilities shall have a routine maintenance program for their piped medical gas and vacuum systems. 5.1.14.4.4 Central supply systems for nonflammable medical gases shall confirm to the following: (1) They shall be inspected annually. (2) They shall be maintenance by a qualified representative of the equipment owner. (3) A record of the annual inspection shall be available for review by the authority having jurisdiction. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1 * Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety

guidelines and usage requirements for medical gases and their cylinders.

11.5.2.1.4 Equipment shall be serviced only by personnel trained in the maintenance and operation of the equipment.

11.6.1 Administration. Administrative authorities of health care organizations shall provide policies and procedures for safe practices.

11.6.1.2 Training procedures shall include the following:

(1) Maintenance programs in accordance with the manufacturer's recommendations for the piped gas system

(2) Use and transport of equipment and the proper handling of cylinders, containers, hand trucks, supports, and valve protection caps.

(3) Verification of gas content and mechanical connection specifically of each cylinder or container prior to placing it into service.

Findings:

During a record review, and interview with the Office Manager 2, Office Manager 3, and Facilities Manager on 7/28/25, records were requested and reviewed.

1. At 12:20 p.m., the facility failed to provide records of continuing education of the handling and storage of oxygen tanks. The facility provided a document titled, "Portable Oxygen Tank Monitoring" that indicated inspections are conducted each surgery day in order to ensure oxygen is readily available. During an interview, the Office Manager 3 stated that the oxygen handling in-service was missing.

During the prior Life Safety Code survey on 4/20/17, the facility was cited for missing education and training.

2. At 2:53 p.m., the facility failed to provide records for the inspection of the medical gas piped system at least annually. During an interview, the Facilities Manager stated that the med gas system was last tested in January 2025. Additional time was given to the facility to provide records by 10 a.m. on 7/29/25. As of 7/29/25 the requested records were not submitted to the California Department of Public Health (CDPH).