Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001062	04/30/2018
Name of Provider or Supplier	**Street Address, City, State**	
Sacramento Eye Surgicenter	3150 J Street, Sacramento, 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: 37135
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 416.54(a)(1)-(2) 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 460.84(a)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 483.475(a)(1)-(2), 484.102(a)(1)-(2), 485.68(a)(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-

hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at 418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at 483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at 483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.

This STANDARD is not met as evidenced by:
Based on document review and interview, the facility failed to base the emergency plan on a risk assessment. This was evidenced by the failure to identify potential natural, man-made, and facility specific hazards based on risk assessment unique to the facility, community, and geographic location. This affected all patients and could result in the facility inadequately prepared for hazards that could be identified by a risk assessment.

Findings:

During document and interview with the Administrator on 4/30/18, the risk assessment was requested.

1. At 1:55 p.m., the facility failed to provide a risk assessment to identify potential hazards for the facility. Upon interview, Administrator confirmed the finding.

E0013	Development of EP Policies and Procedures CFR(s): 416.54(b) 403.748(b), 416.54(b), 418.113(b), 441.184(b), 460.84(b), 482.15(b), 483.73(b), 483.475(b), 484.102(b), 485.68(b), 485.625(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b). (b) Policies and procedures. [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. *[For LTC facilities at 483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at 460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at 494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.

This STANDARD is not met as evidenced by:
Based on document review and interview, the facility failed to provide the required emergency policies and procedures. This was evidenced by an emergency plan that did not address a policy and procedure for medical record preservation, the use of volunteers during an emergency, and by the absence of a policy and procedure indicating the facility's role in providing treatment and care under an 1135 waiver at an alternate care site during an emergency. This affected all patients and could result in the facility being unprepared to facilitate volunteer support and/or being inadequately prepared to provide care at an alternate location during an emergency situation.

Findings:

During document review and interview with the Administrator on 4/30/18, the emergency preparedness policies and procedures were requested.

1. At 2:06 p.m., there were no policies and procedures provided that addressed storage, use, and maintenance of medical records during an emergency. Upon interview, the Administrator confirmed the finding.

2. At 2:07 p.m., there was no policy and procedure for the use of volunteers or other staffing strategies during an emergency. Upon interview, the Administrator confirmed

	the finding. 3. At 2:08 p.m., the policy and procedure provided did not include a process for an 1135 waiver for providing care and treatment at an alternate location during a declared emergency. Upon interview, the Administrator confirmed the finding and stated that they were not aware of the requirement.
K0000	K3 BUILDING: 01 K6 PLAN APPROVAL: 1974 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY 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. Representing the California Department of Public Health: 37135 The facility is not in substantial compliance with 42 CFR §416.44 for Ambulatory Surgical Centers (ASCs).
K0161	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height Building construction type and stories meet

Table 20.1.6.1 or Table 21.1.6.1, respectively. Construction Type 1 I (442), I (332), II (222), Any number of stories II (111), III (211), IV (2HH), non-sprinklered or sprinklered V (111) 2 II (000), III (200), V (000) One story non-sprinklered Any number of stories sprinklered Any level below the level of exit discharge shall be separated by Type II (111), Type III (211), or Type V (111) construction unless both of the following are met: 1. Such levels are under the control of the ambulatory health care occupancy. 2. Hazardous spaces are protected per section 8.7. Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 20.3.5 or 21.3.5, respectively) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. 20.1.6.1, 20.1.6.2, 21.1.6.1, 21.1.6.2

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain the building construction. This was evidenced by unsealed penetrations in the walls and ceiling. This affected two all patients and could result in the spread of fire and smoke in the event of a fire.

Findings:

During a tour of the facility and interview with the Administrator on 4/30/18, the walls and ceilings were observed.

1. At 11:15 a.m., the Janitor's Closet was observed. There was an approximate 3 inch diameter penetration located in the ceiling. The penetration had a tube coming from the Nortec machine.

2. At 11:55 a.m., the Procedure Room was observed. There were four penetrations located on the lower area of the west wall. The penetrations were all approximately 1 /4 inch diameter in size.

These findings were confirmed by the Administrator.

K0211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is

continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1

This STANDARD is not met as evidenced by:
Based on document review, observation, and interview, the facility failed to maintain the door openings and means of egress. This was evidenced by the absence of an annual inspection and test for door assemblies and a fire rated door that was obstructed. This affected all patients and could result in the malfunction of the egress doors during an emergency situation.

NFPA 101. Life Safety Code, 2012 Edition

21.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 21.2.2 through 21.2.11.

7.1.10 Means of Egress Reliability.

7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

7.1.10.2 Furnishings and Decorations in Means of Egress.

7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.

7.2.1.15 Inspection of Door Openings.

7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8:

(1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7

(2) Door assemblies in exit enclosures

(3) Electrically controlled egress doors

(4) Door assemblies with special locking arrangements subject to 7.2.1.6

7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for

Smoke Door Assemblies and Other Opening Protectives.

7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives.

7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction.

7.2.1.15.5 Functional testing of door assemblies shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subjected to testing. 7.2.1.15.6 Door assemblies shall be visually inspected from both sides of the opening to assess the overall condition of the assembly.

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

(1) Floor space on both sides of the openings is clear of obstructions, and door leaves open fully and close freely.

(2) Forces required to set door leaves in motion and move to the fully open position do not exceed the requirements in 7.2.1.4.5.

(3) Latching and locking devices comply with 7.2.1.5.

(4) Releasing hardware devices are installed in accordance with 7.2.1.5.10.1.

(5) Door leaves of paired openings are installed in accordance with 7.2.1.5.11.

(6) Door closers are adjusted properly to control the closing speed of door leaves in accordance with accessibility requirements.

(7) Projection of door leaves into the path of egress does not exceed the encroachment permitted by 7.2.1.4.3.

(8) Powered door openings operate in accordance with 7.2.1.9.

(9) Signage required by 7.2.1.4.1(3), 7.2.1.5.5, 7.2.1.6, and 7.2.1.9 is intact and legible.

(10) Door openings with special locking arrangements function in accordance with 7.2.1.6

(11) Security devices that impede egress are not installed on openings, as required by 7.2.1.5.12. 7.2.1.15.8 Door openings not in proper operating condition shall be repaired or replaced without delay.

Findings:

	During document review, a tour of the facility, and interview with the Administrator on 4/30/18, the annual inspection and testing records for fire doors were requested. 1. At 11:05 a.m., the facility was observed with 60 minutes doors. No annual door assemblies inspection and/or testing had been completed. Upon interview, the Administrator confirmed the finding. 2. At 11:25 a.m., the 60 minute fire doors near Operating Room 2 was observed. The right leaf had two metal tray tables stationed directly in front of the door. Upon interview, the Administrator confirmed the finding.
K0223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: * Required manual fire alarm system, and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5 This STANDARD is not met as evidenced by: Based on observation, testing, and interview, the facility failed to maintain the egress doors. This was evidenced by two doors that were equipped with an automatically release device that failed to close during fire alarm activation. This affected all patients and could result in the inability to contain smoke and/or fire. NFPA 101, Life Safety Code 2012 Edition 21.2.2.4 Any door required to be self-closing shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The required manual fire alarm system and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.

	Findings: During a tour of the facility and interview with the Administrator on 4/30/18, the fire alarm system was tested and its components were observed. 1. At 11:45 a.m. the door that separated the Lobby Waiting area and the Surgery Hallway was observed held open by a magnetic hold open device. When the fire alarm system activated, the door failed to released. 2. At 11:46 a.m., the door that separated the Surgery center and Suite A was observed held open by a magnetic hold open device. When the fire alarm system activated, the door failed to released. Upon interview, the Administrator acknowledged the findings.
K0232	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width The clear width of any corridor or passageway required for egress shall be not less than 44 inches wide. Where a corridor is 6 feet wide, projections of not more than 6 inches from the corridor wall above the handrail height are permitted for alcohol-based hand rub dispensers. 20.2.3.2, 20.2.3.3, 21.2.3.2, 21.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a minimum aisle width to ensure a safe path of travel to the exit during emergency evacuation. This was evidenced by an aisle exit that measured less 44 inches wide. This affected all patients and could result in the delay in evacuating the building during an emergency. NFPA 101. Life Safety Code, 2012 Edition

	21.2.3.2 The clear width of any corridor or passageway required for exit access shall be not less than 44 in. (1120 mm). 21.2.3.3 Where minimum corridor width is 6 ft (1830 mm), projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted for the installation of hand-rub dispensing units in accordance with 21.3.2.6. Findings: During a tour of the facility and interview with the Administrator on 4/30/18, the means of egress were observed. 1. At 11:56 a.m., the corridor area outside the Procedure Room was observed. The corridor was 66 inches wide. There were seven arm chairs stationed on one side of the corridor. The chairs were not secured and were approximately 24 inches wide, leaving approximately 42 inch clearance. Upon interview, the Administrator confirmed the finding.
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 document review and interview, the facility failed to maintain the exit signs. This was evidenced by four of four battery powered exit signs that were not tested as required. This affected all patients and could result in the malfunction of the battery operated exit signs during an emergency. 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 Testing and Maintenance. 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 Periodic Testing of Emergency Lighting Equipment.

7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.

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 11?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.

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

(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.

(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.

(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.

(4) A visual inspection shall be performed at intervals not exceeding 30 days.

(5) Functional testing shall be conducted annually for a minimum of 11?2 hours.

(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 11?2-hour test.

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

7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be

	conducted as follows: (1) Computer-based, self-testing/self-diagnostic battery operated emergency lighting equipment shall be provided. (2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. (3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 11?2 hours. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3). (5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times. Findings: During document review and interview with the Administrator on 4/30/18, the exit sign records were requested. 1. At 1:10 p.m., records provided indicated that the facility had four battery powered exit signs that were tested on a monthly basis. The records did not indicate the amount of time the exit signs were tested for. There were no records provided that indicated that four of four battery powered exit signs were being tested for 30 seconds on a monthly basis 2. At 11:11 p.m., there were no records that indicated the battery operated exit signs were tested for 90 minutes on an annual basis. Upon interview, the Administrator confirmed the finding.
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 document review and interview, the facility failed to maintain the fire alarm system. This was evidenced the failure to automatically transmit alarm notification to the offsite central fire alarm station and 12 of 12 system smoke detectors that were not tested for smoke sensitivity. This affected all patients and could result in the malfunction of the smoke detector in the event of a fire.

NFPA 101, Life Safety Code, 2012 Edition.

21.3.4.3.2 Emergency Forces Notification.

21.3.4.3.2.1 Fire department notification shall be accomplished

in accordance with 9.6.4.

9.6.4 Emergency Forces Notification.

9.6.4.1 Where required by another section of this Code, emergency forces notification shall be provided to alert the municipal fire department and fire brigade (if provided) of fire or other emergency.

9.6.4.2 Where fire department notification is required by another section of this Code, the fire alarm system shall be arranged to transmit the alarm automatically via any of the following means acceptable to the authority having jurisdiction and shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code:

(1) Auxiliary fire alarm system

(2) Central station fire alarm system

(3) Proprietary supervising station fire alarm system

(4) Remote supervising station fire alarm system

9.6.4.3 For existing installations where none of the means of notification specified in 9.6.4.2(1) through (4) are available, an approved plan for notification of the municipal fire department shall be permitted.

21.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.4.

9.6.2.10.1.1 Where required by another section of this Code, single-station and multiple-station smoke alarms shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code, unless otherwise provided in 9.6.2.10.1.2, 9.6.2.10.1.3, or 9.6.2.10.1.4.

NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition.

29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer ' s published instructions and per the requirements of Chapter 14.

14.4.5.3* In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7.

14.4.5.3.1 Sensitivity shall be checked within 1 year after installation.

14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3.

14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.

14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained.

14.4.5.3.3.2 In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.

14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods:

(1) Calibrated test method

(2) Manufacturer's calibrated sensitivity test instrument

(3) Listed control equipment arranged for the purpose

(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range

(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction

Findings:

During document review and interview with the Administrator on 4/30/18, the fire alarm records were reviewed and requested.

1. At 11:43 a.m., the inspector's test valve (ITV) was tested. The activation of the ITV initiated the fire alarm system along with the chimes/strobes.

At 1:05 p.m., the monitoring report from the offsite central fire alarm station was provided. The report did not indicate that a signal was received by the offsite central fire alarm station for ITV. Upon interview, the Administrator confirmed the finding.

1. At 1:20 p.m., there were no records provided that indicated 12 of 12 system smoke detectors were tested for smoke sensitivity. Upon interview, the Administrator confirmed the finding and stated that they would check with the vendor. The facility was given until 5:00 p.m. to provided current smoke sensitivity records to the California Department of Public Health (CDPH).

At 5:00 p.m. on 4/30/18, CDPH did not receive current smoke sensitivity records from the facility.

K0346	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Fire alarms that are out of service for 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the fire alarm system out of service policy. This was evidenced by the absence of notification to the authority having jurisdiction (AHJ) due to malfunction system. This affected all patients and could result in delayed emergency assistance in the event of a fire during fire alarm system disruption. Findings: During document review and interview with the Administrator on 4/30/18, the fire alarm system out of service policy was requested. 1. At 11:02 a.m., the policy did not include notification to the AHJ (California Department of Public Health) when the fire alarm system was of service for more than four hours in a 24-hour period. Upon interview, the Administrator confirmed the finding.
K0353	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

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This STANDARD is not met as evidenced by:
Based on document review, observation, and interview, the facility failed to maintain the automatic sprinkler system and its components. This was evidenced by the absence of seven of twelve monthly inspections, four sprinklers with foreign material, and two with penetrations near the escutcheon plates. This affected all patients and could result in the malfunction of the automatic sprinkler system in the event of a fire.

NFPA 101, Life Safety Code, 2012 Edition.

21.3.7.6 Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating,

and air-conditioning systems where adjacent smoke compartments are protected throughout by an approved, supervised

automatic sprinkler system in accordance with Section 9.7..

9.7 Automatic Sprinklers and Other Extinguishing Equipment

9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by the Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition.

4.3 Records

4.3.1* Records shall be made inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request.

5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).

5.2.4 Gauges

5.2.4.1* Gauges on a wet pipe sprinkler shall be inspected monthly to ensure that they

are in good condition and the normal water supply pressure is being maintained.

13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.

13.3.2.2* The valve inspection shall verify that the valves are in the following condition:

(1) In the normal open or closed position

(2)*Sealed, locked, or supervised

(3) Accessible

(4) Provided with correct wrenches

(5) Free from external leaks

(6) Provided with applicable identification

13.4.1.1* Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following:

(1) The gauges indicate normal supply water pressure is being maintained.

(2) The valve is free of physical damage.

(3) All valves are in the appropriate open or closed position.

(4) The retarding chamber or alarm drains are not leaking.

13.6.1.1.1 Valves secured with locks or electrically supervised in accordance with applicable NFPA standards shall be inspected monthly.

Findings:

During document review, a tour of the facility, and interview with the Administrator on 4/30/18, the automatic sprinkler system was observed and records were requested.

1. At 11:00 a.m., records indicated that the monthly visual inspections for the alarm and system riser check valves and pressure gauge for the following months were not completed: May, July, August, October, and November of 2017, and January and February of 2018. Upon interview, the Administrator confirmed the finding.

	2. At 11:20 a.m., the sprinkler located in the Janitor's Closet had an escutcheon plate that had separated from the ceiling, creating an approximately 2-1/2 inch diameter penetration. 3. At 11:23 a.m., three sprinklers where observed in Operating Room 2. The sprinkler located near the entry door leading into the corridor had white foreign material on the deflector. 4. At 11:27 a.m., three sprinklers where observed in Operating Room 1. The sprinkler located near the entry door leading into the corridor had white foreign material on the deflector and the sprinkler located in the center of the room had white foreign material on the deflector and frame. 5. At 12:05 p.m., the sprinkler in the Women's Locker Room was observed. The sprinkler had dust and lint covering half of the deflector. The sprinkler also had an approximately 1-1/2 inch by 1/2 inch penetration on one side of the escutcheon plate. These findings were confirmed by the Administrator.
K0354	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25)

	This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the automatic sprinkler system out of service policy. This was evidenced by the absence of notification to the authority having jurisdiction (AHJ) due to malfunction system. This affected all patients and could result in delayed emergency assistance in the event of a fire during automatic sprinkler system disruption. Findings: During document review and interview with the Administrator on 4/30/18, the automatic sprinkler system out of service policy was requested. 1. At 11:02 a.m., the policy did not include notification to the AHJ (California Department of Public Health) when the automatic sprinkler system was of service for more than ten hours in a 24-hour period. Upon interview, the Administrator confirmed the finding.
K0372	Subdivision of Building Spaces Smoke Barrier Construction CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5

	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of the smoke barrier walls. This was evidenced by unsealed penetration in the smoke barrier walls. This affected all patients and could result in the spread of smoke and increase the risk of injury to patients and staff in the event of a fire. Findings: During an tour of the facility and interview with the Administrator on 4/30/18, the smoke barrier walls were observed. 1. At 2:27 p.m., the one hour rated smoke barrier wall between the Surgery Center and Suite B was observed. The area above the entry door from Suite B was observed with an approximately 2 inch diameter penetration. The penetration had a brass pipe going through it. Upon interview, the Administrator confirmed the finding.
K0500	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 20.5 and 21.5 Building Services 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 on Form CMS-2567. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical system. This was evidenced by two electrical panels that had circuit breaker switches that were not labeled correctly, one panel that was missing circuit breaker switch cover plates, and another that was covered with dust and lent. This affected all patients and could result in the ignition of an electrical fire. NFPA 101, Life Safety Code, 2012 edition 21.5.1 Utilities. 21.5.1.1 Utilities shall comply with the provisions of Section 9.1

9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 70 National Electrical Code, 2011 Edition

110.22 Identification of Disconnecting Means.

(A) General. Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.

408.4 Field Identification Required.

(A) Circuit Directory or Circuit Identification. Every circuit and circuit modification shall be legibly identified as to its clear, evident, and specific purpose or use. The identification shall include sufficient detail to allow each circuit to be distinguished from all others. Spare positions that contain unused overcurrent devices or switches shall be described accordingly. The identification shall be included in a circuit directory that is located on the face or inside of the panel door in the case of a panelboard, and located at each switch or circuit breaker in a switchboard. No circuit shall be described in a manner that depends on transient conditions of occupancy.

408.7 Unused Openings. Unused openings for circuit breakers and switches shall be closed using identified closures, or other approved means that provide protection substantially equivalent to the wall of the enclosure.

Findings:

During a tour of the facility with the Administrator on 4/30/18, the electrical system was observed.

1. At 11:28 a.m., the electrical panels located in the corridor area outside OR 1 were observed. Circuit breaker switches 16 and 35 in Panel S were in the on position, but were not labeled. Circuit breaker switches 39 and 40 in Panel E were missing filler plates. Panel F had lint and dust covering the lower portion of the circuit breaker switches.

2. At 12:02 p.m., the electrical panel in the UPS Room was observed. Circuit breaker switches 16, 19, 21, and 23 were in the on position, but were not labeled.

	These findings were confirmed by the Administrator.
K0908	Gas and Vacuum Piped Systems Central Supply System Alarms CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on document review, observation, and interview, the facility failed to maintain the piped in medical gas system. This was evidenced by the failure to correct discrepancies noted on the medical gas inspection report and the absence of labels for the shutoff valves. This affected all patients and could result in an oxygen manifold malfunction. NFPA 99, Health Care Facilities Code, 2012 Edition 5.1.4.2 Accessibility. All valves, except valves in zone valve box assemblies, shall be located in secured areas such as locked piped chases, or be locked or latched in their operating position, and be labeled as to gas supplied and the area(s) controlled. 5.1.11.2 Shutoff Valves. 5.1.11.2.1 Shutoff valves shall be identified with the following: (1) Name or chemical symbol for the specific medical gas or vacuum system (2) Room or areas served (3) Caution to not close or open the valve except in emergency

Findings:

During document review, a tour of the facility, and interview with the Administrator on 4/30/18, the piped in medical gas system was observed and records were requested.

1. At 2:00 p.m., a maintenance and testing report dated 12/26/17 was provided and reviewed

-Page 3-12 of the report indicated that there were three discrepancies found on the Master Panel.

-Page 3-13 of the report indicated that there were discrepancies in the Configuration of the Oxygen Manifold.

-Page 3-13 also indicated that there were discrepancies in the System Configuration & Performance, CO Monitor, and Dew Point Monitor of the Medical Air Compressor.

-Page 3-14 of the report indicated that there were medical gas outlet discrepancies found in the Central Sterile Room, the Decontamination Room, and the Recovery Room.

-Page 3-15 of the report indicated that there were medical gas zone valve box discrepancies due to lack of labels on the boxes located in Recovery Room, outside OR 2, outside Central Sterile, and by the Waiting Room door.

-Page 3-16 of the report indicated there were discrepancies with the area alarm panel in the Recovery Room and outside OR 2.

Upon interview, the Administrator confirmed these findings and stated they had received a quote for the repairs, but had not set a date to have the vendor start the repairs.

2. At 2:20 p.m., the medical gas zone valve boxes inside the Surgery Suite were not labeled.

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 document review, observation, and interview, the facility failed to maintain the uninterruptible power system (UPS). This was evidenced by a semi-annual maintenance report in which deficiencies were found and not corrected, and by a UPS that had accumulated dust and had combustibles stored beside it. This affected three all patients and could result in the malfunction of the UPS during an emergency situation. NFPA 99, Health Care Facilities Code, 2012 Edition 6.6.4.1.1.3 Stored Energy Power Source. Maintenance and testing of stored energy power supply systems shall be in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems, Section 6.1 through 6.4.5. NFPA 111, Stored Electrical Energy Emergency and Standy Power Systems, 2010 Edition 8.1 General. The SEPSS shall have routine maintenance and operational testing based on the manufacturer ' s recommendations, instruction manuals, and the minimum

	requirements of this chapter and subject to the approval of the authority having jurisdiction. Findings: During document review, a tour of the facility, and interview with the Administrator on 4/30/18, the UPS was observed and records were requested. 1. At 10:58 a.m., the semi-annual maintenance report dated 4/18/18 was provided. The report indicated that battery 13 was bad and needed to be replaced. Upon interview, the Administrator confirmed the finding and stated the vendor will be coming out to replace the battery on Thursday, 5/3/18. 2. At 12:00 p.m., the UPS was observed. There was dust and build up in the area around the UPS. There was also four 4 feet by 2 feet lay in ceiling tiles, two 2 feet by 2 feet lay in ceiling tiles, and pieces of plastic being stored approximately 2 inches from the UPS. The users manual stated the following under the Environment-Ventilation section: "The air around the unit must be clean, dust free, and free of corrosive chemicals or other contaminants." Chapter 8 of the UPS users manual stated the following under the Maintenance and Service section: "...it is important to keep the air vents free of any obstruction. If the environment tends to be extremely dusty, occasionally blow away any accumulation of dust on components." Upon interview, the Administrator confirmed the finding.
K0920	Electrical Equipment Power Cords and Extension Cords 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 STANDARD is not met as evidenced by:
Based on observation, the facility failed to maintain the electrical equipment. This was evidenced by the use of power strips and extension cord. This affected all patients and could result in an electrical fire.

NFPA 101, Life Safety Code, 2012 Edition.

21.5.1 Utilities.

21.5.1.1 Utilities shall comply with the provisions of Section 9.1.

9.1 Utilities

9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 70, National Electrical Code, 2011 Edition.

240.5 Protection of Flexible Cords, Flexible Cables, and Fixture Wires. Flexible cord and flexible cable, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either 240.5(A) or (B).

(A) Ampacities. Flexible cord and flexible cable shall be protected by an overcurrent device in accordance with their ampacity as specified in Table 400.5(A)(1) and Table 400.5(A)(2). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402.5. Supplementary overcurrent protection, as covered in 240.10, shall be permitted to be an acceptable means for providing this protection.

(B) Branch-Circuit Overcurrent Device. Flexible cord shall be protected, where supplied by a branch circuit, in accordance with one of the methods described in 240.5 (B)(1), (B)(3), or (B)(4). Fixture wire shall be protected, where supplied by a branch

	circuit, in accordance with 240.5(B)(2). Findings: During a tour of the facility and interview with the Administrator on 4/30/18, the electrical equipment was observed. 1. At 11:24 a.m., the electrical equipment in the Operating Room 2 was observed. There was a three outlet extension cord plugged into the wall receptacle. The extension cord had a six outlet power strip plugged into it. The power strip had a laser machine, a printer, and a monitor plugged into it. Upon interview, the Administrator confirmed the finding. 2. At 11:26 a.m., the electrical equipment in the Operating Room 1 was observed. There was a six outlet power strip plugged into the wall receptacle. The power strip had a recording equipment and a Sony iPod sound system plugged into it. Upon interview, the Administrator confirmed the finding.