Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001076	07/10/2019
Name of Provider or Supplier	**Street Address, City, State**	
Plastic Surg Assoc Of Orange County	1310 Stewart Drive, Suite 610, Orange, 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 Plan Survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §416.54, Condition of Participation for Ambulatory Surgical Center (ASC). Representing the California Department of Public Health: 29566 Abbreviations: Emergency Preparedness Plan (EPP)
E0022	Policies/Procedures for Sheltering in Place CFR(s): 416.54(b)(3) 403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 460.84(b)(5), 482.15(b)(4), 483.73(b)(4), 483.475(b)(4), 485.68(b)(2), 485.625(b)(4), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3). (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:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients,

	staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at 418.113 (b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, facility failed to ensure complete emergency preparedness plan. This was evidenced by failing to provide documents to show policies and procedures for shelter in place. This could result in facility not being prepared for a disaster and cause possible harm to patients, staff, and visitors. This affected two of two smoke compartments. Findings: During record review with the Medical Assistance on 7/10/19, the emergency preparedness plan was reviewed. At 12:15 p.m., the facility's emergency preparedness plan failed to have policies and procedures for a means of sheltering in places for patients, staff and volunteers (until safe for the facility to evacuate). During an interview with the Medical Assistance, she stated the facility has documents but she was unable to locate them.
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), 485.625(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 ensure complete emergency preparedness planning. This was evidenced by failing to provide documents to show policies and procedures for patient care and treatments at an alternate site in the event of an emergency or disaster. This could result in facility not being prepared for a disaster and cause possible harm to patients, staff, and visitors. Findings: During record review with the Medical Assistance on 7/10/19, the emergency preparedness plan was reviewed. At 12:10 p.m., the facility's emergency preparedness plan failed to have policies and procedures for methods of taking care of their patients at an alternate site in the event of an emergency. During an interview with the Medical Assistance, she stated she was unfamiliar with the requirement.
E0032	Primary/Alternate Means for Communication CFR(s): 416.54(c)(3) 403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 460.84(c)(3), 482.15(c)(3), 483.73(c)(3), 483.475(c)(3), 484.102(c)(3), 485.68(c)(3), 485.625(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at 483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure to have a complete emergency preparedness communication plan. This was evidenced by failing to provide documents to show the primary and the alternate means of communication. This could result in facility not prepared for a disaster and cause possible harm to patients, staffs and visitors.

	Findings. During record review with the Medical Assistance on 7/10/19, the EPP plan was reviewed. At 12:21 p.m., facility's emergency preparedness communication plan failed to address the primary and alternate methods of communicating with the staff and with external emergency officials. During an interview with the Medical Assistance, she stated staff verbally discuss their method but failed to document their method in the EPP.
E0033	Methods for Sharing Information CFR(s): 416.54(c)(4)-(6) 403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 460.84(c)(4)-(6), 441.184(c)(4)-(6), 460.84(c)(4)-(6), 482.15(c)(4)-(6), 483.73(c)(4)-(6), 483.475(c)(4)-(6), 484.102(c)(4)-(5), 485.68(c)(4), 485.625(c)(4)-(6), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under 484.102(c), CORFs under 485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at 403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at 491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure complete emergency preparedness communication plan. This was evidenced by failing to provide documents to show procedures for the release of patients' information in the event of a disaster. This could result in the facility not being prepared for a disaster

	and cause possible harm to patients, staff, and visitors. Findings: During record review with the Medical Assistance on 7/10/19, the EPP plan was reviewed. At 12:14 p.m., the facility's EPP failed to address the method for the release of patients' information and location {under 45 CFR164.510(b)(4)} in the event of an emergency. During an interview with the Nursing Director, she stated verbally how the facility would release patient information in the event of an emergency, but stated there was no policies and procedures documented in the EPP.
E0036	EP Training and Testing CFR(s): 416.54(d) 403.748(d), 416.54(d), 418.113(d), 441.184(d), 460.84(d), 482.15(d), 483.73(d), 483.475(d), 484.102(d), 485.68(d), 485.625(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d). *[For RNCHIs at 403.748, ASCs at 416.54, Hospice at 418.113, PRTFs at 441.184, PACE at 460.84, Hospitals at 482.15, HHAs at 484.102, CORFs at 485.68, CAHs at 486.625, "Organizations" under 485.727, CMHCs at 485.920, OPOs at 486.360, and RHC/FHQs at 491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at 483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at 483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at 483.470(i). *[For ESRD Facilities at 494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b)

	of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff were annually trained on their EPP. This was evidenced by failing to provide documents to show annual training of all staff on their EPP. This could result in staff being unfamiliar with the facility's emergency procedures and cause possible harm to patients, staff, and visitors, in the event of a disaster. Findings: During record review with the Medical Assistance on 7/10/19, the emergency preparedness plan was reviewed. At 12:11 p.m., the facility failed to provide documents to show all staff were trained annually and tested their knowledge on the facility's EPP within the last 12 months. The Nursing Director stated she was in the process of training staff on the new EPP.
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), 485.625(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, 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 conduct drills to test their emergency preparedness plan. This was evidenced by failing to provide documents to show two of two disaster drills were based on their emergency preparedness plan. This could result in the facility not being prepared for a disaster and cause possible harm to patients, staffs and visitors. This affected two of two smoke compartments.

Findings:

During record review with the Medical Assistance on 7/10/19, the EPP was reviewed.

	At 12:40 p.m., the facility's record failed to provide documents to show two of two disaster drills were based on their emergency preparedness plan. The Medical Assistance confirmed the disasters drills records failed to indicate they were based on the facility's EPP.
K0000	K3 BUILDING: 01 K6 PLAN APPROVAL: 1992 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: SIX STORIES with ASC on sixth floor, CONSTRUCTION TYPE 1 (111), FULLY-SPRINKLERED. The following reflects the findings of the California Department of Public Health, during a re-certification Life Safety Code survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §416.44(b)(c)(f) for Ambulatory Surgery Center, 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: 29566 Abbreviations: Ambulatory Surgical Center (ASC)
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 interview and record review, the facility failed to ensure that the fire alarm system is maintained in reliable operating condition. This was evidenced by failing to provide documents to show that sensitivity testing of smoke detectors were conducted in the last two years. This could result in delay in notification of fire and possible harm to patients and staff. This affected two of two smoke compartments.

NFPA 101, Life Safety Code, 2012 Edition

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.

9.6.1.3 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

10.18.3.1 A complete record of the tests and operations of each system shall be kept until the next test and for 1 year thereafter.

10.18.3.2 The record shall be available for examination and, if required, reported to the authority having jurisdiction. Archiving of records by any means shall be permitted if hard copies of the records can be provided promptly when requested.

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.

14.4.5.3.5 Unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.

Findings:

	During the review of records with the Nursing Director on 7/10/19, the fire alarm system records were requested and reviewed. At 11:37 a.m., the facility failed to provide documents to show that sensitivity testing was conducted on their smoke detectors for the last two years. During an interview with the Nursing Director, she stated that she believed the Building Maintenance staff was responsible for conducting the smoke detector sensitivity testing.
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 25 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to maintain their automatic sprinkler system in a reliable operating condition. This was evidenced by incomplete maintenance and inspection records. This could result in the disruption of the sprinkler system, a delay in extinguishing a fire, and potential harm to patients and staff in the event of a fire. This affected the ASC. NFPA 25, Standards for the Inspection, Testing and Maintenance of Water Based Fire Protection System, 2011 Editions. 5.2.4.1* Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. 13.3.2 All system valves shall be protected from physical damage and shall be accessible.

13.2.5* Main Drain Test. A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. (See also 13.3.3.4.)

13.2.5.1 In systems where the sole water supply is through a backflow preventer and /or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis.

13.3.2.1 All valves shall be inspected weekly.

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

13.3.3.1 Each control valve shall be operated annually through its full range and returned to its normal position.

13.3.3.2* Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve.

Table 13.1.1.2 Summary of Valves, Valve Components, and Trim Inspection, Testing,

and Maintenance

Item (Frequency)

Inspection

Control Valves

Sealed (Weekly)

Locked (Monthly)

Tamper switches (Monthly)

Alarm Valves

Exterior (Monthly)

Testing

Table 8.1.1.2 Summary of Fire Pump Inspection, Testing, and Maintenance

Electric motor driven pump (Monthly)

13.7.1 Fire department connections shall be inspected quarterly to verify the following:

(1) The fire department connections are visible and accessible.

(2) Couplings or swivels are not damaged and rotate smoothly.

(3) Plugs or caps are in place and undamaged.

(4) Gaskets are in place and in good condition.

(5) Identification signs are in place.

(6) The check valve is not leaking.

(7) The automatic drain valve is in place and operating properly.

(8) The fire department connection clapper(s) is in place and operating properly.

13.6.2.1* All backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer.

13.6.3.1 Maintenance of all backflow prevention assemblies shall be conducted by a trained individual following the manufacturer's instructions in accordance with the procedure and policies of the authority having jurisdiction.

14.3.1* An obstruction investigation shall be conducted for system or yard main piping wherever any of the following conditions exist:

(1) Defective intake for fire pumps taking suction from open bodies of water

(2) The discharge of obstructive material during routine water tests

(3) Foreign materials in fire pumps, in dry pipe valves, or in check valves

(4)*Foreign material in water during drain tests or plugging of inspector ' s test connection(s)

(5) Plugged sprinklers

(6) Plugged piping in sprinkler systems dismantled during building alterations

(7) Failure to flush yard piping or surrounding public mains following new installations or repairs

(8) A record of broken public mains in the vicinity

(9) Abnormally frequent false tripping of a dry pipe valve(s)

(10) A system that is returned to service after an extended shutdown (greater than 1 year)

(11) There is reason to believe that the sprinkler system contains sodium silicate or highly

corrosive fluxes in copper systems

(12) A system has been supplied with raw water via the fire department connection

(13) Pinhole leaks

(14) A 50 percent increase in the time it takes water to travel to the inspector's test connection from the time the valve trips during a full flow trip test of a dry pipe sprinkler system when compared to the original system acceptance test.

Findings:

During the tour of the facility with the Medical Assistant on 7/10/19, the sprinkler system was observed and records reviewed. Facility was equipped with main drain /control valve riser, inspector test valve, backflow preventer, fire department connection, and post indicator valve.

1. At 11:10 a.m., there were rags and other items, including cardboard, resting on the main riser and on the fire pump switch panel in the automatic sprinkler fire pump room.

2. At 11:15 a.m., the facility failed to provide documents to show monthly inspections of their automatic sprinkler system's gauges and control valves for the last 12 months.

3. At 11:16 a.m., the facility's fire pump vendor report, dated 9/4/18 (annual inspection), indicated "readings are off at 100% and 150%. Send in line flow meter

	out to be recalibrated and retest fire pump." The facility failed to provide documents to show the fire pump was recalibrated and retested, and no monthly testing records were provided. 4. At 11:16 a.m., during an interview with the Nursing Director she stated that the building maintenance/property management was responsible for the maintenance of the automatic sprinkler system. 5. At 11:20 a.m., the facility failed to provide documents to show a five-year inspection and testing of their automatic sprinkler system was completed in the past five years. 6. At 11:21 a.m., the facility failed to provide documents to show an annual inspection and testing of the back flow preventer. 7. At 11:22 a.m., the backflow preventer had green substance (algae/moss) growing on the pipes and at the valve connection. 8. At 11:22 a.m., the automatic fire sprinkler main drain pipe was leaking.
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 their fire/smoke dampers. This was evidenced by no record of fire/smoke damper inspection and testing. This affected the facility and could result in the failure of the fire damper to close, and cause possible harm to patients and staff in the event of a fire. NFPA 101, Life Safety Code, 2012 Edition 21.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of

Section 9.2 and shall be in accordance with the manufacturer's specifications, unless otherwise modified by 21.5.2.2.

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

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

5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.

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

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 Each damper shall be tested and inspected 1 year after installation.

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.

19.4.2 All tests shall be completed in a safe manner by personnel wearing personal protective equipment.

19.4.3 Full unobstructed access to the fire or combination fire smoke damper shall be verified and corrected as required.

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 if so equipped.

	Findings: During record review with the Medical Assistance on 7/10/19, the fire damper maintenance records and architectural plans were requested. At 11:25 a.m., there were no record of fire/smoke damper inspection and testing completed within the last 4 yours. At 11:26 a.m., during an interview with the Building Maintenance Staff, he believed the facility was equipped with fire/smoke damper and it was the facility responsibility to conduct the maintenance and testing of the fire/smoke dampers. At 11:26 a.m., during an interview with the Nursing Administrator she stated that she was not sure if the facility was equipped with fire/smoke dampers and she could not locate the architectural plan for the facility.
K0712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 21.7.1.4 through 21.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide complete documentation of fire drills. This was evidenced by failing to conduct three of four fire drills for the last 12 months. This affected the facility. This finding could result in failure of staff to protect their patients in the event of a fire. NFPA 101. Life Safety Code 2012 Edition 21.7.1.4* Fire drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.

	21.7.2.3.1 All personnel shall be instructed in the use of and response to fire alarms. Findings: During record review with the Medical Assistance on 7/10/19, the fire drills records were reviewed. 1. At 9:30 a.m., the facility failed to provide documents to show three of four fire drills were conducted within the last 12 months. During an interview with Medical Assistance, she stated the Building Maintenance is in charge of conducting the fire drills and believed the requirement was one fire drill per year. 2. At 9:32 a.m., the facility's fire drill record, dated 6/19, failed to indicate real life fire condition scenarios.
K0914	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For, LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review, facility failed to maintain electrical receptacles. This was evidenced by failing to provide complete documents of inspection and testing of electrical receptacles, and have a maintenance program for their hospital grade receptacles. This affected two of two smoke compartments. This could potentially cause a fire and potential harm to patients and staff, in the event of a fire.

	National Fire Prevention Association 99, Healthcare Facilities Code, 2012 Edition 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. 6.3.4.2.1.1 A record shall be maintained of the tests required by this chapter and associated repairs or modification. 6.3.4.2.1.2 At a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. Findings: During tour of the facility with the Medical Assistance on 7/10/19, the electrical receptacle maintenance record was reviewed. At 11:42 a.m., facility failed to provide complete documentation to show maintenance of receptacles testing and inspection. There was no information on the physical integrity of the receptacles, continuity of the grounding circuit verified, correction polarity of the hot and neutral connection and the retention force. At 11:43 a.m., during an interview with the Nursing Director, she stated that she believed the vendor was conducting the maintenance, inspections, and testing of the receptacles.
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, interview, and record review, the facility failed to maintain their stored electrical power source in a reliable operating condition. This was evidenced by failing to provide documents to show complete maintenance of their uninterruptible power supply (UPS), and by failing to readily identify their emergency electrical panel. This could result in a possible UPS malfunction and potential risk of injury to the patients in the event of an emergency. This affected two of two smoke compartments.

NFPA 101, Life Safety Code, 2012 Editions

21.5.1.1 Utilities shall comply with the provisions of Section 9.1.

9.1.4 Stored Electrical Energy Systems. Stored electrical energy systems shall be installed, tested, and maintained in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems.

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

7.5.1 The grounding, distribution, and wiring systems within the EPS shall be installed in accordance with applicable standards. (See NFPA 70, National Electrical Code.)

8.2.1 At least two sets of instruction manuals for the SEPSS shall be supplied by the manufacturer of the SEPSS and shall contain the following:

(1) A detailed explanation of the operation of the system

(2) A schematic wiring diagram

(3) A function block diagram

(4) The energy storage device's specification, installation instructions, maintenance

information, and wiring diagrams

(5) Instructions for routine maintenance

(6) Recommended spare parts list with part numbers and part sources

(7) Routine troubleshooting procedures

8.4.1* Level 1 equipment shall be inspected monthly and tested in accordance with the manufacturer's 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 regressed, 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.

8.4.3.1 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.

8.4.5 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 program shall be performed by qualified personnel.

	NFPA 70, National Electrical Code, 2011 Edition 700.10 Wiring, Emergency System. (A) Identification. All boxes and enclosures (including transfer switches, generators, and power panels) for emergency circuits shall be permanently marked so they will be readily identified as a component of an emergency circuit or system. Findings: During record review with the Nursing Director on 7/10/19, the UPS maintenance records were requested for reviewed. 1. At 11:05 a.m., the facility failed to provide the manufactured maintenance instruction manual to their UPS stored energy power source. 2. At 11:05 a.m., the facility failed to provide documentation to show load test was performed on their UPS. The facility UPS vendor confirmed that an annual load test was not performed. 3. At 11:36 a.m., the electrical circuit panel by the Operating Room was not permanently marked to be readily identified as an emergency panel. The facility staff acknowledged that the electrical circuit panel that housed the emergency power switches for the Operating Room and Recovery area was not marked.
K0933	Features of Fire Protection Fire Loss Prevention CFR(s): NFPA 101 Features of Fire Protection - Fire Loss Prevention in Operating Rooms Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: * packaging is non-flammable. * applicators are in unit doses. * Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are

established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure fire and safety precaution training for the operating room. This was evidenced by no record of staff annual review of the fire safety precaution and procedures in the operating room. This affected one of one operating room that could result in a hazard condition and potentially cause harm to patients, in the event of disaster.

Findings:

During record review with the Nursing Director on 7/10/19, surgical fire safety procedures were reviewed and staff interviewed.

At 11:40 a.m., the facility failed to provide documents to show staff annually reviewed the fire safety precautions and procedures in the operating room. During an interview with the Nursing Director, she stated that the facility plans on completing operating room fire safety training in the future and will document the training.