STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634006	A. BUILDING _____ B. WING _____	12/7/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR NURSING & REHAB CENTER LLC	50 N PERRY ST, 1ST FLOOR PONTIAC, MI 48342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000 SS=	Initial Comments On December 6, 2023, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Oakland Manor Nursing and Rehabilitation was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0039 SS= F	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is	E0039	Element #1 Facility failed to conduct a full scale community based emergency preparedness exercise. Residents/staff did not suffer no ill/latent effects. Element #2 All residents/staff have the potential to be affected. Element #3 Policy entitled: Emergency Preparedness Training and Testing Program was reviewed by Regional Maintenance Director and LNHA and deemed appropriate. Staff will be educated on emergency preparedness and a full scale community based emergency preparedness exercise will be conducted by 1/15/2024. Element #4 Results of the community based emergency preparedness exercise will be reviewed and discussed by the QAPI committee and any concerns will be addressed immediately. The Administrator is responsible for sustained compliance.	1/15/2024

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

Electronically Signed | 12/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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			

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	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			

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	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			

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	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			

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	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			

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	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			

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	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 REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that a full-scale community-based emergency preparedness exercise was conducted in the past twelve months. This could result in critical deficiencies in the ability of the facility to respond to an actual community-wide emergency. This will effect all occupants in the event of an emergency event.			

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	Findings include: On December 6, 2023 at approximately 2:00 PM, record review revealed the facility could not produce documentation to verify a full scale exercise was conducted in the previous 12 months. This could leave facility staff unprepared to deal with an emergency situation that can be preplanned for. Documentation was unavailable at the time of request and not presented by the time of the exit conference. These findings were confirmed by interview with the maintenance director at the time of record review.			

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K0000 SS=	INITIAL COMMENTS On December 6, 2023 and December 7, 2023, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Oakland Manor Nursing & Rehab Center, LLC - Pontiac was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is located on the 2nd floor of a 3 story mixed medical occupancy building of Type II (222) construction, built in 1964. The 2nd floor healthcare occupancy is fully sprinklered and separated by a 2-hour fire barrier. The facility has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 39 certified beds. At the time of the survey the census was 3.	K0000		
K0321 SS= E	Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective	K0321	Element#1 Resident room 165 is being used for storage and does not have a required automatic door closure on the door. Element#2 An audit was conducted to ensure that no other resident rooms were being used for storage and it was determined that no other rooms in the facility are being used for storage at this time. Element#3	1/15/2024

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	plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide Hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. This deficient practice could affect 10 occupants in the event of fire. Findings Include: On December 6, 2023 at approximately 1:10 PM, observation revealed Resident Room 165 has been converted to a storage room and contains large fire load of combustible cardboard boxes and patient ventilation units. The room is not equipped with a self closing door. This will		Any rooms that are designated to be used for storage will have the required automatic door closure placed on the door. Facility will review and update preventative maintenace round forms to include ongoing monthly inspections of doors. Element#4 The Administrator/designee will inspect/audit all rooms monthly for three months and then randomly thereafter. Any concerns will be addressed immediately. Results of the inspection/audits will be brought to the QAPI committee for review and recommendations. Administrator is responsible for sustained compliance.	

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	potentially allow smoke, heat and fire to escape the space and enter the adjacent areas. These findings were confirmed through interview with the maintenance director at the time of observation.			
K0353 SS= F	Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the automatic sprinklers are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8. This deficient practice could affect all occupants in the event of a fire. Findings Include: 1. On December 6, 2023 at approximately 12:20	K0353	Element#1 Missing sprinkler head escutcheon missing in shower room Missing sprinkler head escutcheon(two) missing in room 165. Sprinkler head over the nurses station and outside of room 153 covered with dust and debris. Plastic material stuck to sprinkler head in room 110/custodial closet and outside of the biohazard/soiled utility room. Element#2 The missing sprinkler head escutcheon in shower room was replaced on 12/19/23. The missing sprinkler heads in room 165 were replaced on 12/19/23. Dust and debris covering the sprinkler heads over the nurses station and outside of room 153 were cleaned 12/8/23. Plastic material stuck on sprinkler heads located in the room 110/custodial closet and sprinkler head outside the biohazard soiled utility room was removed on 12/6/23. All residents/staff have the potential to be affected, there is no evidence of any ill/latent effects, concerns noted. Element#3 Facility will conduct an inspection of all sprinkler heads to identify any other sprinkler heads that may have dust or debris, plastic stuck to them or missing escutcheon plates by 1/15/24. Any identified concerns will be rectified by 1/15/24.	1/15/2024

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	634006	A. BUILDING _____ B. WING _____	12/7/2023

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	PM, observation revealed the sprinkler head escutcheon plate is missing from the sprinkler head in the main shower room. This may potentially lead to the sprinkler head not functioning as designed when needed during a fire. 2. On December 6, 2023 at approximately 1:00 PM, observation revealed the sprinkler head in the corridor outside of resident room 153 next to the air diffuser and the sprinkler over the nurse station is loaded and covered with dust and debris. This will potentially delay activation of the automatic wet fire sprinkler system when needed during a fire by preventing the sprinkler from discharging at the designed temperature. 3. On December 6, 2023 at approximately 1:15 PM, observation revealed the sprinkler heads in resident room 165 are both missing the escutcheon plate fittings. This may potentially lead to the sprinkler head not functioning as designed when needed during a fire. 4. On December 6, 2023 at approximately 1:20 PM, observation revealed plastic material stuck to the sprinkler heads located in the Room 110 custodial closet and the sprinkler head outside of the biohazard soiled utility room. This will potentially lead to the sprinkler heads not functioning as designed when needed during a fire. These findings were confirmed through interview with the maintenance director at the time of observation.		Element#4 Facility will conduct a visual inspection of 20% of sprinkler heads weekly for four weeks and then monthly for three months. Any identified concerns will be scheduled for cleaning/repair. Results of the inspections will be brought to the QAPI committee for review and recommendations. Administrator is responsible for sustained compliance.	
K0363 SS= E	Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-	K0363	Element#1 Resident room 153 door does not latch when closed. Resident rook 155 door does not latch when closed.	1/15/2024

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	bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits or hazardous areas are 1		Resident room 164 door does not latch when closed. Cross corridor double doors from the resident unit to the lobby space have a gap between the doors exceeding 1/8 inch. Cross corridor south double doors from the resident unit to the dining corridor have a gap between the doors exceeding 1/8 inch. Element#2 All residents and staff have the potential to be affected, there is no evidence of ill/latent effects. Element#3 Facility will adjust door hardware on resident room 153 to allow the door to latch when closed. Facility will adjust door hardware on resident room 155 to allow the door to latch when closed. Facility will adjust door hardware on resident room 164 to allow the door to latch when closed. Facility will install an approved seal on the cross corridor double doors from the resident unit to the lobby space to ensure that the doors will resist passage of smoke. Facility will install an approved seal on the cross corridor corridor south double doors from the resident unit to the dining corridor to ensure that the doors will resist passage of smoke. Facility will inspect all doors to identify any door that does not close to a positive latch or that may have a gap larger than 1/8 inch that would allow passage of smoke by 1/15/24. Element#4 Facility designee will inspect 20% of doors weekly for four weeks and then monthly for	

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	3/4 inch solid-bonded core wood or capable of resisting the passage of smoke. There is no impediment to the closing of doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. This deficient practice could affect 20 occupants in the event of fire. Findings Include: 1. On December 6, 2023 at approximately 1:05 PM observation revealed resident room 164 door does not latch when closed. This will potentially allow smoke heat and fire to pass through the resident corridor door and into the occupied space. 2. On December 6, 2023 at approximately 1:30 PM observation revealed resident room 153 door does not latch when closed. This will potentially allow smoke heat and fire to pass through the resident corridor door and into the occupied space. 3. On December 6, 2023 at approximately 1:30 PM observation revealed resident room 155 door does not latch when closed. This will potentially		three months. Any identified concerns will be addressed immediately. The results of the inspections will be brought to QAPI committee for review and recommendations. The Administrator is responsible for sustained compliance.	

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	allow smoke heat and fire to pass through the resident corridor door and into the occupied space. 4. On December 6, 2023 at approximately 1:15 PM observation revealed the cross corridor double doors from the resident unit to the Lobby space have a gap between the doors exceeding 1/8 inch. This will allow the passage of smoke through the doors into the adjacent space. 5. On December 6, 2023 at approximately 1:15 PM observation revealed the cross corridor south double doors from the resident unit to the dining corridor have a gap between the doors exceeding 1/8 inch. This will allow the passage of smoke through the doors into the adjacent space. These findings were confirmed through interview with the Maintenance Director at the time of observation.			
K0712 SS= F	Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, are held at unexpected	K0712	Element#1 The facility fire drill records for August 2023 to September 2023 only contained employee signatures and documentation of fire simulation. Element#2 No evidence ill/latent effects noted due to deficient practice. Element#3 Facility will obtain quarterly dialer report of fire alarm panel activity from McLaren Oakland facilities manager by 1/15/24. Facility conducted 3rd shift fire drill on 12/28/23. Facility will conduct 1st and second shift fire drills by 1/15/24. Facility will maintain documentation of simulation of fire of the 12/28/23 and all	1/15/2024

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	times under varying circumstances, conducted at least quarterly on each shift and responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all occupants in the event of a fire. Findings Include: On December 6, 2023 at approximately 2:15 PM record review revealed the facility is not conducting fire drills as required by 19.7.1.4. The facility fire drills records for August 2023 to September 2023, only contain signatures of employees participating in the drills. The Fire Drills cannot be verify signals are sent to the monitoring company, or simulation of actual fire event are occurring during the drills. These findings were confirmed through interview with the maintenance director at the time of record review.		subsequent fire drills for review. Element#4 Facility will create and implement a calendar to schedule subsequent fire drills for the next 12 months. Staff will be educated at least quarterly on fire safety. Administrator is responsible for sustained compliance.	
K0914 SS= F	Electrical Systems - Maintenance and Testing 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	K0914	Element#1 Facility failed to record the annual testing of the resident room receptacles. Element#2 Facility will conduct and record the annual testing of the resident room receptacles by 1/15/24. Facility will conduct and a review of life safety documentation to identify any other inspections or documentation that is out of compliance by 1/15/24. Element#3 Facility will review and update preventative maintenance round sheets to include subsequent annual inspections of the outlets in the resident/patient care area.	1/15/2024

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	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 REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure electrical receptacles are maintained and tested as required by 6.3.4 of 2012 NFPA 99. This deficient practice could affect all occupants in the event of electrical outlet failure. Findings Include: On December 7, 2023 at approximately 11:15 AM record review revealed the facility cannot provide documentation to verify outlets in resident/patient care areas are tested at intervals not exceeding 12 months. This could potentially allow outlets in the patient/resident care area to fail when in use. These findings were confirmed with the Manger of Facilities through interview at the time of record review.		Facility will maintain documentation of subsequent inspections for review. Element#4 Administrator will be responsible for sustained compliance	
K0917 SS= E	Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K0917	Oakland Manor Skilled Nursing and Rehab is requesting a temporary waiver for K917. The red emergency outlets in rooms 156, 157, 158 and 159 are fed from emergency panel RP-EP2. Panel RP-EP2 is not wired through an automatic transfer switch. The residents, staff or facility have not suffered any ill/latent effects or health/safety concerns related to the	6/7/2024

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	Based on observation and interview, the facility failed to ensure electrical receptacles or cover plates supplied from life safety and critical branches have a distinctive color marking as required by 6.4.2.2.6, 6.5.2.2.4.2, and 6.6.2.2.3.2 of NFPA 99. This deficient practice could affect 8 occupants in the event of power failure. Findings Include: On December 7, 2023 at approximately 12:30 PM observation revealed red emergency outlets in resident rooms 156, 157, 158, and 159 are fed from emergency panel RP-EP 2. Panel RP-EP 2 is not wired through an automatic transfer switch. Interview with Staff "C" revealed. "The panel only has emergency power if a portable generator is brought to the Mill Street generator hookup site, then connected and turned on." The red outlets will lead staff to believe they are on the automatic emergency power generator and could mistakenly hooked up to power medical equipment at the patient bedside. These findings were confirmed through interview with the Director of Facilities, Maintenance Director and Administrator at the time of observation and exit conference.		deficient practice. No residents will be admitted to rooms 156, 157, 158 or 159 that would require emergency equipment. Signage is posted at the nurses' station to remind staff that the red outlets in rooms 156, 157, 158, and 159 will not have power in case of a power outage. There is also a notice in the emergency preparedness binder that have identified the rooms that do not have emergency power. All staff will be educated in regard to this concern/emergency/red outlet. The red outlets in residents' rooms 156, 157, 158, and 159 will be temporarily removed and will have blank covers installed by 1/30/24. Doing so will stop accidental use of the outlets in an emergency situation. In conjunction with McLaren Oakland Hospital maintenance director and electrician, facility will contact and electrical contractor to move the wiring being fed by the two breakers in the RP-EP 2 panel to be fed by two breakers in the RP-E panel, this will be evaluated by 1/5/24. RP-E contains breakers that feed the lights in the shower room and salon. These breakers can be utilized for the emrgency plugs in rooms 156, 157, 158 and 159. The wiring that feeds the lighting in the shower room and salon can be redirected to the RP-EP 2 panel. All new staff will be educated regarding the deficiency and use of emergency power in the identified rooms during orientation. All staff will be in-serviced monthly in regards to the deficiency. Facility will be in compliance by 6/7/24. Administrator will be responsible for continued education and compliance.	