

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER CROWN BAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 508 WESTLINE DRIVE ALAMEDA, CA 94501	
(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 120	E 000	E007 – Emergency Plan: Patient Population 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/08/2025, the Emergency Preparedness Plan was revised to include specific strategies addressing the needs of at-risk and vulnerable populations such as residents with cognitive impairments, limited mobility, and complex medical needs. 2. Identification of other residents having the potential to be affected was accomplished by: On 5/12/2025, the Interdisciplinary Team reviewed all resident records to determine which individuals were considered at-risk during an emergency. All residents had the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 05/12/25, the Emergency Plan was updated to include a section for identifying vulnerable residents, and care protocols were developed for each type of identified risk (e.g., evacuation assistance, medication needs). 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly review of the Emergency Preparedness Plan. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be	E 007		05/15/25

RECEIVED
By TNewmann at 12:39 pm, May 15, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruby B... TITLE: Administrator (X6) DATE: 05/15/2025

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.

5/19/2025: POC accepted per Beverly Ong-sladek, SSM-1

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E 007	<p>Continued From page 1</p> <p>reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.</p> <p>*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan. This was evidenced by the failure of the emergency preparedness plan to address the client population. This affected 120 of 120 residents and could result in not having the planning and preparation in place to protect the health and safety of the residents.</p> <p>Findings:</p> <p>During record review and interview with the Maintenance Director and Administrator 5/6/25, the facility's emergency preparedness plan was reviewed.</p> <p>At 3:27 p.m., the facility failed to provide strategies the facility has put in place to address the needs of at-risk or vulnerable resident populations. Upon interview, the Administrator stated she was not sure why the policy was not in the binder.</p> <p>The facility was given the opportunity to submit the missing records by 9 a.m. on 5/7/25. CDPH</p>	E 007		05/15/25

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E 007	Continued From page 2 did not receive any records.	E 007		
E 024 SS=C	<p>Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)</p> <p>§403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).</p> <p>[(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:]</p> <p>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in</p>	E 024	<p>E024 – Policies/Procedures: Volunteers and Staffing</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/12/25, the facility developed a written policy outlining procedures for the use of volunteers and alternative staffing during emergencies.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: All residents had the potential to be affected during emergency staffing shortages or volunteer involvement.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 05/12/2025, the policy was incorporated into the facility's Emergency Preparedness Plan. All department heads were trained on how to implement the policy during an emergency.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly review of the Emergency Preparedness Plan. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.</p>	05/15/25

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E 024	Continued From page 3 an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness (EP) plan. This was evidenced by the failure to provide policy and procedure for volunteers explaining the facility's use of volunteers or other staffing strategies in its emergency plan. This affected 120 of 120 residents and could result in an ineffective EP plan. Findings: During document review and interview with the Maintenance Director and Administrator on 5/6/25, the EP policies and procedures were requested and reviewed. At 3:29 p.m., there was no policy and procedure explaining the facility's use of volunteers or other staffing strategies in their emergency plan. Upon interview, the Administrator stated she just started working for the facility and was not aware of the missing policy. The facility was given the opportunity to submit the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records.	E 024		05/15/25
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)	E 026		

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E 026	Continued From page 4 (iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop policies and procedures to provide care and treatment at an alternate site for their residents. This was evidenced the absence of a policy and procedure indicating the facility's role in providing treatment and care under an 1135 waiver at an alternate care site in	E 026	E026 – Roles Under a Waiver Declared by the Secretary 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/12/2025, the Emergency Preparedness Plan was updated to include a policy addressing alternate care sites and adjusted staffing/licensure protocols. 2. Identification of other residents having the potential to be affected was accomplished by: All residents had the potential to be affected in the event of a federally declared emergency requiring relocation or altered care settings. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility incorporated all guidelines into the Emergency Plan and added procedures for continuity of care in alternate locations on (date). 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly inspection of the Emergency Plan to ensure waiver protocols are included and current. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.	05/15/25	

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E 026	Continued From page 5 the event of an emergency. This affected 120 of 120 residents and could result in the facility being inadequately prepared to provide care at an alternate location. Findings: During document review and interview with the Maintenance Director and Administrator on 5/6/25, the Emergency Preparedness policies and procedures were requested. At 3:30 p.m., the facility failed to provide the policy and procedure outlining the facility's plan to provide care and treatment in an alternate location under an 1135 waiver, in the event of an emergency. Upon interview, the Administrator stated she was new to the facility and was not aware the policy was missing. The facility was given the opportunity to submit the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records.	E 026		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(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), §485.542(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, REHs at §485.542, CAHs at §486.625, "Organizations" under	E 036		05/15/25

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E 036	<p>Continued From page 6</p> <p>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.</p> <p>*[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.</p> <p>*[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).</p>	E 036	<p>E036 – Emergency Preparedness Training and Testing</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/09/2025, the facility conducted an Emergency Preparedness training for all staff and completed a tabletop exercise to simulate emergency response procedures.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: All residents had the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 05/09/2025, the facility implemented an annual Emergency Preparedness training and testing calendar and established a system for tracking staff participation. On 05/09/25, the Maintenance Director educated by the Administrator on the requirements and documentation for Emergency Preparedness Training.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly review of training logs and exercise documentation to ensure all staff are trained and drills are conducted annually. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.</p>	05/15/25

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E 036	Continued From page 7 *[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 REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing plan. This was evidenced by the failure to maintain an emergency preparedness training and testing program for staff. This affected 120 of 120 residents and could result in them not having the planning and preparation in place to protect the health and safety of the residents. Findings: During record review and interview with the Maintenance Director and Administrator on 5/6/25, the facility's emergency preparedness plan was reviewed. At 3:31 p.m., the facility failed to provide the policy and procedure on emergency preparedness training and testing program for staff. Upon interview, the Administrator stated she was not aware the policy was missing and would need to find out why it was not there.	E 036		05/15/25

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E 036	Continued From page 8 The facility was given the opportunity to submit the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records.	E 036		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		05/15/25

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E 039	<p>Continued From page 9</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(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:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is</p>	E 039	<p>E039 – Emergency Preparedness Testing Requirements</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>On 05/09/25, the facility implemented an emergency preparedness training program for staff.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p> <p>All residents had the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>On 05/09/25, the facility implemented an annual Emergency Preparedness training and testing calendar and established a system for tracking staff participation. On 05/09/25, the Maintenance Director educated by the Administrator on the requirements and documentation for Emergency Preparedness Training.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Maintenance Director or designee will review the emergency preparedness training program schedule monthly to ensure required drills are completed. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.</p>	05/15/25

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NAME OF PROVIDER OR SUPPLIER CROWN BAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 508 WESTLINE DRIVE ALAMEDA, CA 94501	
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E 039	Continued From page 10 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	E 039		05/15/25

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E 039	Continued From page 11 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	E 039		05/15/25

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E 039	Continued From page 12 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	E 039		05/15/25

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E 039	Continued From page 13 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/ID] 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.	E 039		05/15/25

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E 039	<p>Continued From page 14</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is</p>	E 039		05/15/25

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E 039	Continued From page 15 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	E 039		05/15/25

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E 039	Continued From page 16 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 REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an Emergency Preparedness Training and Testing plan. This was evidenced by the failure to participate in a full-scale community based drill. This affected 120 of 120 residents and could result in them not	E 039		05/15/25

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E 039	Continued From page 17 having the planning and preparation in place to protect the health and safety of the residents and staff. Findings: During record review and interview with the Maintenance Director and Administrator on 5/6/25, the facility's Emergency Preparedness Training program was reviewed. At 2:50 p.m., the facility failed to provide records indicating the facility participated in a full-scale community based emergency preparedness exercise within the last 12 months. Upon interview, the Administrator stated she was informed the facility did not participate in one.	E 039			
K 000	INITIAL COMMENTS K3 BUILDING: 02 K6 PLAN APPROVAL: 08/01/1974 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a) (b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition.	K 000			05/15/25

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K 000	Continued From page 18 The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities. Census: 120	K 000		
K 345 SS=C	Licensed Beds: 135 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - 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 REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by the failure to provide Fire Alarm Control Panel (FACP) battery testing records. This affected 120 of 120 residents in four of four smoke compartments and could result in a malfunctioning FAS in the event of a fire. NFPA 101 Life Safety Code, 2012 Edition 19.3.4 Detection, Alarm and Communications Systems 19.3.4.1 General. Healthcare occupancies shall be provided with a fire alarm system in accordance with section 9.6. 9.6 Fire Detection, Alarm and Communications Systems 9.6.1* General	K 345	K345 – Fire Alarm System: Testing and Maintenance 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/08/2025, the facility's licensed fire safety vendor completed the missing annual battery charger test and the 30-minute battery discharge test for the fire alarm control panel. 2. Identification of other residents having the potential to be affected was accomplished by: All residents had the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 05/08/2025, the Maintenance Director educated by the Administrator on the requirements and documentation for Fire Alarm System: Testing and Maintenance. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly review of the Fire Alarm testing log to ensure required testing; including battery charger and discharge tests are scheduled and completed. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.	05/15/25

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K 345	<p>Continued From page 19</p> <p>9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code.</p> <p>9.7.7 Documentation. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system.</p> <p>NFPA 72: National Fire Alarm and Signaling Code, 2010 Edition</p> <p>14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter.</p> <p>14.4 Testing.</p> <p>14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.</p> <p>Table 14.4.5 Testing Frequencies</p> <p>6. Batteries-fire alarm systems</p> <p>(d) Sealed lead-acid type:</p> <p>(1) Charger test (Replace battery within 5 years after manufacture or more frequently as needed)-annually</p> <p>(2) Discharge test (30 minutes)-annually</p> <p>Findings:</p> <p>During a tour of the facility, record review, and interview with the Maintenance Director on 5/6/25, the FACP was observed with sealed lead acid batteries and FAS records were requested.</p>	K 345		05/15/25

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K 345	Continued From page 20 1. At 3:18 p.m., the facility failed to provide the requested Annual FACP battery charger test within the last 12 months. The facility provided their Annual FAS dated 3/31/25 and Semiannual testing dated 9/16/24 that indicated battery testing, but did not show a battery charger test was performed. Upon interview, the Maintenance Director stated he was sure the vendor performed the service but did not why is was not on the report. The facility was given the opportunity to email a copy of the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records. 2. At 3:19 p.m., the facility failed to provide the requested Annual FACP battery 30 minute discharge test within the last 12 months. The facility provided their Annual FAS dated 3/31/25 and Semiannual testing dated 9/16/24 that indicated battery testing, but did not show a 30 minute discharge test was performed Upon interview, the Maintenance Director stated he was sure the vendor performed the service but did not why is was not on the report. The facility was given the opportunity to email a copy of the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records.	K 345		05/15/25	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1, 19.3.4.5.2	K 347			

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NAME OF PROVIDER OR SUPPLIER CROWN BAY NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 508 WESTLINE DRIVE ALAMEDA, CA 94501		
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K 347	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain their smoke detectors. This was evidenced by missing records of the smoke detector sensitivity testing. This affected 120 of 120 residents in four of four smoke compartments and could result in a malfunctioning smoke detector in the event of a fire.</p> <p>NFPA 101, Life Safety Code, 2012 Edition. 19.3.4 Detection, Alarm, and Communications Systems 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.5 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code.</p> <p>NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. 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</p>	K 347	<p>K347 – Smoke Detection</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/09/2025, the facility contracted with a certified vendor who performed smoke detector sensitivity testing on all applicable smoke detectors. The vendor's report confirmed all devices were within operational parameters.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: All residents had the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 05/12/25, the Maintenance Director educated by the Administrator on the requirements and documentation for smoke detector sensitivity testing requirements per NFPA 72.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will review testing schedules monthly to ensure smoke detector sensitivity testing is completed. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.</p>	05/15/25

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K 347	<p>Continued From page 22</p> <p>of nuisance alarms and subsequent trends of these alarms shall be maintained.</p> <p>14.4.5.3.3.2 In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method</p> <p>(2) Manufacturer's calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>14.4.5.3.5 Unless otherwise permitted by</p> <p>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.</p> <p>14.4.5.3.6 Smoke detectors or smoke alarms listed as field adjustable shall be permitted to either be adjusted within the listed and marked sensitivity range, cleaned, and recalibrated, or be replaced.</p> <p>14.4.5.3.7 The detector or smoke alarm sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector or smoke alarm.</p> <p>Findings:</p> <p>During record review and interview with the</p>	K 347		05/15/25	

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K 347	Continued From page 23 Maintenance Director on 5/6/25, the facility's smoke detector testing records were requested. At 2:25 p.m., the facility failed to provide records indicating that a smoke detector sensitivity testing was performed on the facility's smoke detectors within the last two years. No previous records were provided. Upon interview, the Maintenance Director stated he was sure the vendor performed the test and would need to contact them for the records. The facility was given the opportunity to email a copy of the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records.	K 347		
K 712 SS=C	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. 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 maintain their fire drills. This was evidenced by missing fire drill records. This affected 120 of 120 residents in four of four smoke compartments. This could result in a delayed evacuation in the event of a fire.	K 712		05/15/25

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K 712	Continued From page 24 NFPA 101, Life Safety Code, 2012 Edition 19.7* Operating Features. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1. 19.7.1.3 A copy of the plan required by 19.7.1.1 shall be readily available at all times in the telephone operator's location or at the security center. 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. 19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices. Findings:	K 712	K712 – Fire Drills 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/07/2025, a fire drill was conducted on the NOC shift, which had previously been missed during Q4 of 2024. Documentation was completed and added to the fire drill log. 2. Identification of other residents having the potential to be affected was accomplished by: All residents had the potential to be affected by inadequate staff response during an emergency if drills are not routinely conducted on all shifts. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A fire drill schedule was implemented with quarterly drills planned for all three shifts (day, evening, night). On (date) the Maintenance Director was educated by the Administrator on the requirements and documentation for Fire Drills 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly review of fire drill documentation to ensure each shift completes a fire drill every quarter. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.	05/15/25

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K 712	Continued From page 25 During record review and interview with the Maintenance Director on 5/6/25, the fire drill records were requested. At 2:20 p.m., the facility failed to conduct one of twelve fire drills. The facility did not provide the NOC shift drill during the fourth quarter (October/November/December) of 2024. Upon interview, the Maintenance Director stated he just received the reports and would need to ask the Administrator to see if they were sent. The facility was given the opportunity to email a copy of the missing records by 9 a.m. on 5/7/25. CDPH did not receive any records.	K 712		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their electrical equipment. This was evidenced by an obstructed electrical panel. This affected 36 of 120 residents in one of four smoke compartments and could result in delayed access to the electrical panel in the event of an emergency. NFPA 101 Life Safety Code, 2012 edition 19.5.1.1 Utilities shall comply with the provisions	K 919		05/15/25

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K 919	<p>Continued From page 26</p> <p>of section 9.19.1.3.1 Emergency Generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p> <p>19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1.</p> <p>NFPA 70, National Electric Code, 2011 Edition 110.32 Work Space About Equipment. Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (6 ½ ft) high (measured vertically from the floor or platform) or not less than 914 mm (3 ft) wide (measured parallel to the equipment). The depth shall be as required in 110.34 (A). In all cases, the work space shall permit at least 90 degree opening of doors and hinged panels.</p> <p>Findings:</p> <p>During a tour of the facility and interview with the Maintenance Director on 5/6/25, the facility electrical equipment was observed.</p> <p>At 11:10 a.m., a panel labeled "Fire Alarm Panel Inside" in the Director of Staff Development Room was observed. The panel was being obstructed by a desk, boxes and backpack that</p>	K 919	<p>K919 – Electrical Equipment – Other</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include: On 05/07/2025, the desk and boxes obstructing electrical panel "D" in the DSD office were removed, restoring the required 36 inches of clearance.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: On (date), the Maintenance Director conducted a facility-wide audit of all electrical panels and determined that no other panels were obstructed.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 05/12/2025 the Maintenance Director was educated by the Administrator on the requirements and documentation for maintaining a 36-inch clearance around all electrical panels in accordance with NFPA 70.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Maintenance Director or designee will complete a monthly inspection of all electrical panels to ensure required clearance is maintained. Any issues identified will be immediately corrected. This plan of correction has been integrated into the facility Quality Assurance Committee, and the results of these audits will be reviewed quarterly until substantial compliance has been achieved.</p>	05/15/25	

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K 919	Continued From page 27 were approximately one foot away from the panel. Upon interview, the Maintenance Director stated the desk is new as they had new staff and was not there for long.	K 919		05/15/25	