

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

PRINTED: 06/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>05A371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/09/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRESTWOOD WELLNESS AND RECOVERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3062 CHURN CREEK RD. REDDING, CA 96002</b>	
(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 = 90	E 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction contained is prepared and/or executed solely because it is required by the provisions of health and safety code, the State of California, and CMS.  <b>RECEIVED</b> <i>By TNewmann at 8:13 am, Jun 23, 2025</i>	
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)  §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).  The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:  (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 all of the following:	E 004	The facility recognizes the importance of maintaining the emergency preparedness plan. The facility will continue to maintain the emergency preparedness plan every year by reviewing and updating the plan annually.  The facility shall update the EPP June 26, 2025 during the QA Committee meeting. The facility shall include the EPP review and update the EPP as part of the facility's annual review for all facility Policies and Procedures, to be conducted in January 2026 and then each consecutive year in the following January.  The update will be communicated to staff during the all staff meeting scheduled for June 26, 2025, coordinated by the Administrator and facility Environmental Services Supervisor.	June 27, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Administrative*

(X6) DATE

*6/20/2025*

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.

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E 004	<p>Continued From page 1</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the emergency preparedness plan (EPP). This was evidenced by missing updated for the EPP. This could result in not having the planning and preparation in place to protect the health and safety for 90 of 90 residents.</p> <p>Findings: During record review and interview with Staff on 6/9/25, the EPP was requested and reviewed. At 1:50 p.m., the facility failed to provide an EPP updated annually. The EPP was last updated on</p>	E 004	<p>Further issues regarding the EPP annual update and approval will be received during the QA process and brought to the QAPI Committee for review. The Environmental Services Supervisor, Administrator, and QA Manager will be responsible to ensure ongoing compliance.</p>		

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E 004	Continued From page 2	E 004		
E 013 SS=F	<p>11/15/23. Upon interview, Staff 2 stated that the EPP last review date was 2023.</p> <p>Development of EP Policies and Procedures CFR(s): 483.73(b)</p> <p>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency</p>	E 013	<p>The facility recognizes the importance of maintaining the emergency preparedness plan ( EPP ) . The facility shall continue to ensure the emergency preparedness plan has updated policies and procedures.</p> <p>The facility shall update the emergency preparedness plan policies and procedures June 26, 2025 during the QA Committee meeting.</p> <p>The facility shall include the reviewed and updated emergency preparedness plan policies and procedures as part of the annual review for all facility's polices and procedures to be conducted in January 2026, and then each consecutive year in the following January.</p> <p>Further issues regarding the facility's emergency preparedness plan's policies and procedures shall be received during the QA process and brought to the QAPI Committee for review and discussion.</p> <p>The Administrator, Environmental Services Supervisor, QA Manager, and Director of Nursing shall be responsible to ensure ongoing compliance.</p>	June 27, 2025

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E 013	<p>Continued From page 3</p> <p>plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain the emergency preparedness plan (EPP). This was evidenced by missing an updated EPP polices and procedures. This could result in not having the planning and preparation in place to protect the health and safety for 90 of 90 residents.</p> <p>Findings:</p>	E 013	This page is purposefully left blank.		

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E 013	Continued From page 4 During record review and interview with Staff on 6/9/25, the EPP was requested and reviewed.  At 1:55 p.m., the facility failed to update the EPP polices and procedures annually. The last update was 11/15/23. Upon interview, Staff 2 stated that the EPP last review date was 2023.	E 013			
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c)  §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).  (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the emergency preparedness plan (EPP). This was evidenced by missing an updated policies and procedures for a communication plan. This could result in not having the planning and preparation in place to protect the health and safety for 90 of 90 residents.  Findings:  During record review and interview with Staff on 6/9/25, the EPP was requested and reviewed.	E 029	The facility recognizes the importance of maintaining an updated communication plan. The facility shall continue to maintain an updated communication plan and review it annually.  The facility shall update the emergency preparedness communication plan June 26, 2025 during the QA Committee meeting.  The communication plan shall be included when the facility reviews the emergency preparedness plan annually in January 2026 and the each year consecutively in the following January.  Futher issues regarding the facility's development of a communication plan as part of the emergency preparedness plan shall be received during the QA process and brought to the QAPI Committee for review and discussion.	June 27, 2025	

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E 029	Continued From page 5 At 1:59 p.m., the facility failed to provide an updated communication plan reviewed annually. The last update was 11/15/23. Upon interview, Staff 2 stated that the EPP last review date was 2023.	E 029	The Administrator, Environmental Services Supervisor, QA Manager, and DON shall be responsible for monitoring and ongoing compliance.		
E 036 SS=F	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 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.  *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this	E 036	The facility recognizes the importance of developing and maintaining an emergency preparedness training and testing program. The facility shall continue to provide an EPP training and testing program update annually.  The Emergency preparedness training and testing program shall be reviewed June 26, 2025 during the QA Committee meeting.  The emergency training and testing program shall be included in the annual review of facility policy and procedures in January 2026 and then each year consecutively in the following January.  Further issues regarding the training and testing program of the EPP shall be received during the QA process and brought to the QAPI Committee for review and discussion at least quarterly, or more frequent if necessary.  The Administrator, Environmental Services Supervisor, QA Manager, and DON shall be responsible for monitoring and ongoing compliance.	June 27, 2025	

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E 036	<p>Continued From page 6</p> <p>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> <p>*[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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the emergency preparedness plan (EPP). This was evidenced by missing an updated EPP training and testing program. This</p>	E 036	This page is purposefully left blank.		

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E 036	Continued From page 7 could result in not having the planning and preparation in place to protect the health and safety for 90 of 90 residents.  Findings:  During record review and interview with Staff on 6/9/25, the EPP was requested and reviewed.  At 2:10 p.m., the facility failed to provide an EPP training and testing program update annually. The last update was 11/15/23. Upon interview, Staff 2 stated that the EPP last review date was 2023.	E 036	This page is purposefully left blank.	
K 000	INITIAL COMMENTS  K3 BUILDING: 01 K6 PLAN APPROVAL: 2/5/1988 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED.  Resident Certified Beds: 99 Resident Census: 90  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.  The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 342 SS=D	Fire Alarm System - Initiation CFR(s): NFPA 101	K 342		

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K 342	Continued From page 8  Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by a smoke detector failing to initiate the alarm. This affected 14 of 90 residents in one of ten smoke compartments and could result in the delay of notification to emergency forces in the event of an emergency.  NFPA 101 Life Safety Code, 2012 edition 19.3.4 Detection, Alarm and Communication Systems. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 19.3.4.2 Initiation. 19.3.4.2.1 Initiation of the required fire alarm systems shall be manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices or detection systems, unless otherwise permitted by 19.3.4.2.2 9.6.2.10 Smoke Alarms.	K 342	The facility recognizes the importance of maintaining the fire alarm system. The facility shall continue to maintain the smoke detectors and fire alarm system.  The facility contacted Sa-Fire to inspect the current locations of the smoke detectors. Facility plans to move / re-locate the 4 ceiling mount smoke detectors away from the proximity of the air registers that may have affected the smoke detectors, causing the testing issues.  Sa-Fire will be placing the system on test to complete the work, and the annual fire alarm inspection is scheduled to be completed July 25, 2025. The detectors will be re-tested at that point.  Further issues regarding the fire alarm system and/or the smoke detectors will be received during the QA process and brought to the QAPI Committee for review and discussion.  The Administrator, Environmental Services Supervisor, maintenance staff, and nursing staff shall be responsible for monitoring and ongoing compliance.	July 25, 2025	

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K 342	Continued From page 9 9.6.2.10.1 General. 9.6.2.10.1.1 Where required by another section of this Code single-station and multiple-station smoke alarms shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code, unless otherwise provided in 9.6.2.10.1.2, 9.6.2.10.1.3, or 9.6.2.10.1.4  NFPA 72 Inspection, Testing and Maintenance, 2010 edition. 29.8.3.4 Specific Location Requirements. The installation of smoke alarms and smoke detectors shall comply with the following requirements: (6) Smoke alarms and smoke detectors shall not be installed within a 36 in. (910mm) horizontal path from the supply registers of a forced air heating or cooling system and shall be installed outside of the direct airflow from those registers  Findings:  During a tour of the facility and interview with Staff on 6/9/25, the smoke detectors were tested.  At 11:49 a.m., the system based smoke detector outside resident room 209 was tested with artificial smoke and the alarm did not initiate. The air condition (AC) vent was approximately 36 inches from the smoke detector. Upon interview, Staff 1 stated that they were unaware why the smoke detector was not working.  At 11:54 a.m., the smoke detector was retested with artificial smoke and the alarm did not initiate. Upon interview, Staff 1 stated that the AC vent may be causing the smoke detector to not pick up the artificial smoke.	K 342	This page is purposefully blank.	
K 346 SS=C	Fire Alarm System - Out of Service	K 346		

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NAME OF PROVIDER OR SUPPLIER  <b>CRESTWOOD WELLNESS AND RECOVERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3062 CHURN CREEK RD. REDDING, CA 96002</b>	
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K 346	Continued From page 10 CFR(s): NFPA 101  Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire alarm system (FAS). This was evidenced by missing components of the fire watch policy. This affected 90 of 90 residents in ten of ten smoke compartments and could result in the spread of a fire.  Findings:  During record review and interview with Staff on 6/9/25, the fire watch policy was reviewed.  At 1:38 p.m., the facility failed to provide a fire watch policy that included verbiage indicating fire watch would be implemented after no more than four hours of the fire alarm system being out of service. Upon interview, Staff 1 stated that a time frame was not included in the fire watch policy.	K 346	The facility recognizes the importance of maintaining the fire alarm system. The facility shall continue to maintain the fire alarm system, and shall update the fire watch policy.  When the fire alarm system is "out of service", the facility's fire watch policy shall include language stating "fire watch will be implemented after no more than four hours of the fire alarm system being out of service".  The updated Fire Watch Policy will be reviewed, updated, and adopted June 26, 2025 during the QA Committee meeting.  Further issue regarding the fire alarm system fire watch policy shall be received during the QA process and brought to the QAPI Committee for review and discussion.  The Administrator, Environmental Services Supervisor, QA Manager, DON, maintenance staff, and nursing staff shall be responsible for monitoring and ongoing compliance.	June 27, 2025
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		

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K 353	<p>Continued From page 11</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 maintain the Sprinkler System. This was evidenced by a failed water flow test. This could result in the delay of sprinkler protection. This affected 90 of 90 residents and ten of ten smoke compartments.</p> <p>NFPA 101 Life Safety Code, 2012 edition 19.3.5. Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5 9.7.2 Supervision. 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a</p>	K 353	<p>The facility recognizes the importance of maintaining the Sprinkler System. The facility shall continue to maintain the Sprinkler System, including the water flow test.</p> <p>The repair and retest of the Sprinkler System was conducted and completed by Environmental Services Supervisor June 9, 2025. The facility will continue to complete the Sprinkler System flow test monthly in July, August, and September - then will revert back to normal quarterly testing in October.</p> <p>Further issues regarding the facility Sprinkler System will be received during the QA process and brought to the QAPI Committee for review and discussion at least quarterly, or as necessary.</p> <p>The Administrator, Environmental Services Supervisor, QA Manager, and maintenance staff shall be responsible for monitoring and ongoing compliance.</p>	July 25, 2025

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K 353	Continued From page 12 condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.  NFPA 72 Inspection, Testing and Maintenance, 2010 edition. 17.12 Sprinkler Waterflow Alarm-Initiating Devices 17.12.1 The Provisions of Section 17.12 shall apply to devices that initiate an alarm indicating a flow of water in a sprinkler system. 17.12.2 Activation of the initiating device shall occur within 90 seconds of waterflow at the alarm-initiating device when flow occurs that is equal or greater than that from a single sprinkler of the smallest orifice size installed in the system.  Findings:  During a tour of the facility and interview with staff on 6/9/25, the water flow was tested.  At 11:40 a.m., the inspector test valve (ITV) was observed in an exterior electrical closet near the generator. The water flow was tested for over 90 seconds and did not initiate the alarm. The last water flow test was during the annual inspection/test was dated 5/16/25. Upon interview, Staff 1 stated that they were unaware the water flow was not working, and that the facility will implement fire watch after ten hours.	K 353	This page is purposefully blank.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101  Sprinkler System - Out of Service	K 354		

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K 354	Continued From page 13 Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the Sprinkler System. This was evidenced by missing components of the fire watch policy. This affected 90 of 90 residents in ten of ten smoke compartments and could result in the spread of a fire.  Findings:  During record review and interview with Staff on 6/9/25, the fire watch policy was reviewed.  At 1:39 p.m., the facility failed to provide a fire watch policy that included verbiage indicating fire watch would be implemented after no more than ten hours of the sprinkler system being out of service. Upon interview, Staff 1 stated that a time frame was not included in the fire watch policy.	K 354	The facility recognizes the importance of maintaining the Sprinkler System. The facility shall continue to maintain the Sprinkler System.  When the Sprinkler System is out of service, the facility shall update the Fire Watch policy to include language indicating "fire watch will be implemented after no more than ten hours of the sprinkler system being out of service".  The updated Fire Watch policy will be reviewed , updated, and approved June 26, 2025 during the QA Committee meeting.  Further issues regarding the Fire Watch policy or the sprinkler system shall be received during the QA process and brought to the QAPI Committee for review and discussion.  The Administrator, Environmental Services Supervisor, QA Manager, maintenance staff, and nursing staff shall be responsible for monitoring and ongoing compliance.	June 27, 2025
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101  Electrical Equipment - Power Cords and	K 920		

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K 920	<p>Continued From page 14</p> <p><b>Extension Cords</b> Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the electrical equipment. This was evidenced by a suspended power strip. This could result in a fire and affected one of ten smoke compartments.</p> <p>Findings: During a tour of the facility and interview with Staff on 6/9/25, the electrical equipment was observed. At 11:15 a.m., the Trinity center was observed with a suspended power strip that was</p>	K 920	<p>The facility recognizes the importance of maintaining electrical equipment. The facility shall continue to properly maintain electrical equipment.</p> <p>Environmental Services Supervisor removed the suspended power strip in the Trinity Center June 9, 2025.</p> <p>In-service was provided to maintenance staff on NFPA code and to look for during room inspections, specific to power strips. Power strip audits will be conducted monthly, using the facility Monthly Maintenance Log.</p> <p>Further issues regarding electrical equipment shall be received during the facility QA process and brought to the QAPI Committee for review and discussion.</p> <p>The Environmental Services Supervisor, Administrator, maintenance staff, nursing staff, and housekeeping staff shall be responsible to monitor for ongoing compliance.</p>	July 26, 2025	

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K 920	Continued From page 15 suspended approximately one foot off the ground and plugged into a television. Upon interview, Staff 1 stated that staff accidentally suspended the power strip.	K 920	This page is purposefully left blank.		