STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105317	A. BUILDING 01 - MAIN FED B. WING	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIVER HEALTH AND REHABILITATION CENTER	136 NORTHEAST 12TH AVENUE , CRYSTAL RIVER, Florida, 34429

(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
K0000 Bldg. 01	INITIAL COMMENTS An unannounced Fire and Life Safety recertification survey was conducted . at Crystal River Health and Rehabilitation Center, a nursing home in Crystal River, Florida. Crystal River Health and Rehabilitation Center is not in compliance with 42 CFR 483.90 (a) & (b), and National Fire Protection Association (NFPA) 101(2012 edition) and Tentative Interim Amendments ('s) , , , and . NFPA 99 (2012 edition) and Tentative Interim Amendments 's , , , and requirements for nursing homes. The following is description of the noncompliance. Initial Plan Review date: 1970 Existing NFPA 220 Construction Type: II (000) Number of licensed beds: 150 Number of rooms sampled: 150	K0000		
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep or general is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM	K0914	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0914 and assure continued compliance, the following plan has been put in place. K0914 – Electrical Receptacle Testing Immediate Correction: Re-testing of electrical receptacles in affected patient care areas was performed. Outlets were verified for polarity and grounding continuity in addition to tension requirements.	

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 reverse for further 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.

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

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K0914 SS = F Bldg. 01	Continued from page 1 circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to properly maintain and test electrical receptacles in accordance with NFPA 99. This can cause faulty electrical equipment which can result in fire. This deficient practice affects the whole facility. Findings include: During record review on at 11:00 AM the facility's electrical receptacle testing log only indicated tension testing. Nothing in the inspection report indicated testing of polarity. Concurrent with the above finding during staff interview, the Maintenance Director acknowledged the finding, and indicated the facility staff never tested polarity of the receptacles. NFPA 99 (2010 Edition) 6.3.3.2, 6.3.3.2.3	K0914	Continued from page 1 Identification of Others: A comprehensive re-testing of all receptacles in resident care areas was initiated. The Testing Log was revised to include dedicated columns for Polarity, Grounding Integrity, and Tension. Systemic Changes: The facility procured UL-listed polarity analyzers. Staff were trained on NFPA 99, Section 6.3.4.1 regarding hospital-grade electrical verification. Monitoring (QA): The Maintenance Supervisor will audit 10% of testing logs monthly. Findings will be reported to the QAPI Committee to ensure all data points are consistently recorded.	
K0345 SS = D Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain the fire alarm system in accordance with NFPA 72. This in the event of a fire can result in the fire alarm system not performing as designed. This deficient practice affects the whole facility. Findings include:	K0345	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0345 and assure continued compliance, the following plan has been put in place. K0345 – Fire Alarm System Maintenance Immediate Correction: A fire alarm provider diagnosed and repaired the trouble signal, restoring the system to a "System Normal" state. Residents in the affected zone were monitored for safety during the repair. Identification of Others: A 100% audit of the Fire Alarm Control Panel (FACP) was conducted to ensure no other trouble or supervisory signals were present facility-wide.	

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K0345 SS = D Bldg. 01	Continued from page 2 During observation on , at 3:30 PM, the fire alarm control panel indicated a trouble signal. Concurrent with the observation, during staff interview, the facility Maintenance Director acknowledged the finding, indicating it was due to a faulty heat detector, and he is working with the vendor to address the trouble signal. NFPA 101 (2012 Edition) 19.3, 19.3.4.1, 9.6, 9.6.1, 9.6.1.3 NFPA 72 (2010 Edition) 14.2 ,14.2.1.2.2, 14.4, 14.4.4.3.2, 14.4.5.3.2,	K0345	Continued from page 2 Systemic Changes: Maintenance and administrative staff were re-educated on responding to trouble signals within 24 hours and documenting all actions in the maintenance log. Monitoring (QA): The Maintenance Supervisor will conduct daily visual inspections of the FACP. The Safety Committee will review all service reports monthly, reporting findings to the QAPI Committee.	
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ---------- b) Who provided system test ---------- c) Water system supply source ---------- Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the proper fire sprinkler system inspection reports in accordance with NFPA 25. This in the event of a fire can result in the sprinkler system failing to perform as designed. This deficient practice affects the whole facility. Findings include:	K0353	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0353 and assure continued compliance, the following plan has been put in place. K0353 – Sprinkler System Testing (5-Year Internal) Immediate Correction: A licensed fire sprinkler vendor was to perform the 5-year internal piping inspection per NFPA 25 to ensure the system is free of obstructions. Identification of Others: All fire protection systems were audited. The internal pipe inspection report is now maintained in the Life Safety binder for immediate surveyor review. Systemic Changes: A Master Regulatory Calendar was implemented to track multi-year NFPA requirements. The service contract was updated to require the vendor to provide 90-day advance notice of all upcoming 3-year and 5-year tests. Monitoring (QA): The Maintenance Supervisor will audit the Master Calendar monthly. Results will be reported to the QAPI Committee quarterly.	

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K0353 SS = D Bldg. 01	Continued from page 3 During record review on at 10:50 AM, the recent sprinkler system report dated , indicated the facility is past due for 5-year internal inspection. The facility did not provide their most recent 5 year inspection report. Concurrent with record review, during staff interview, the Maintenance Director acknowledged the finding and indicated he will work with the vendor to provide the missing report. NFPA 101 (2012 Edition): 19.3.5.1, 9.7, 9.7.5 NFPA 25 (2011 Edition): 4.3	K0353		
K0511 SS = D Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical utility equipment in accordance with NFPA 70. This can result in electric or fire. This deficient practice affects 1 out of 7 smoke compartments. Findings include: During observation on at 3:15 PM, the cover of the circuit breaker panel was fastened through the use of sheet metal screws. Concurrent with the observation during staff interview, the facility maintenance director acknowledged the findings, indicating he will replace the screws with proper blunt end fasteners. NFPA 101 (2012 Edition): 19.5.1, 9.1.2 NFPA 70 (2011 Edition): 314.23(B)(1)	K0511	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0511 and assure continued compliance, the following plan has been put in place. K0511 – Electrical Panel Fasteners Immediate Correction: Unauthorized sheet metal screws were removed from the cited circuit breaker panel and replaced with OEM-approved, blunt-end machine screws to prevent internal wire damage. Identification of Others: A facility-wide audit of all electrical panels, sub-panels, and pull boxes was conducted. Any non-compliant fasteners found were immediately replaced with blunt-end hardware. Systemic Changes: The Electrical Safety Policy was updated to prohibit self-tapping or pointed screws. Maintenance staff were trained on NFPA 70 hardware requirements to maintain equipment integrity. Monitoring (QA): "Panel Fastener Integrity" was added to the Monthly Life Safety Walkthrough. Audit logs will be reviewed during quarterly QAPI meetings.	

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K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to maintain and inspect backup generator batteries in accordance with NFPA 110. Testing batteries ensures the reliability of the prime mover starting system. Failure to conduct these tests could result in the loss of power to the facility. This would endanger the occupants of the building from the loss of power to life support and the life safety features of the facility. Findings include: During record review on at 11:34 PM, the facility did not provide documentation on generator battery testing.	K0918	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0918 and assure continued compliance, the following plan has been put in place. K0918 – Generator Battery Testing Immediate Correction: A comprehensive generator battery test, including specific gravity and conductance testing, was performed and recorded in the EPSS Log to ensure peak cranking capacity. Identification of Others: The EPSS was audited to ensure all maintenance components were documented. The Life Safety binder was reorganized to house these records separately for easy retrieval. Systemic Changes: The Generator Maintenance Log was revised to include specific fields for weekly visual checks and monthly battery conductance/voltage testing. Staff were re-trained on NFPA 110 battery maintenance standards. Monitoring (QA): The Maintenance Director will conduct a monthly audit of the generator log. These audits will be presented to the QAPI Committee quarterly to identify any trends in battery degradation.	

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K0918 SS = D Bldg. 01	Continued from page 5 Concurrent with the above observation, during staff interview, the Maintenance Director acknowledged the finding, and indicated he could not find the requested documentation. NFPA 99 (2012 Edition) 6.4.4.1.3, 6.4.4.2, NFPA 110 (2010 Edition) : 8.3.7	K0918		
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review, observation, and staff interview, the facility failed to inspect patient care related equipment in accordance with NFPA 99. This can result in adverse outcomes such as electrical and fire. This deficient practice affects 1 out of 7 smoke compartments. Findings include: During record review on at 10:40 AM, biomedical inspection records revealed patient	K0921	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0921 and assure continued compliance, the following plan has been put in place. K0921 – Electrical Equipment Testing & Stickers Immediate Correction: Non-compliant items (microwaves, toaster, E-Stim machine) were removed and inspected by a licensed Biomedical vendor. All items passed and now bear current 2026 inspection stickers. Identification of Others: A "Wall-to-Wall" audit of all electrical equipment was conducted. Any item found with an expired or missing sticker was sequestered for testing and repair. Systemic Changes: The Master Equipment Inventory (MEI) was updated to track Last Test and Next Due dates. Staff were re-educated on checking for stickers before use and "Red Tagging" expiring equipment. Monitoring (QA): The Maintenance Director will perform monthly spot checks of 10 random electrical items. Results will be presented at the monthly Safety Committee and quarterly QAPI meetings.	

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K0921 SS = D Bldg. 01	Continued from page 6 electrical equipment was last inspected . During observation on at 2:45 PM, in the , , gym, the following items had overdue equipment inspection stickers from 2024: 2 Microwaves 1 Toaster oven "E Stem" Concurrent with the above observation, during staff interview, the , , Assistant indicated that the above listed equipment was outsourced from the corporate office, and that a different company from the facility is responsible for said equipment. NFPA 99 (2012 Edition): 10.3, 10.5.2.1	K0921		
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic Storage locations are designed, constructed, and in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 (5 if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum hr. fire protection rating. Less than or equal to 300 cubic In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K0923	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with K0923 and assure continued compliance, the following plan has been put in place. K0923 – Gas Cylinder Storage & Security Immediate Correction: All 38 cylinders in the storage room were segregated and labeled. The 25 cylinders located outside were moved to a secured, locked enclosure. Identification of Others: All medical gas storage areas were audited. Permanent "Full" and "Empty" signs and "No Smoking" signage were installed at all entrances. Systemic Changes: A lockable enclosure was established for outdoor storage with a new "Key Control" log. Staff were re-trained on Medical Gas Safety and the mandatory requirement for locked storage. Monitoring (QA): The Maintenance Director will perform daily rounds for 30 days, then weekly	

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K0923 SS = D Bldg. 01	Continued from page 7 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid . Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store cylinders in accordance with NFPA 99. This in the event of a fire can cause oxidizing gases to intensify the effects of fire. This deficient practice affects 1 out of 7 smoke compartments. Findings include: During observation on at 4:09 PM, the outside storage room had 38 cylinders that did not have proper signage indicating storage space and indicating full and empty cylinders were observed to be comingled. Adjacent to the storage area outside contained 25 cylinders that were not properly secured from unauthorized use. The facility did not have any means necessary to prevent unauthorized access. Concurrent with the above finding, during staff interview, the facility Maintenance Director acknowledged the finding, and indicating he did not know of the requirement of storage. NFPA 101 (2012 Edition) 19.3, 19.3.2.4 NFPA 99 (2012 Edition) 11.3,11.3.4, 11.6 ,11.6.2.3(3)	K0923	Continued from page 7 thereafter, to ensure segregation and security. Findings will be reviewed at monthly QAPI meetings.	

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E0000	Initial Comments During the Fire and Life Safety recertification survey conducted on . . at Crystal River Health and Rehabilitation Center, a nursing home, Emergency Preparedness was reviewed. Crystal River Health and Rehabilitation Center is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities. The following is a description of the noncompliance.	E0000		
E0034 SS = D	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E0034	This Plan of Correction constitutes written compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. To comply with E0034 and assure continued compliance, the following plan has been put in place. E0034 – Communication Plan (HFRS) Immediate Correction: The Emergency Preparedness Communication Plan was updated to include a dedicated section for the Health Facility Reporting System (HFRS), explicitly outlining requirements for reporting emergency status, planning, and operations. Identification of Others: All residents have the potential to be affected by communication failures. The Administrator audited the entire Emergency Plan to ensure HFRS Superuser access, login procedures, and technical support contacts (850-412-4303/4304) were included. Systemic Changes: Administrative and nursing leadership were trained on the AHCA HFRS manual and internal procedures for updating census and	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105317	A. BUILDING B. WING	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL RIVER HEALTH AND REHABILITATION CENTER	136 NORTHEAST 12TH AVENUE , CRYSTAL RIVER, Florida, 34429

(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
E0034 SS = D	Continued from page 1 *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to include a means of providing information about their occupancy in their communication plan. This in the event of an emergency would cause the facility to be unprepared in communicating needs of residents to the incident commander. This deficient practice affects the whole facility. Findings include: During record review on at 2:00 PM, the facility's communication plan contained no information on the Healthcare Facility Reporting System. Concurrent with the above finding, during staff interview, the Administrator acknowledged that the communication plan did not have the required information, and indicated he will print a copy to put in the emergency preparedness plan.	E0034	Continued from page 1 utility data. A screenshot of the facility's HFRS registration was added as an appendix to the Plan. Monitoring (QA): The Safety Committee will review the plan semi-annually to ensure protocols remain current. Results will be documented in the QAPI meeting minutes.	