STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105609	A. BUILDING **01 - MAIN FED** B. WING	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NSPIRE HEALTHCARE TAMARAC	**5901 NW 79TH AVENUE , TAMARAC, Florida, 33321**

(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	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on at Nspire Healthcare Tamarac, a nursing home in Tamarac, Florida. Nspire Healthcare Tamarac is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1994 Existing NFPA 220 Construction Type: II {111} Number of beds: 151 Census: 122 The following is a description of the noncompliance.	K0000		/2026
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K0222	Corrective Action for Affected Residents: The facility will correct the delayed-egress door deficiencies to ensure proper operation and compliance with NFPA 101. Specifically: The first floor West Wing Rehabilitation Room delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be repaired right away to ensure the door does not automatically reset and operates in accordance with delayed-egress requirements. Identification of Other Residents Potentially Affected: The facility will conduct a facility-wide inspection of all delayed-egress doors to verify: Required signage is present and has a contrasting background and delayed-egress doors function properly and do not automatically reset. Any additional deficiencies identified will be corrected. Measures to Prevent Recurrence: Delayed-egress doors	/2026

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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K0222 SS = E	Continued from page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors equipped with delayed egress locking arrangements in accordance with NFPA 101, for 1 of 8 sampled delayed egress doors. This deficiency affects all staff and residents in the smoke compartment.	K0222	Continued from page 1 will be routinely inspected to confirm required signage is present and door operation complies with NFPA 101. Maintenance leadership will be educated on NFPA 101 requirements related to delayed-egress door signage and functionality. Monitoring / Quality Assurance: Delayed-egress door inspections will be documented and reviewed during routine maintenance rounds. Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	

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K0222 SS = E	Continued from page 2 The findings included: On , at the following times, during the fire safety tour of the facility with the Regional Maintenance Director, the following was observed: 1. At 2:05 PM, the first floor West Wing Rehabilitation Room delayed egress exit door did not have the required signage with a contrasting background. 2. At 2:20 PM, the Service Hallway delayed egress exit door did not have the required signage with a contrasting background. Also, the delayed egress exit door automatically reset when it was tested. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2012 Edition) 7.1.9, 7.2.1.5.9, 7.2.1.6.1.1(3)(a-d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.2.4(2) Photographic evidence obtained.	K0222		
K0345 SS = D	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 record review, and staff interview, the facility failed to maintain their fire alarm system in	K0345	Corrective Action for Affected Residents: All smoke detectors and duct detectors identified as not sensitivity tested or inconsistently documented will be addressed/tested. The facility will be coordinating with the licensed fire alarm vendor to: Complete sensitivity testing on the 11 of 73 smoke detectors that were not tested during the biennial testing dated . Complete sensitivity testing on the two (2) duct detectors that were not included in prior sensitivity testing. Reconcile and correct discrepancies between: Smoke detector sensitivity testing reports, Duct detector differential pressure testing reports and Annual fire alarm inspection reports Identification of Other Residents Potentially Affected: A 100% review of fire alarm testing records was conducted to ensure all devices are included and properly documented.	/2026

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K0345 SS = D	Continued from page 3 accordance with NFPA 101, for 1 of 1 fire alarm system. This deficiency affects all residents and staff in the affected smoke compartments. The findings included: On , at 10:45 AM, during record review with the Regional Maintenance Director, it was revealed that the biennial smoke detector sensitivity testing, dated , included 11 of 73 smoke detectors not tested. The repairs inspection report from did not state that the smoke detectors were sensitivity tested and did not include the results. The annual fire alarm report from stated that there are 23 duct detectors in the inventory. The duct detector differential pressure testing dated stated that 24 duct detectors were tested. The smoke detector sensitivity testing dated stated that 22 duct detectors were tested. Two duct detectors were not sensitivity tested. An interview was conducted with the Regional Maintenance Director concurrently with the record review and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2012 Edition) 4.6.12, 9.6, 19.3.4.1 NFPA 72 (2010 Edition) 7.7.1.1, 14.4.2.2, 14.4.5.3.2, 14.6.2.1 Photographic evidence obtained.	K0345	Continued from page 3 Measures to Prevent Recurrence: Maintenance leadership will be re-educated on NFPA 72 sensitivity testing requirements and the importance of reconciling all fire alarm testing reports for consistency and completeness prior to acceptance. Monitoring / Quality Assurance: Annual testing will be verified by the Maintenance Director and reviewed by the Administrator during Life Safety reviews.	
K0353 SS = D	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	K0353	Corrective Action for Affected Residents: The facility will correct the identified sprinkler system deficiency to ensure consistent and reliable fire protection within the affected smoke compartment. Specifically: The two (2) sprinkler heads in the Main Lobby that were identified as standard response sprinklers were scheduled for replacement. These sprinkler heads will be replaced with quick response sprinkler heads to ensure uniform sprinkler response characteristics throughout the area. Replacement will be completed by a licensed fire sprinkler contractor, and documentation will be maintained on-site. Identification of Other Residents Potentially Affected: To identify any additional areas that may be affected	/2026

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K0353 SS = D	Continued from page 4 --- 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 observations, record review, and staff interview, the facility failed to maintain their automatic fire sprinkler system (AFSS) in accordance with NFPA 101, for 1 of 12 sampled smoke compartments. This deficiency affects all residents and staff in the smoke compartment. The findings included: On , at 2:30 PM, during the fire safety tour of the facility with the Regional Maintenance Director, it was observed that the Main Lobby had mixed sprinkler coverage. Two (2) of the 4 sprinklers were quick response and the other two were standard sprinklers. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 13 (2010 Edition) 26.1 NFPA 25 (2011 Edition) 4.3.1, 5.1.1.2, 8.3.3.2 NFPA 101 (2012 Edition) 2.1, 4.6.12, 9.7.1.1, 19.3.5, 19.7.6 Photographic evidence obtained.	K0353	Continued from page 4 by the same deficient practice: A facility-wide inspection of sprinkler heads was conducted by maintenance leadership to verify Sprinkler type, Response classification (quick response vs. standard response) and Consistency within smoke compartments and common areas. Any future discrepancies identified will be corrected immediately. Measures to Prevent Recurrence: All future sprinkler repairs or replacements will require verification that sprinkler heads match the existing sprinkler type in the area. The Maintenance Director will review and approve all sprinkler work to ensure system consistency. The Maintenance Director was educated on applicable NFPA requirements related to sprinkler system consistency and sprinkler response type. Monitoring / Quality Assurance: Inspection and testing records will be maintained and reviewed annually through QAPI.	
K0917 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0917	Corrective Action for Affected Residents: The room medication refrigerator will be correctly tied into critical branch breaker to ensure it is supplied by the critical branch of the essential electrical	/2026

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K0917 SS = D	Continued from page 5 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure the critical branch supplied power to select receptacles serving medication preparation areas in accordance with NFPA 99, for 1 of 3 sampled medication refrigerators. This deficiency affects all residents that receive refrigerated medication from the , room. The findings included: On , at 2:10 PM, during the fire safety tour of the facility with Regional Maintenance Director, it was observed that the , Room medicine refrigerator was not connected to a distinctly marked receptacle powered by the critical branch. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2012 Edition) 6.1.3, 6.4.1, 6.7.2.2.5(B), 6.7.5, 6.7.5.1.3, 6.7.5.1.3.2(2)(b)(c) Photographic evidence obtained.	K0917	Continued from page 5 system along with a distinctly marked critical branch receptacle, ensuring uninterrupted power during normal and emergency conditions for residents receiving refrigerated medications. Identification of Other Residents Potentially Affected: The facility conducted a review of all medication refrigerators and receptacles supplied by the essential electrical system, including , and medication preparation areas, to verify proper connection to and identification of critical branch power. Measures to Prevent Recurrence: All medication refrigerators will be verified to be connected to and powered by the critical branch. The Maintenance Director was educated on NFPA 99 requirements related to essential electrical system branch identification and medication refrigeration power sources. Monitoring / Quality Assurance: Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	
K0918 SS = F 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	K0918	Corrective Action for Affected Residents: The facility will correct deficiencies related to generator maintenance and testing documentation to ensure the Essential Electrical System (EES is maintained in accordance with NFPA requirements. Specifically:Weekly generator inspection forms provided by TELs will be updated to include battery voltage readings for both generator batteries, Monthly generator testing forms will be updated to include battery conductance testing for sealed batteries,Monthly generator load testing documentation will reflect testing at a minimum of	/2026

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K0918 SS = F Bldg. 01	Continued from page 6 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 the Essential Electrical System (EES) in accordance with NFPA 99, for 1 of 1 EES. This deficiency affects all residents and staff in the facility. The findings included: On , at the following times, during record review with the Regional Director of Plant Operations, the following was revealed: 1. At 12:00 PM, no documentation was provided for the 1.5-hour load bank testing for 2024 or thirty percent under load monthly being recorded. 2. At 12:03 PM, no documentation for the weekly voltage being recorded for the two generator batteries. 3. At 12:05 PM, no documentation for the monthly conductance testing being recorded prior to ,	K0918	Continued from page 6 thirty percent (30%) of nameplate capacity and A four (4) hour continuous load bank test was completed in , and will be conducted annually, with the next test due , and annually thereafter. These actions will ensure reliable emergency power is available to protect residents, staff, and essential services. Identification of Other Residents Potentially Affected: The facility will conduct a review of all generator maintenance and testing records to ensure compliance with NFPA 110 requirements, including weekly inspections, monthly testing, battery monitoring, and extended load testing. Measures to Prevent Recurrence: Generator inspection and testing forms provided by TELs will be permanently revised to include required weekly battery voltage readings and monthly battery conductance testing,The four (4) hour load bank test will be scheduled annually, with the next test due , and annually thereafter. The Maintenance Director will be educated on NFPA 99 and NFPA 110 requirements related to generator testing, battery monitoring, and documentation. Monitoring / Quality Assurance: Generator logs will be reviewed monthly by leadership and monitored through the QAPI program.	

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K0918 SS = F Bldg. 01	Continued from page 7 2025 for the generator's two sealed batteries. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2012 Edition) 6.4, 6.7.4.1.1.3, 6.7.4.1.1.5, 6.7.4.1.2.3 NFPA 101 (2012 Edition) 2.1, 9.1.3, 9.1.3.1, 19.5.1.1, 19.5.1.3 NFPA 110 (2010 Edition) 8.1, 8.3, 8.3.7, 8.3.7.1, 8.4.2.3	K0918		

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E0000	Initial Comments During the Fire & Life Safety Recertification survey, conducted on at Nspire Healthcare Tamarac, a nursing home, Emergency Preparedness was reviewed. Nspire Healthcare Tamarac is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E0000		/2026
E0030 SS = F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians ( ) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the	E0030	Corrective Action for Affected Residents: The Administrator added a phone list of all employees and primary physicians that attend the facility. Identification of Other Residents Potentially Affected: This deficient practice did not affect any residents. Measures to Prevent Recurrence: Administrator was educated by the Regional Maintenance Director on reviewing annually the Emergency Preparedness Manual to ensure all contacts are current. Monitoring / Quality Assurance: Emergency Preparedness Manual will be reviewed annually and finding submitted to QAPI.	/2026

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E0030 SS = F	Continued from page 1 following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians ( ) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. ( ) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. ( ) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement.	E0030		

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E0030 SS = F	Continued from page 2 (iii) Patients' physicians. ( ) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. ( ) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. ( ) Other OPOs. (v) , and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to provide a complete communication plan in their Emergency Preparedness Program (EP) in accordance with the Code of Federal Regulations (CFR). The findings included: On , at 4:00 PM, during record review of the facility's EP with the Administrator, the facility's EP did not include contact information for all staff and for residents' physicians in the communication plan. An interview was conducted with the Administrator concurrently with the observations and he acknowledged the findings. The findings were reviewed with the	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105609	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0030 SS = F	Continued from page 3 Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. 42 CFR 483.73(c)(1)(i, iii)	E0030		
E0032 SS = F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure their alternate means of communication described in their Emergency Preparedness Program (EP), was available for inspection as required in accordance with Code of Federal Regulations (CFR). The findings included: On , at 4:15 PM, during record review of the facility's EP with the Administrator, the facility's EP has satellite phones listed as an option for	E0032	Corrective Action for Affected Residents: The Administrator added updated list of primary and alternate means of communication. The facility does not use satellite phones. Identification of Other Residents Potentially Affected: This deficient practice did not affect any residents. Measures to Prevent Recurrence: Administrator was educated by the Regional Maintenance Director on reviewing annually the Emergency Preparedness Manual to insure primary and alternate means of communication for the facility are listed. Monitoring / Quality Assurance: Emergency Preparedness Manual will be reviewed annually and finding submitted to QAPI.	/2026

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E0032 SS = F	Continued from page 4 alternative means of communication. The facility was unable to produce a satellite phone for inspection upon request. An interview was conducted with the Administrator concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. 42 CFR 483.73(c)(3)	E0032		

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12150962	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MAIN LIC B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on at Nspire Healthcare Tamarac, a nursing home in Tamarac, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C.) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K0000		/2026
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 18/19.2.2.2.5 shall be permitted. (2) Delayed-egress electrical locking systems complying with 7.2.1.6.1 shall be permitted. (3) Sensor-release of electrical locking systems complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.4 shall be permitted. (5) Approved existing door-locking installations shall be permitted. 18.2.2.2.4 through 18.2.2.2.7, 19.2.2.2.4 through 19.2.2.2.7	K0222	Corrective Action for Affected Residents: The facility will correct the delayed-egress door deficiencies to ensure proper operation and compliance with NFPA 101. Specifically: The first floor West Wing Rehabilitation Room delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be repaired right away to ensure the door does not automatically reset and operates in accordance with delayed-egress requirements. Identification of Other Residents Potentially Affected: The facility will conduct a facility-wide inspection of all delayed-egress doors to verify: Required signage is present and has a contrasting background and delayed-egress doors function properly and do not automatically reset. Any additional deficiencies identified will be corrected. Measures to Prevent Recurrence: Delayed-egress doors will be routinely inspected to confirm required signage is present and door operation complies with NFPA 101. Maintenance leadership will be educated on NFPA 101 requirements related to delayed-egress door signage and	/2026

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: 12150962	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MAIN LIC B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0222 SS = E	Continued from page 1 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors equipped with delayed egress locking arrangements in accordance with NFPA 101, for 1 of 8 sampled delayed egress doors. This deficiency affects all staff and residents in the smoke compartment. The findings included: On , at the following times, during the fire safety tour of the facility with the Regional Maintenance Director, the following was observed: 1. At 2:05 PM, the first floor West Wing Rehabiiitation Room delayed egress exit door did not have the required signage with a contrasting background. 2. At 2:20 PM, the Service Hallway delayed egress exit door did not have the required signage with a contrasting background. Also, the delayed egress exit door automatically reset when it was tested. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2021 Edition) 7.1.9, 7.2.1.5.9, 7.2.1.6.1.1(3)(a-d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.2.4(2) Photographic evidence obtained. Class III	K0222	Continued from page 1 functionality. Monitoring / Quality Assurance: Delayed-egress door inspections will be documented and reviewed during routine maintenance rounds. Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	
K0345 SS = D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance Detection systems, where required, shall be in accordance with Section 9.6. Fire alarm systems	K0345	Corrective Action for Affected Residents: All smoke detectors and duct detectors identified as not sensitivity tested or inconsistently documented will be addressed/tested. The facility will be coordinating with the licensed fire alarm vendor to: Complete sensitivity testing on the 11 of 73 smoke detectors that were not tested during the biennial testing dated . Complete sensitivity testing on the two (2)	/2026

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K0345 SS = D	Continued from page 2 required by this Code shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA70 and NFPA72 unless otherwise permitted by 9.6.1.4. 18.3.4.1, 19.3.4.1, 9.6, and NFPA 70, and NFPA 72 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interview, the facility failed to maintain their fire alarm system in accordance with NFPA 101, for 1 of 1 fire alarm system. This deficiency affects all residents and staff in the affected smoke compartments. The findings included: On , at 10:45 AM, during record review with the Regional Maintenance Director, it was revealed that the biennial smoke detector sensitivity testing, dated , included 11 of 73 smoke detectors not tested. The repairs inspection report from did not state that the smoke detectors were sensitivity tested and did not include the results. The annual fire alarm report from stated that there are 23 duct detectors in the inventory. The duct detector differential pressure testing dated stated that 24 duct detectors were tested. The smoke detector sensitivity testing dated stated that 22 duct detectors were tested. Two duct detectors were not sensitivity tested. An interview was conducted with the Regional Maintenance Director concurrently with the record review and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2021 Edition) 4.6.12, 9.6, 19.3.4.1 NFPA 72 (2019 Edition) 7.7.1.1, 14.4.3.2, 14.4.4.3.2, 14.6.2.1 Photographic evidence obtained. Class III	K0345	Continued from page 2 duct detectors that were not included in prior sensitivity testing. Reconcile and correct discrepancies between: Smoke detector sensitivity testing reports, Duct detector differential pressure testing reports and Annual fire alarm inspection reports Identification of Other Residents Potentially Affected: A 100% review of fire alarm testing records was conducted to ensure all devices are included and properly documented. Measures to Prevent Recurrence: Maintenance leadership will be re-educated on NFPA 72 sensitivity testing requirements and the importance of reconciling all fire alarm testing reports for consistency and completeness prior to acceptance. Monitoring / Quality Assurance: Annual testing will be verified by the Maintenance Director and reviewed by the Administrator during Life Safety reviews.	
K0353 SS = D	Sprinkler System - Maintenance and Testing	K0353	Corrective Action for Affected Residents: The facility	/2026

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K0353 SS = D	Continued from page 3 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. 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. 19.7.6, 4.6.12, 4.6.12.1, 9.11 through 9.11.3.2, and NFPA 25 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interview, the facility failed to maintain their automatic fire sprinkler system (AFSS) in accordance with NFPA 101, for 1 of 12 sampled smoke compartments. This deficiency affects all residents and staff in the smoke compartment. The findings included: On , at 2:30 PM, during the fire safety tour of the facility with the Regional Maintenance Director, it was observed that the Main Lobby had mixed sprinkler coverage. Two (2) of the 4 sprinklers were quick response and the other two were standard sprinklers. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 1 (2021 Edition) 13.3.1.2, 13.3.3.2 NFPA 13 (2019 Edition) 31.1 NFPA 25 (2020 Edition) 4.3.1, 5.1.1.2, 9.4.3.2 NFPA 101 (2021 Edition) 2.1, 4.6.12, 9.7.1.1, 19.3.5, 19.7.6	K0353	Continued from page 3 will correct the identified sprinkler system deficiency to ensure consistent and reliable fire protection within the affected smoke compartment. Specifically: The two (2) sprinkler heads in the Main Lobby that were identified as standard response sprinklers were scheduled for replacement. These sprinkler heads will be replaced with quick response sprinkler heads to ensure uniform sprinkler response characteristics throughout the area. Replacement will be completed by a licensed fire sprinkler contractor, and documentation will be maintained on-site. Identification of Other Residents Potentially Affected: To identify any additional areas that may be affected by the same deficient practice: A facility-wide inspection of sprinkler heads was conducted by maintenance leadership to verify Sprinkler type, Response classification (quick response vs. standard response) and Consistency within smoke compartments and common areas. Any future discrepancies identified will be corrected immediately. Measures to Prevent Recurrence: All future sprinkler repairs or replacements will require verification that sprinkler heads match the existing sprinkler type in the area. The Maintenance Director will review and approve all sprinkler work to ensure system consistency. The Maintenance Director was educated on applicable NFPA requirements related to sprinkler system consistency and sprinkler response type. Monitoring / Quality Assurance: Inspection and testing records will be maintained and reviewed annually through QAPI.	

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K0353 SS = D	Continued from page 4 Photographic evidence obtained. Class III	K0353		
K0917 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.7.6.3.2 (NPA 99) This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure the critical branch supplied power to select receptacles serving medication preparation areas in accordance with NFPA 99, for 1 of 3 sampled medication refrigerators. This deficiency affects all residents that receive refrigerated medication from the , room. The findings included: On , at 2:10 PM, during the fire safety tour of the facility with Regional Maintenance Director, it was observed that the , Room medicine refrigerator was not connected to a distinctly marked receptacle powered by the critical branch. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2021 Edition) 6.1.3, 6.4.1, 6.7.2.2.5(B), 6.7.5, 6.7.5.1.3, 6.7.5.1.3.2(2)(b)(c) Photographic evidence obtained. Class III	K0917	Corrective Action for Affected Residents: The , room medication refrigerator will be correctly tied into critical branch breaker to ensure it is supplied by the critical branch of the essential electrical system along with a distinctly marked critical branch receptacle, ensuring uninterrupted power during normal and emergency conditions for residents receiving refrigerated medications. Identification of Other Residents Potentially Affected: The facility conducted a review of all medication refrigerators and receptacles supplied by the essential electrical system, including , and medication preparation areas, to verify proper connection to and identification of critical branch power. Measures to Prevent Recurrence: All medication refrigerators will be verified to be connected to and powered by the critical branch. The Maintenance Director was educated on NFPA 99 requirements related to essential electrical system branch identification and medication refrigeration power sources. Monitoring / Quality Assurance: Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	/2026

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K0917 SS=D SS = F Bldg. 05	Electrical Systems - Essential Electric Syste CFR(s): NFPA 99 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40-day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions includes 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 and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.9.1, 6.9.2, 6.9.3, 6.9.4, 6.10.18, 6.11 through 6.11.4.4 (NFPA 99), NFPA 110, NFPA 111, NFPA 70 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to maintain the Essential Electrical System (EES) in accordance with NFPA 99, for 1 of 1 EES. This deficiency affects all residents and staff in the facility. The findings included: On , at the following times, during record review with the Regional Director of Plant Operations, the following was revealed: 1. At 12:00 PM, no documentation was provided for the	K0917 K0918	Corrective Action for Affected Residents: The facility will correct deficiencies related to generator maintenance and testing documentation to ensure the Essential Electrical System (EES is maintained in accordance with NFPA requirements. Specifically:Weekly generator inspection forms provided by TELs will be updated to include battery voltage readings for both generator batteries, Monthly generator testing forms will be updated to include battery conductance testing for sealed batteries,Monthly generator load testing documentation will reflect testing at a minimum of thirty percent (30%) of nameplate capacity and A four (4) hour continuous load bank test was completed in , and will be conducted annually, with the next test due , and annually thereafter. These actions will ensure reliable emergency power is available to protect residents, staff, and essential services. Identification of Other Residents Potentially Affected: The facility will conduct a review of all generator maintenance and testing records to ensure compliance with NFPA 110 requirements, including weekly inspections, monthly testing, battery monitoring, and extended load testing. Measures to Prevent Recurrence: Generator inspection and testing forms provided by TELs will be permanently revised to include required weekly battery voltage readings and monthly battery conductance testing,The four (4) hour load bank test will be scheduled annually, with the next test due , and annually thereafter. The Maintenance Director will be educated on NFPA 99 and NFPA 110 requirements related to generator testing, battery monitoring, and documentation. Monitoring / Quality Assurance: Generator logs will be reviewed monthly by leadership and monitored through the QAPI program.	/2026

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K0918 SS = F Bldg. 05	Continued from page 6 1.5-hour load bank testing for 2024 or thirty percent under load monthly being recorded. 2. At 12:03 PM, no documentation for the weekly voltage being recorded for the two generator batteries. 3. At 12:05 PM, no documentation for the monthly conductance testing being recorded prior to , for the generator's two sealed batteries. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2021 Edition) 6.4, 6.7.4.1.1.3, 6.7.4.1.1.5, 6.7.4.1.2.3 NFPA 101 (2021 Edition) 2.1, 9.1.3, 9.1.3.1, 19.5.1.1, 19.5.1.3 NFPA 110 (2019 Edition) 8.1, 8.3, 8.3.6, 8.3.6.1, 8.4.2.3 Class III	K0918		

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K0000	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on at Nspire Healthcare Tamarac, a nursing home in Tamarac, Florida. Nspire Healthcare Tamarac is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1994 Existing NFPA 220 Construction Type: II (111) Number of beds: 151 Census: 122 The following is a description of the noncompliance.	K0000		/2026
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K0222	Corrective Action for Affected Residents: The facility will correct the delayed-egress door deficiencies to ensure proper operation and compliance with NFPA 101. Specifically: The first floor West Wing Rehabilitation Room delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be repaired right away to ensure the door does not automatically reset and operates in accordance with delayed-egress requirements. Identification of Other Residents Potentially Affected: The facility will conduct a facility-wide inspection of all delayed-egress doors to verify: Required signage is present and has a contrasting background and delayed-egress doors function properly and do not automatically reset. Any additional deficiencies identified will be corrected. Measures to Prevent Recurrence: Delayed-egress doors	/2026

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NSPIRE HEALTHCARE TAMARAC	5901 NW 79TH AVENUE , TAMARAC, Florida, 33321

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K0222 SS = E	Continued from page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors equipped with delayed egress locking arrangements in accordance with NFPA 101, for 1 of 8 sampled delayed egress doors. This deficiency affects all staff and residents in the smoke compartment.	K0222	Continued from page 1 will be routinely inspected to confirm required signage is present and door operation complies with NFPA 101. Maintenance leadership will be educated on NFPA 101 requirements related to delayed-egress door signage and functionality. Monitoring / Quality Assurance: Delayed-egress door inspections will be documented and reviewed during routine maintenance rounds. Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	

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K0222 SS = E	Continued from page 2 The findings included: On , at the following times, during the fire safety tour of the facility with the Regional Maintenance Director, the following was observed: 1. At 2:05 PM, the first floor West Wing Rehabilitation Room delayed egress exit door did not have the required signage with a contrasting background. 2. At 2:20 PM, the Service Hallway delayed egress exit door did not have the required signage with a contrasting background. Also, the delayed egress exit door automatically reset when it was tested. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2012 Edition) 7.1.9, 7.2.1.5.9, 7.2.1.6.1.1(3)(a-d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.2.4(2) Photographic evidence obtained.	K0222		
K0345 SS = D	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 record review, and staff interview, the facility failed to maintain their fire alarm system in	K0345	Corrective Action for Affected Residents: All smoke detectors and duct detectors identified as not sensitivity tested or inconsistently documented will be addressed/tested. The facility will be coordinating with the licensed fire alarm vendor to: Complete sensitivity testing on the 11 of 73 smoke detectors that were not tested during the biennial testing dated . Complete sensitivity testing on the two (2) duct detectors that were not included in prior sensitivity testing. Reconcile and correct discrepancies between: Smoke detector sensitivity testing reports, Duct detector differential pressure testing reports and Annual fire alarm inspection reports Identification of Other Residents Potentially Affected: A 100% review of fire alarm testing records was conducted to ensure all devices are included and properly documented.	/2026

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K0345 SS = D	Continued from page 3 accordance with NFPA 101, for 1 of 1 fire alarm system. This deficiency affects all residents and staff in the affected smoke compartments. The findings included: On , at 10:45 AM, during record review with the Regional Maintenance Director, it was revealed that the biennial smoke detector sensitivity testing, dated , included 11 of 73 smoke detectors not tested. The repairs inspection report from did not state that the smoke detectors were sensitivity tested and did not include the results. The annual fire alarm report from stated that there are 23 duct detectors in the inventory. The duct detector differential pressure testing dated stated that 24 duct detectors were tested. The smoke detector sensitivity testing dated stated that 22 duct detectors were tested. Two duct detectors were not sensitivity tested. An interview was conducted with the Regional Maintenance Director concurrently with the record review and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2012 Edition) 4.6.12, 9.6, 19.3.4.1 NFPA 72 (2010 Edition) 7.7.1.1, 14.4.2.2, 14.4.5.3.2, 14.6.2.1 Photographic evidence obtained.	K0345	Continued from page 3 Measures to Prevent Recurrence: Maintenance leadership will be re-educated on NFPA 72 sensitivity testing requirements and the importance of reconciling all fire alarm testing reports for consistency and completeness prior to acceptance. Monitoring / Quality Assurance: Annual testing will be verified by the Maintenance Director and reviewed by the Administrator during Life Safety reviews.	
K0353 SS = D	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	K0353	Corrective Action for Affected Residents: The facility will correct the identified sprinkler system deficiency to ensure consistent and reliable fire protection within the affected smoke compartment. Specifically: The two (2) sprinkler heads in the Main Lobby that were identified as standard response sprinklers were scheduled for replacement. These sprinkler heads will be replaced with quick response sprinkler heads to ensure uniform sprinkler response characteristics throughout the area. Replacement will be completed by a licensed fire sprinkler contractor, and documentation will be maintained on-site. Identification of Other Residents Potentially Affected: To identify any additional areas that may be affected	/2026

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K0353 SS = D	Continued from page 4 --- 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 observations, record review, and staff interview, the facility failed to maintain their automatic fire sprinkler system (AFSS) in accordance with NFPA 101, for 1 of 12 sampled smoke compartments. This deficiency affects all residents and staff in the smoke compartment. The findings included: On , at 2:30 PM, during the fire safety tour of the facility with the Regional Maintenance Director, it was observed that the Main Lobby had mixed sprinkler coverage. Two (2) of the 4 sprinklers were quick response and the other two were standard sprinklers. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 13 (2010 Edition) 26.1 NFPA 25 (2011 Edition) 4.3.1, 5.1.1.2, 8.3.3.2 NFPA 101 (2012 Edition) 2.1, 4.6.12, 9.7.1.1, 19.3.5, 19.7.6 Photographic evidence obtained.	K0353	Continued from page 4 by the same deficient practice: A facility-wide inspection of sprinkler heads was conducted by maintenance leadership to verify Sprinkler type, Response classification (quick response vs. standard response) and Consistency within smoke compartments and common areas. Any future discrepancies identified will be corrected immediately. Measures to Prevent Recurrence: All future sprinkler repairs or replacements will require verification that sprinkler heads match the existing sprinkler type in the area. The Maintenance Director will review and approve all sprinkler work to ensure system consistency. The Maintenance Director was educated on applicable NFPA requirements related to sprinkler system consistency and sprinkler response type. Monitoring / Quality Assurance: Inspection and testing records will be maintained and reviewed annually through QAPI.	
K0917 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0917	Corrective Action for Affected Residents: The , room medication refrigerator will be correctly tied into critical branch breaker to ensure it is supplied by the critical branch of the essential electrical	/2026

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K0917 SS = D	Continued from page 5 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure the critical branch supplied power to select receptacles serving medication preparation areas in accordance with NFPA 99, for 1 of 3 sampled medication refrigerators. This deficiency affects all residents that receive refrigerated medication from the , room. The findings included: On , at 2:10 PM, during the fire safety tour of the facility with Regional Maintenance Director, it was observed that the , Room medicine refrigerator was not connected to a distinctly marked receptacle powered by the critical branch. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2012 Edition) 6.1.3, 6.4.1, 6.7.2.2.5(B), 6.7.5, 6.7.5.1.3, 6.7.5.1.3.2(2)(b)(c) Photographic evidence obtained.	K0917	Continued from page 5 system along with a distinctly marked critical branch receptacle, ensuring uninterrupted power during normal and emergency conditions for residents receiving refrigerated medications. Identification of Other Residents Potentially Affected: The facility conducted a review of all medication refrigerators and receptacles supplied by the essential electrical system, including , and medication preparation areas, to verify proper connection to and identification of critical branch power. Measures to Prevent Recurrence: All medication refrigerators will be verified to be connected to and powered by the critical branch. The Maintenance Director was educated on NFPA 99 requirements related to essential electrical system branch identification and medication refrigeration power sources. Monitoring / Quality Assurance: Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	
K0918 SS = F 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	K0918	Corrective Action for Affected Residents: The facility will correct deficiencies related to generator maintenance and testing documentation to ensure the Essential Electrical System (EES is maintained in accordance with NFPA requirements. Specifically:Weekly generator inspection forms provided by TELs will be updated to include battery voltage readings for both generator batteries, Monthly generator testing forms will be updated to include battery conductance testing for sealed batteries,Monthly generator load testing documentation will reflect testing at a minimum of	/2026

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K0918 SS = F Bldg. 01	Continued from page 6 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 the Essential Electrical System (EES) in accordance with NFPA 99, for 1 of 1 EES. This deficiency affects all residents and staff in the facility. The findings included: On , at the following times, during record review with the Regional Director of Plant Operations, the following was revealed: 1. At 12:00 PM, no documentation was provided for the 1.5-hour load bank testing for 2024 or thirty percent under load monthly being recorded. 2. At 12:03 PM, no documentation for the weekly voltage being recorded for the two generator batteries. 3. At 12:05 PM, no documentation for the monthly conductance testing being recorded prior to ,	K0918	Continued from page 6 thirty percent (30%) of nameplate capacity and A four (4) hour continuous load bank test was completed in , and will be conducted annually, with the next test due , and annually thereafter. These actions will ensure reliable emergency power is available to protect residents, staff, and essential services. Identification of Other Residents Potentially Affected: The facility will conduct a review of all generator maintenance and testing records to ensure compliance with NFPA 110 requirements, including weekly inspections, monthly testing, battery monitoring, and extended load testing. Measures to Prevent Recurrence: Generator inspection and testing forms provided by TELs will be permanently revised to include required weekly battery voltage readings and monthly battery conductance testing,The four (4) hour load bank test will be scheduled annually, with the next test due , and annually thereafter. The Maintenance Director will be educated on NFPA 99 and NFPA 110 requirements related to generator testing, battery monitoring, and documentation. Monitoring / Quality Assurance: Generator logs will be reviewed monthly by leadership and monitored through the QAPI program.	

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K0918 SS = F Bldg. 01	Continued from page 7 2025 for the generator's two sealed batteries. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2012 Edition) 6.4, 6.7.4.1.1.3, 6.7.4.1.1.5, 6.7.4.1.2.3 NFPA 101 (2012 Edition) 2.1, 9.1.3, 9.1.3.1, 19.5.1.1, 19.5.1.3 NFPA 110 (2010 Edition) 8.1, 8.3, 8.3.7, 8.3.7.1, 8.4.2.3	K0918		

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E0000	Initial Comments During the Fire & Life Safety Recertification survey, conducted on at Nspire Healthcare Tamarac, a nursing home, Emergency Preparedness was reviewed. Nspire Healthcare Tamarac is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E0000		/2026
E0030 SS = F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians ( ) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the	E0030	Corrective Action for Affected Residents: The Administrator added a phone list of all employees and primary physicians that attend the facility. Identification of Other Residents Potentially Affected: This deficient practice did not affect any residents. Measures to Prevent Recurrence: Administrator was educated by the Regional Maintenance Director on reviewing annually the Emergency Preparedness Manual to ensure all contacts are current. Monitoring / Quality Assurance: Emergency Preparedness Manual will be reviewed annually and finding submitted to QAPI.	/2026

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.

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E0030 SS = F	Continued from page 1 following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians ( ) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. ( ) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. ( ) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement.	E0030		

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E0030 SS = F	Continued from page 2 (iii) Patients' physicians. ( ) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. ( ) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. ( ) Other OPOs. (v) , and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to provide a complete communication plan in their Emergency Preparedness Program (EP) in accordance with the Code of Federal Regulations (CFR). The findings included: On , at 4:00 PM, during record review of the facility's EP with the Administrator, the facility's EP did not include contact information for all staff and for residents' physicians in the communication plan. An interview was conducted with the Administrator concurrently with the observations and he acknowledged the findings. The findings were reviewed with the	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105609	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

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E0030 SS = F	Continued from page 3 Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. 42 CFR 483.73(c)(1)(i, iii)	E0030		
E0032 SS = F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure their alternate means of communication described in their Emergency Preparedness Program (EP), was available for inspection as required in accordance with Code of Federal Regulations (CFR). The findings included: On , at 4:15 PM, during record review of the facility's EP with the Administrator, the facility's EP has satellite phones listed as an option for	E0032	Corrective Action for Affected Residents: The Administrator added updated list of primary and alternate means of communication. The facility does not use satellite phones. Identification of Other Residents Potentially Affected: This deficient practice did not affect any residents. Measures to Prevent Recurrence: Administrator was educated by the Regional Maintenance Director on reviewing annually the Emergency Preparedness Manual to insure primary and alternate means of communication for the facility are listed. Monitoring / Quality Assurance: Emergency Preparedness Manual will be reviewed annually and finding submitted to QAPI.	/2026

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E0032 SS = F	Continued from page 4 alternative means of communication. The facility was unable to produce a satellite phone for inspection upon request. An interview was conducted with the Administrator concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. 42 CFR 483.73(c)(3)	E0032		

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12150962	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MAIN LIC B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on at Nspire Healthcare Tamarac, a nursing home in Tamarac, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C.) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K0000		/2026
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 18/19.2.2.2.5 shall be permitted. (2) Delayed-egress electrical locking systems complying with 7.2.1.6.1 shall be permitted. (3) Sensor-release of electrical locking systems complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.4 shall be permitted. (5) Approved existing door-locking installations shall be permitted. 18.2.2.2.4 through 18.2.2.2.7, 19.2.2.2.4 through 19.2.2.2.7	K0222	Corrective Action for Affected Residents: The facility will correct the delayed-egress door deficiencies to ensure proper operation and compliance with NFPA 101. Specifically: The first floor West Wing Rehabilitation Room delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be provided with the required delayed-egress signage with a contrasting background. The Service Hallway delayed-egress exit door will be repaired right away to ensure the door does not automatically reset and operates in accordance with delayed-egress requirements. Identification of Other Residents Potentially Affected: The facility will conduct a facility-wide inspection of all delayed-egress doors to verify: Required signage is present and has a contrasting background and delayed-egress doors function properly and do not automatically reset. Any additional deficiencies identified will be corrected. Measures to Prevent Recurrence: Delayed-egress doors will be routinely inspected to confirm required signage is present and door operation complies with NFPA 101. Maintenance leadership will be educated on NFPA 101 requirements related to delayed-egress door signage and	/2026

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: 12150962	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MAIN LIC B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0222 SS = E	Continued from page 1 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors equipped with delayed egress locking arrangements in accordance with NFPA 101, for 1 of 8 sampled delayed egress doors. This deficiency affects all staff and residents in the smoke compartment. The findings included: On , at the following times, during the fire safety tour of the facility with the Regional Maintenance Director, the following was observed: 1. At 2:05 PM, the first floor West Wing Rehabilitation Room delayed egress exit door did not have the required signage with a contrasting background. 2. At 2:20 PM, the Service Hallway delayed egress exit door did not have the required signage with a contrasting background. Also, the delayed egress exit door automatically reset when it was tested. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2021 Edition) 7.1.9, 7.2.1.5.9, 7.2.1.6.1.1(3)(a-d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.2.4(2) Photographic evidence obtained. Class III	K0222	Continued from page 1 functionality. Monitoring / Quality Assurance: Delayed-egress door inspections will be documented and reviewed during routine maintenance rounds. Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	
K0345 SS = D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance Detection systems, where required, shall be in accordance with Section 9.6. Fire alarm systems	K0345	Corrective Action for Affected Residents: All smoke detectors and duct detectors identified as not sensitivity tested or inconsistently documented will be addressed/tested. The facility will be coordinating with the licensed fire alarm vendor to: Complete sensitivity testing on the 11 of 73 smoke detectors that were not tested during the biennial testing dated . Complete sensitivity testing on the two (2)	/2026

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K0345 SS = D	Continued from page 2 required by this Code shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA70 and NFPA72 unless otherwise permitted by 9.6.1.4. 18.3.4.1, 19.3.4.1, 9.6, and NFPA 70, and NFPA 72 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interview, the facility failed to maintain their fire alarm system in accordance with NFPA 101, for 1 of 1 fire alarm system. This deficiency affects all residents and staff in the affected smoke compartments. The findings included: On , at 10:45 AM, during record review with the Regional Maintenance Director, it was revealed that the biennial smoke detector sensitivity testing, dated , included 11 of 73 smoke detectors not tested. The repairs inspection report from did not state that the smoke detectors were sensitivity tested and did not include the results. The annual fire alarm report from stated that there are 23 duct detectors in the inventory. The duct detector differential pressure testing dated stated that 24 duct detectors were tested. The smoke detector sensitivity testing dated stated that 22 duct detectors were tested. Two duct detectors were not sensitivity tested. An interview was conducted with the Regional Maintenance Director concurrently with the record review and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 101 (2021 Edition) 4.6.12, 9.6, 19.3.4.1 NFPA 72 (2019 Edition) 7.7.1.1, 14.4.3.2, 14.4.4.3.2, 14.6.2.1 Photographic evidence obtained. Class III	K0345	Continued from page 2 duct detectors that were not included in prior sensitivity testing. Reconcile and correct discrepancies between: Smoke detector sensitivity testing reports, Duct detector differential pressure testing reports and Annual fire alarm inspection reports Identification of Other Residents Potentially Affected: A 100% review of fire alarm testing records was conducted to ensure all devices are included and properly documented. Measures to Prevent Recurrence: Maintenance leadership will be re-educated on NFPA 72 sensitivity testing requirements and the importance of reconciling all fire alarm testing reports for consistency and completeness prior to acceptance. Monitoring / Quality Assurance: Annual testing will be verified by the Maintenance Director and reviewed by the Administrator during Life Safety reviews.	
K0353 SS = D	Sprinkler System - Maintenance and Testing	K0353	Corrective Action for Affected Residents: The facility	/2026

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K0353 SS = D	Continued from page 3 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. 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. 19.7.6, 4.6.12, 4.6.12.1, 9.11 through 9.11.3.2, and NFPA 25 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interview, the facility failed to maintain their automatic fire sprinkler system (AFSS) in accordance with NFPA 101, for 1 of 12 sampled smoke compartments. This deficiency affects all residents and staff in the smoke compartment. The findings included: On , at 2:30 PM, during the fire safety tour of the facility with the Regional Maintenance Director, it was observed that the Main Lobby had mixed sprinkler coverage. Two (2) of the 4 sprinklers were quick response and the other two were standard sprinklers. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 1 (2021 Edition) 13.3.1.2, 13.3.3.2 NFPA 13 (2019 Edition) 31.1 NFPA 25 (2020 Edition) 4.3.1, 5.1.1.2, 9.4.3.2 NFPA 101 (2021 Edition) 2.1, 4.6.12, 9.7.1.1, 19.3.5, 19.7.6	K0353	Continued from page 3 will correct the identified sprinkler system deficiency to ensure consistent and reliable fire protection within the affected smoke compartment. Specifically: The two (2) sprinkler heads in the Main Lobby that were identified as standard response sprinklers were scheduled for replacement. These sprinkler heads will be replaced with quick response sprinkler heads to ensure uniform sprinkler response characteristics throughout the area. Replacement will be completed by a licensed fire sprinkler contractor, and documentation will be maintained on-site. Identification of Other Residents Potentially Affected: To identify any additional areas that may be affected by the same deficient practice: A facility-wide inspection of sprinkler heads was conducted by maintenance leadership to verify Sprinkler type, Response classification (quick response vs. standard response) and Consistency within smoke compartments and common areas. Any future discrepancies identified will be corrected immediately. Measures to Prevent Recurrence: All future sprinkler repairs or replacements will require verification that sprinkler heads match the existing sprinkler type in the area. The Maintenance Director will review and approve all sprinkler work to ensure system consistency. The Maintenance Director was educated on applicable NFPA requirements related to sprinkler system consistency and sprinkler response type. Monitoring / Quality Assurance: Inspection and testing records will be maintained and reviewed annually through QAPI.	

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K0353 SS = D	Continued from page 4 Photographic evidence obtained. Class III	K0353		
K0917 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.7.6.3.2 (NPFA 99) This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure the critical branch supplied power to select receptacles serving medication preparation areas in accordance with NFPA 99, for 1 of 3 sampled medication refrigerators. This deficiency affects all residents that receive refrigerated medication from the , room. The findings included: On , at 2:10 PM, during the fire safety tour of the facility with Regional Maintenance Director, it was observed that the , Room medicine refrigerator was not connected to a distinctly marked receptacle powered by the critical branch. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2021 Edition) 6.1.3, 6.4.1, 6.7.2.2.5(B), 6.7.5, 6.7.5.1.3, 6.7.5.1.3.2(2)(b)(c) Photographic evidence obtained. Class III	K0917	Corrective Action for Affected Residents: The , room medication refrigerator will be correctly tied into critical branch breaker to ensure it is supplied by the critical branch of the essential electrical system along with a distinctly marked critical branch receptacle, ensuring uninterrupted power during normal and emergency conditions for residents receiving refrigerated medications. Identification of Other Residents Potentially Affected: The facility conducted a review of all medication refrigerators and receptacles supplied by the essential electrical system, including , and medication preparation areas, to verify proper connection to and identification of critical branch power. Measures to Prevent Recurrence: All medication refrigerators will be verified to be connected to and powered by the critical branch. The Maintenance Director was educated on NFPA 99 requirements related to essential electrical system branch identification and medication refrigeration power sources. Monitoring / Quality Assurance: Compliance will be reviewed by the Administrator or designee through the facility's QAPI program, and corrective action will be taken immediately if deficiencies are identified.	/2026

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K0917 SS=D K0918 SS = F Bldg. 05	Electrical Systems - Essential Electric Syste CFR(s): NFPA 99 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40-day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions includes 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 and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.9.1, 6.9.2, 6.9.3, 6.9.4, 6.10.18, 6.11 through 6.11.4.4 (NFPA 99), NFPA 110, NFPA 111, NFPA 70 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to maintain the Essential Electrical System (EES) in accordance with NFPA 99, for 1 of 1 EES. This deficiency affects all residents and staff in the facility. The findings included: On , at the following times, during record review with the Regional Director of Plant Operations, the following was revealed: 1. At 12:00 PM, no documentation was provided for the	K0917 K0918	Corrective Action for Affected Residents: The facility will correct deficiencies related to generator maintenance and testing documentation to ensure the Essential Electrical System (EES is maintained in accordance with NFPA requirements. Specifically:Weekly generator inspection forms provided by TELs will be updated to include battery voltage readings for both generator batteries, Monthly generator testing forms will be updated to include battery conductance testing for sealed batteries,Monthly generator load testing documentation will reflect testing at a minimum of thirty percent (30%) of nameplate capacity and A four (4) hour continuous load bank test was completed in , and will be conducted annually, with the next test due , and annually thereafter. These actions will ensure reliable emergency power is available to protect residents, staff, and essential services. Identification of Other Residents Potentially Affected: The facility will conduct a review of all generator maintenance and testing records to ensure compliance with NFPA 110 requirements, including weekly inspections, monthly testing, battery monitoring, and extended load testing. Measures to Prevent Recurrence: Generator inspection and testing forms provided by TELs will be permanently revised to include required weekly battery voltage readings and monthly battery conductance testing,The four (4) hour load bank test will be scheduled annually, with the next test due , and annually thereafter. The Maintenance Director will be educated on NFPA 99 and NFPA 110 requirements related to generator testing, battery monitoring, and documentation. Monitoring / Quality Assurance: Generator logs will be reviewed monthly by leadership and monitored through the QAPI program.	/2026

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K0918 SS = F Bldg. 05	Continued from page 6 1.5-hour load bank testing for 2024 or thirty percent under load monthly being recorded. 2. At 12:03 PM, no documentation for the weekly voltage being recorded for the two generator batteries. 3. At 12:05 PM, no documentation for the monthly conductance testing being recorded prior to , for the generator's two sealed batteries. An interview was conducted with the Regional Maintenance Director concurrently with the observations and he acknowledged the findings. The findings were reviewed with the Administrator and the Regional Maintenance Director at the exit conference on at 4:45 PM. NFPA 99 (2021 Edition) 6.4, 6.7.4.1.1.3, 6.7.4.1.1.5, 6.7.4.1.2.3 NFPA 101 (2021 Edition) 2.1, 9.1.3, 9.1.3.1, 19.5.1.1, 19.5.1.3 NFPA 110 (2019 Edition) 8.1, 8.3, 8.3.6, 8.3.6.1, 8.4.2.3 Class III	K0918		