STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105649	A. BUILDING **01, 03, 04** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS CARE CENTER	**490 S OLD WIRE RD** **WILDWOOD, FL 34785**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments During the Fire & Life Safety survey conducted on 18-19 March 2025, at Cypress Care Center and Rehabilitation in Wildwood Florida, a nursing home, Emergency Preparedness, was reviewed. Cypress Care Center is Not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	E 004		

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

Electronically Signed

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

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E 004	Continued From page 1 State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to review and update their Emergency Preparedness Program (EPP). This in the event of a disaster or other emergency would leave the facility and its occupants vulnerable to the hazards of the event. Findings include: During record review with the Administrator and the Maintenance Director on 3/18/25 at 11:15 a.m., it was found the facility produced the Emergency Preparedness Program (EPP) which was last reviewed and updated in 2018. The EPP presented did not meet the requirements of an established plan. During an interview on 3/18/25 at 11:15 a.m. the	E 004		

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E 004	Continued From page 2 Director of Maintenance concurred with the findings. Per 42 CFR 483.73(a) These findings were acknowledged by the Administrator and the Director of Maintenance at the exit conference on 3/19/25 at 2:30 p.m.	E 004		
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 18, 19 March 2025 at Cypress Care Center and Rehabilitation, a nursing home in Wildwood, Florida. The Facility is NOT in compliance with 42 CFR 483.90 (a), and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1982 and 1997 New or Existing: Existing NFPA 220 Construction Type: II (III) Number of beds: 167 Census: 159 The facility was found not in compliance at the time of this survey.	K 000		
K 100	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 100		

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K 100	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the roof remains clean and free of additional flammable materials. Findings include: During a tour of the exterior of the facility on 3/18/25 at 10:30 a.m. with the Maintenance Director, at the main entrance and multiple sides of the roof there was a large amount of combustible materials consisting of tree vegetation, leaves, Spanish moss, and a visible small tree growing on the roof. The addition of flammable materials can contribute to extreme fire conditions and reduce the flammability rating of the roof materials or fire ratings. This could cause harm to residents and staff if not properly maintained in accordance with NFPA 101. (Photographic evidence obtained) During an interview on 3/18/25 at 10:30 a.m. the Maintenance Director concurred with the findings. NFPA 101 (2012 Edition) 4.6.12.1 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 3/19/25 at 2:30 p.m.	K 100		
K 271	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of	K 271		

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K 271	Continued From page 4 obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the exit discharge in accordance with NFPA 101. Findings include: During an observation on 3/18/25 at 10:30 a.m. with the Maintenance Director, it was observed the Exit door leading from the Spanish Villa corridor to the west exit discharge, the exit failed to have a hard-packed all-weather travel surface to the public way to provide transition from the facility to safe exit in the event of an emergency requiring evacuation from this EXIT discharge. (Photographic evidence obtained) During an interview on 3/18/25 at 10:30 a.m. the Maintenance Director commented he understood the requirements and he wasn't sure why it wasn't connected to the sidewalk. NFPA 101 (2012 Edition) 19.2.7, 7.7, 7.7.1 These findings were acknowledged by the Administrator and the Director of Maintenance at the exit conference on 3/19/25 at 2:30 p.m.	K 271		
K 281	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or	K 281		

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K 281	Continued From page 5 capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide proper illumination of means of egress walkways, exit passageways leading to the public way. Not lighting proper means to egress in hours of darkness from the facility could endanger the residents, staff, or other building occupants. (Photographic evidence obtained) The findings include: During a tour on 3/18/25 at 10:30 a.m. with the Director of Maintenance, located in the following areas, the facility is non-compliant with illumination of means of egress lighting per NFPA 101. a) Exit doors leading from the French Quarter wing to the courtyard to the smoking patio has no egress lighting as required. b) Exit doors to the left of the main entrance and the administrative hallway; do not have egress lighting to provide egress lighting in hours of darkness. c) Exit doors at the end of the Spanish Villa wing does not have exit lights which provide a means to light the path of travel to the public way. During an interview on 3/18/25 following the tour the Maintenance Director concurred with the findings. NFPA 101 (2012) 7.8.1, 7.8.1.2, 7.8.1.3	K 281		

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K 281	Continued From page 6 These findings were acknowledged by the Administrator and the Director of Maintenance at the exit conference on 3/19/25 at 2:30 p.m.	K 281		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide test results of the annual duct detector sensitivity testing. This could result in the device failing to perform as designed resulting in no notification of a fire in the ventilation system. Failure to test the duct detectors could result in injury to residents or staff. Findings include: During the record review on 3/18/25 at 10:45 a.m., the facility failed to provide evidence the annual duct detector differential testing was conducted. During an interview on 3/18/25 at 10:45 a.m. the Director of Maintenance stated he was unable to locate the required documents. NFPA 101 (2012 Edition) 19.3.4.1, 9.6	K 345		

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K 345	Continued From page 7 NFPA 72 (2010 Edition) 14.4.2.2, 14.4.2.2(14)(g)(6) These findings were acknowledged by the Administrator at the exit conference on 3/19/25 at 2:30 p.m.	K 345		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system in accordance with NFPA, failure to maintain the sprinkler heads could result in endangerment of the staff and residents. Findings include:	K 353		

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K 353	Continued From page 8 During a tour of the facility on 3/19/2025 at 10:30 a.m. with the Director of Maintenance while observing the kitchen area it was observed 6 of the 24 sprinkler heads in the zone were laden with grease and foreign debris which could cause the sprinkler heads to activate sooner or not at all in accordance with the manufacturer temperature ratings. (Photographic evidence obtained) During an interview on 3/19/25 at 10:30 a.m. the Director of Maintenance concurred with the findings. NFPA 101 (2012 Edition) 19.3.5.1 NFPA 25 (2011 edition) 5.2.1.1.1 (5) These findings were acknowledged by the Administrator at the exit conference on 3/19/2025 at 2:30 p.m.	K 353		
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the portable fire extinguishers as required. Failure to maintain the portable fire extinguisher in accordance with NFPA 10 can cause a delay in fire suppression or cause a fire to intensify which could result in injury during an emergency to residents, staff, and visitors.	K 355		

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K 355	Continued From page 9 Findings include: During a tour of the facility on 3/18/25 at 10:30 a.m. with the Director of Maintenance, located to the left of the main entrance to the cooking facility a class "K" fire extinguisher was observed without the required safety seal which secures the pull pin and could prevent accidental discharge of the fire extinguisher. (Photographic evidence obtained) During an interview on 3/18/25 at 10:30 a.m. the Director of Maintenance concurred with the findings. NFPA 101 (2021 edition) 9.7.4.1 NFPA 10 (2010 edition) 7.2.2.2 (2) These findings were acknowledged by the Administrator and the Director of Maintenance, at the exit conference on 3/19/25 at 2:30 p.m.	K 355		
K 741	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.	K 741		

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K 741	Continued From page 10 (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain designated smoking areas in accordance with NFPA 101, and failed to ensure the smoking environment for the facility was safe. (Photographic evidence obtained) Findings include: During a tour of the exterior of the facility on 3/19/25 at 10:30 a.m. with the Director of Maintenance the following deficient practice was observed of the designated smoking area: a) Smoke ashtrays self-closing missing closing device on all three ashtrays. b) Plastic smoking bins are prohibited and should be removed. c) Observations in the trash can revealed smoking debris was dumped into the trash can and not the required metal safety can. Located outside the Sable Palms wing an observation was made of an area that is not designated as a smoking area with a quantity of	K 741		

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K 741	Continued From page 11 smoking debris discarded in the mulch and yard debris. This area did not have containers for the smoking debris to be deposited into. During an interview on 3/19/25 at 10:30 a.m. the Director of Maintenance verified the observations and concurred with the findings. NFPA 101 (2018) 19.7.4 These findings were acknowledged by the Administrator and Director of Maintenance, at the exit conference on 3/19/25 at 2:30 p.m.	K 741		
K 914	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	K 914		

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K 914	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide accurate testing of the receptacles individually and failed to provide documented performance data for receptacles located in resident care rooms and bed locations. This could result in an electrical device failing to perform as designed resulting in electric shock or electrocution to residents or staff and the facility failed to provide safe installation of electrical equipment by allowing permanent electrical connections to be installed and used as permanent wiring that was observed to be passing through the ceiling into interstitial space. (Photographic evidence obtained) Findings include: During the record review of the maintenance records on 3/18/25 at 11:45 a.m. evidence of the receptacle testing was provided. The report did not include testing of receptacles in resident rooms individually for each outlet, resident bed locations, and GFCI (Ground Fault Circuit Interrupt) outlets in resident restrooms. During an interview on 3/18/25 the Director of Maintenance concurred with the record review and confirmed the findings. NFPA 101 (2021 edition) 4.5.7, 4.5.8, 4.6.12, 9.1.2 Per NFPA 99 (2012 edition) 6.3.3.2 During a tour of the facility on 3/18/25 at 10:30 with the Director of Maintenance, located to the right hallway at the main entry door, a power cord was observed passing through the ceiling into the	K 914		

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K 914	Continued From page 13 interstitial space. An observation of the interstitial space revealed a power strip was being used as permanent wiring and is located above the fire sprinkler system. This situation could result in a fire above the designed sprinkler system which could result in harm to staff and residents. (Photographic evidence obtained) During an interview on 3/18/25 the Director of Maintenance concurred with the observations and confirmed the findings. NFPA 101 (2012 edition) 4.5.7, 4.5.8, 4.6.12, 9.1.2 NFPA 70 (2023 edition) 400.12 (1), (2), (5) These findings were acknowledged by the Administrator at the exit conference on 3/19/25 at 2:30 p.m.	K 914		
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105649	A. BUILDING **01, 03, 04** B. WING _____	**03/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS CARE CENTER	**490 S OLD WIRE RD** **WILDWOOD, FL 34785**

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K 918	Continued From page 14 simulated cold 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain two sets of Generator Manuals as required per NFPA 110 (10), Section 8.2.2. Findings include: During record review on 3/18/25 at 10:30 a.m. with the Director of Maintenance, the facility failed to provide evidence showing two sets of generator manuals are maintained at the facility at the time. During an interview on 3/18/25 at 10:30 a.m. the Director of Maintenance concurred with the findings. NFPA 110 8.1.1 NFPA 99 (2018 edition) 6.7.1.2.4.1, 6.7.4.1.1.3	K 918		

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K 918	Continued From page 15 These findings were acknowledged by the Administrator and the Director of Maintenance at the exit conference on 3/19/25 at 2:30 p.m.	K 918		
K 921	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced	K 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105649	A. BUILDING **01, 03, 04** B. WING _____	**03/19/2025**

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K 921	Continued From page 16 by: Based on observation and interviews, the facility failed to provide documentation for electrical testing of fixed and portable medical equipment. Failure to test medical equipment in resident care areas could result in electrical shock or possible death to residents and/or staff. Findings include: During a tour of the facility on 3/19/25 at 12:20 p.m. with the Director of Maintenance an observation was made of the Rose Brook wing nursing station. A portable blood pressure machine was connected to an electrical outlet charging and was ready for use. The portable blood pressure monitoring machine had not been tagged for the required Bio-Medical testing prior to being placed into service. (Photographic evidence obtained) During an interview on 3/19/25 at 12:20 p.m. the staff nurse stated the machine was new and being used on a daily basis for over two months. During an interview on 3/19/25 at 12:24 p.m. the Director of Maintenance confirmed the observation and concurred with the findings. Per NFPA 99 (2012 Edition) 10.3, 10.5.2.1 These findings were acknowledged by the Administrator and the Director of Maintenance, at the exit conference on 3/19/25 at 2:30 p.m.	K 921		