STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE LAKE CITY, FL 32024**

(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 recertification survey conducted on April 8, 2025 through April 9, 2025 at Bedrock Rehabilitation and Nursing Center at Lake City (currently known as Lake City Healthcare and Rehabilitation Center), a nursing home, Emergency Preparedness was reviewed. The facility was 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	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE LAKE CITY, FL 32024**

(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 004	Continued From page 1 §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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 4/8/25 at 11:15 AM, the facility produced the Emergency Preparedness Program (EPP). There was no documented information showing the EPP had been reviewed and updated annually at the time of the survey.	E 004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE LAKE CITY, FL 32024**

(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 004	Continued From page 2 During an interview on 4/8/25 at 11:15 AM, the Maintenance Director concurred with the findings. Per 42 CFR 483.73(a) These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	E 004		
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification was conducted on April 8, 2025 through April 9, 2025 at Bedrock Rehabilitation and Nursing Center at Lake City (currently known as Lake City Healthcare and Rehabilitation Center), a nursing home in Lake City, 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. Year Built: 2018, NFPA 220 Construction Type: III (211) Square Footage: 88,664 Sprinklered Generator: 300 kw Diesel Number of beds: 113 Census: 112 The following is description of the deficiencies identified at the time of the visit.	K 000		
K 324	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 324	Continued From page 3 with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the kitchen hood cooking fire suppression system for inspection and maintenance which can allow the system to fail in the event of fire endangering residents, staff and other building occupants. Findings include: During record review with the Administrator and the Maintenance Director on 4/8/25 at 11:15 AM, the facility failed to produce one of the semiannual maintenance inspections. Last semiannual inspection dated 7/29/24 with noted discrepancies showed no correction and verified at the time of the facility tour.	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE LAKE CITY, FL 32024**

(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
K 324	Continued From page 4 During an interview on 4/8/25 at 11:15 AM, the Maintenance Director concurred with the findings. NFPA 17A (2017) 7.1 NFPA 96 (2011) 10.1, 10.2, 10.2.6 (1-4) NFPA 101 (2012) 4.5.7, 4.5.8, 4.6.12, 9.2.3, 19.3.2.5 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 324		
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 observation, record review, and interview, the facility failed to maintain their fire alarm system in accordance with NFPA 72, maintaining the integrity of the system to alarm in the event of a fire to allow relocation of residents, staff, or other building occupants, which could result in injury during an emergency to residents, staff and visitors. Findings include: 1) During record review with the Administrator and the Maintenance Director on 4/8/25 at 11:15	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE LAKE CITY, FL 32024**

(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
K 345	Continued From page 5 AM, the fire alarm testing records showed not all devices had been tested, inspected, and maintained. 5 out of 12 duct detector devices were missed, and not accessible according to the fire alarm vendor. NFPA 101 (2012) 9.6, 9.6.1.5, 19.3.4.1 NFPA 72 (2010) 14.1, 14.1.1, 14.2.1.1, 14.2.1.2, 14.2.6.2, 14.4.2.2, Table 14.4.2.2(14)(g)(6), 14.4.5, Table 14.4.5 2) During record review with the Administrator and the Maintenance Director on 4/8/25 at 11:15 AM, the facility failed to provide evidence of the smoke detectors biennial sensitivity testing being conducted. There was no documentation when the last testing of the test was completed. NFPA 101(2012 Edition) 19.3.4.4, 9.6.5.1 NFPA 72 (2010 Edition) 14.4.5.3.2 3) During the tour of the facility with the Administrator and the Maintenance Director on 4/8/25 at 1:35 PM, on main service hallway across from door number six in the supply closet, a smoke detector was within 36" from HVAC supply vent. NFPA 101 (2012 Edition) 19.3.4.1., 9.6.1 NFPA 72 (2010 Edition) A.17.7.4.1 During an interview on 4/8/25 at 11:15 AM, the Maintenance Director acknowledged the smoke detector was 36" from HVAC supply. These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 353	Continued From page 6	K 353		
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, record review, and interview, the facility failed to maintain the automatic sprinkler system in accordance with NFPA 101. Findings include: 1) During record review with the Administrator and the Maintenance Director on 4/8/25 at 11:15 AM, the facility could not produce the 5-year internal backflow inspection report at the time of the survey. 2) During the facility tour with the Administrator and the Maintenance Director on 4/8/25 at 1:15	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 353	Continued From page 7 PM, located at the main facility entrance to the right of the facility, the fire back-flow was "Red Tagged". This failure indicates the system is in failure and inoperable and should be repaired. During an interview on 4/8/25 at 11:15 AM, the Maintenance Director concurred with the findings. NFPA 101 (2012 Edition) 19.3.5, 19.3.5.1, 9.7.1.1 (1), 9.11.1 NFPA 13 (2010 Edition) 26.1 NFPA 25 (2011 Edition) 13.6.1, 13.6.1.2.2 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 353		
K 363	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 363	Continued From page 8 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide regular inspections, testing and maintenance of fire and smoke door assemblies. This, in the event of a fire, could lead to doors failing to perform as designed resulting in the spread of fire, smoke, and fire gases, endangering the occupants and staff of the building. Findings include: During record review with the Administrator and the Maintenance Director on 4/8/25 at 11:15 AM, the facility failed to produce documentation, training of a competent, certified fire, smoke door responsible person in accordance with NFPA 80, NPFA 105. The facility failed to provide documentation for the annual smoke doors annual inspections. During an interview on 4/8/25 at 11:15 AM, the Maintenance Director concurred with the findings. NFPA 101 (2012 edition) 19.7.6, 8.3.3.1 NFPA 80 (2010 edition) 5.2, 5.2.3, 5.2.4 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 363		
K 521	HVAC CFR(s): NFPA 101	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 521	Continued From page 9 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain their fire alarm system in accordance with NFPA 72 maintaining the integrity of the system to alarm, in the event of a fire, to allow relocation of residents, staff, or other building occupants which could result in injury during an emergency to residents, staff and visitors. Findings include: During record review with the Administrator and the Maintenance Director on 4/8/25 at 11:15 AM, the facility failed to provide documentation of the four-year fire and smoke damper inspection, testing and maintenance in accordance with NFPA 80. Reviewing the vendor documentation only stated the fire and smoke dampers were functioning without the number of dampers, locations and type of system installed. During an interview on 4/8/25 at 11:15 AM, the Maintenance Director concurred with the findings. NFPA 101 (2012 Edition) 8.3.1, 4.2, 4.2.3 NFPA 80 (2010 Edition) 19.4, 19.4.1	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 521	Continued From page 10 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 521		
K 916	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Emergency Power System (EPS) in accordance with NFPA 80, 110. Failure to maintain the EPS could result in no facility back-up power in the event of an emergency. Findings include: During the facility tour with the Administrator and the Maintenance Director on 4/8/25 at 1:15 PM, located near the central hallway, the generator annunciator panel located on the wall behind the central nurses station was tested. The annunciator had no power, indicating this annunciator panel was disconnected or disabled. During an interview on 4/8/25 at 1:15 PM, the Maintenance Director concurred with the findings.	K 916		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 916	Continued From page 11 NFPA 101 (2012 edition) 19.7.6, 8.3.3.1 NFPA 80 (2010 edition) 5.2, 5.2.3, 5.2.4 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 916		
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 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	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106126	A. BUILDING **01, 02** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY HEALTHCARE AND REHABILITATION CENTER	**298 SW PROSPERITY PLACE** **LAKE CITY, FL 32024**

(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
K 918	Continued From page 12 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 record review, and interview, the facility failed to maintain the Emergency Power System (EPS) in accordance with NFPA 80, 110. Failure to maintain the EPS could result in no facility back-up power in the event of an emergency. Findings include: During record review with the Administrator and the Maintenance Director on 4/8/25 at 1:15 PM, the emergency generator engine manufacturers' recommendations were not available. The facility failed to test the generator diesel fuel annually as required. During an interview on 4/8/25 at 1:15 PM, the Maintenance Director concurred with the findings. NFPA 99 (2012 Edition) 6.4.1.1.15 NFPA 110 (2010 Edition) 8.3.8 These findings were acknowledged by the Administrator and the Maintenance Director at the exit conference on 4/9/25 at 4:30 PM.	K 918		