STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	524041	A. BUILDING _____ B. WING _____	4/3/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTWOOD NURSING CENTER	900 MAAS ST NEGAUNEE, MI 49866

(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
E0000 SS=	Initial Comments On April 3, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Eastwood Nursing Center of Negaunee was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0015 SS= F	Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.	E0015	1. The facility failed to establish relations and obtain an agreement with a water supplier to provide the facility water in the event of an emergency. 2. Failure to ensure the facility has an agreement with a drinking water supplier could affect all residents, employees and visitors in the event of an emergency. 3. The maintenance director has obtained an emergency drinking water agreement with Norway Springs to provide the facility with drinking water in the event of an emergency. The maintenance director has been educated on the importance of maintaining drinking water sources/agreements. 4. The Administrator is responsible for ensuring drinking water agreements are established and implemented at the facility and report to the QA committee. 1. The facility failed to maintain an accurate policy for emergency water within the emergency preparedness plan, specifically pertaining to the use of an existing onsite water well resource. 2. Failure to ensure all water emergency water sources are in place and accurate could affect all residents, employees and visitors in the event of an emergency.	6/2/2025

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

Electronically Signed | 04/23/2025

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

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	(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop, at a minimum, policies and procedures that address; the provision of subsistence needs for staff and patients whether they evacuate or shelter in place, including, but not limited to: Food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm systems, and sewage and waste disposal. This deficient practice could affect all occupants in the event of an emergency. Findings Include: 1) On April 3, 2025 at approximately 1:45 PM, record review of the emergency loss of water plan revealed the facility would establish relations and obtain an agreement with a water supplier to provided the facility with drinking water in the event of an emergency. No documentation was		3. The onsite water well is currently not in use and has been removed from the facility emergency preparedness plan. The maintenance director has been educated on the importance of maintaining accurate emergency water resources and policies within the facility. 4. The Administrator is responsible for the implementation of accurate policies and procedures pertaining to emergency water in the event of an emergency and report to the QA committee.	

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	provided by the exit of this survey to show the facility and the water supplier have established relations and developed an emergency contract. 2) On April 3, 2025, at approximately 1:50 PM, record review of the emergency loss of water plan on page 26 of the emergency plan revealed the facility has an onsite well that can be used in the event of an emergency. Interview with the Maintenance Director at this time revealed he has not seen the well work since he has worked here (approximately 3 years). In addition, the Maintenance Director stated his maintenance assistant who has worked at the facility for 16 years stated he has not seen the well work either.			
E0037 SS= F	EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated	E0037	1. The facility failed to provide annual emergency preparedness refresher training to all facility employees. 2. Failure to provide the annual emergency preparedness refresher training to facility employees could affect all residents, employees and visitors in the event of an emergency. 3. The education director has educated all employees on the emergency preparedness plan via the Relias education platform. The education director has been educated on the importance of the annual emergency preparedness refresher training. 4. The administrator is responsible for ensuring all employees are educated during the annual emergency refresher training and report to the QA committee.	6/2/2025

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	policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under			

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	arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting			

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	equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide initial training in emergency			

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	preparedness policies and procedures to all new and exiting staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. Provide Emergency Preparedness training at least annually, maintain documentation of the training and demonstrate staff knowledge of emergency procedures. This deficient practice could affect all occupants in the event of an emergency. Findings Include: On April 3, 2025 at approximately 2:30 PM, interview with the facility education director revealed the facility failed to provided annual emergency preparedness refresher training as required by 42 CFR 483.73(d)(1)(2). No documentation was provided to indicated facility staff were provided any refresher training, at least annually.			

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K0000 SS=	INITIAL COMMENTS On April 3, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Eastwood Nursing Center of Negaunee was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a single story building of type V (111) construction, built in 1993. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 100 certified beds. At the time of the survey the census was 95.	K0000		
K0161 SS= F	Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in	K0161	1. The facility did not maintain the dry sprinkler system in proper working condition throughout the building. 2. A malfunctioning dry sprinkler system poses a risk to the safety of all residents, staff, and visitors in the event of a fire emergency. 3. Corrective actions have been completed as follows: o Excel Fire Protection replaced the 3-inch and 4-inch system piping. o Superiorland Electronics installed a second air compressor and replaced 12 feet of main sprinkler piping. o The sprinkler system was flooded and tested, revealing two leaks (located above a	6/2/2025

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	accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure building construction types and numbers of stories met the requirements of Table 19.1.6.1, unless permitted by 19.1.6.2 through 19.1.6.7. This deficient practice could affect all occupants in the event of a fire. Findings Include: On April 3, 2025 at approximately 9:55 AM, record review of the annual dry sprinkler inspection report dated 10-2-24, revealed the dry sprinkler system in the attic space failed inspection due to system being capped and only 6 heads in operation. 73 CFR 47075 requires all LTC facilities to be fully sprinklered by August 13, 2013, and also requires the facility to maintain the system. Interview with the Maintenance Director at this time confirmed the sprinkler system in the attic was not working properly.		resident room and in the boiler room); both have been repaired. o Superiorland Electronics will conduct a trip test to confirm the system is functioning properly. o The Maintenance Director has been educated on the critical importance of maintaining the dry sprinkler system in working order. o Superioland Electronics will complete the hydrostatic testing of the system by 5/23/25. 4. The Maintenance Director is responsible for ongoing monitoring of the dry sprinkler system to ensure it remains operational at all times and will report system status and maintenance updates to the Quality Assurance (QA) Committee.	

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K0351 SS= F	Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a sprinkler system installed as required by NFPA 13. This deficient practice could affect approximately all occupants in the event of a fire emergency. Findings Include: On April 3 2024, at approximately 9:55 AM, record review revealed the dry sprinkler system installed throughout the attic space has been capped off, leaving the attic space without 100% sprinkler protection as required by 42 CFR 483.90 (a)(1)(5)(iii)(B). This finding was confirmed by the Maintenance Director at the time of record review.	K0351	1. The facility failed to maintain the dry sprinkler system in proper working condition throughout the entire building. 2. A non-functioning dry sprinkler system poses a serious risk to the safety of all residents, staff, and visitors during a fire emergency. 3. Corrective actions have been implemented as follows: o Excel Fire Protection replaced the 3-inch and 4-inch system piping. o Superiorland Electronics was engaged to install a second air compressor and replace 12 feet of main sprinkler piping. o The system was water-tested, during which two leaks were identified (above a resident room and in the boiler room); both were repaired. o A trip test will be conducted by Superiorland Electronics to verify full functionality of the system. o The Maintenance Director has received training on the importance of routine inspection and upkeep of the dry sprinkler system. o Superioland Electronics will complete the hydrostatic testing of the system by 5/23/25. 4. The Maintenance Director is now responsible for ensuring the sprinkler system remains fully operational and will report on system status and any maintenance issues during regular Quality Assurance (QA) Committee meetings.	6/2/2025

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K0352 SS= F	Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, as required by 9.7.2.1. This deficient practice could affect all occupants in the event of a fire. Findings Include: On April 3, 2025 at approximately 9:55 AM, record review of the annual dry sprinkler inspection dated 10-2-24, revealed the system has been capped and failed the inspection. Record review of the FACP at approximately 11:00 AM, revealed supervisory and/or trouble alarms were present on the panel to indicate a portion of the system has been shut down. This finding was confirmed by the Maintenance Director at the time of discovery.	K0352	1. The facility failed to maintain the automatic sprinkler system□s supervisory attachment panel in proper working condition. 2. A malfunctioning supervisory panel compromises the effectiveness of the sprinkler system, potentially placing all residents, staff, and visitors at risk during a fire emergency. 3. Corrective actions are underway as follows: o Superiorland Electronics has been contacted and has ordered a new dry pipe valve and a new control valve equipped with a tamper switch. o Once parts are installed, the system will be tested to ensure full functionality. o The Maintenance Director has been educated on the importance of maintaining a properly functioning automatic sprinkler system supervisory panel. 4. The Maintenance Director is responsible for ensuring the panel remains operational and will report system status and maintenance updates to the Quality Assurance (QA) Committee.	6/2/2025
K0353 SS= F	Sprinkler System - Maintenance and Testing 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.	K0353	1. The facility failed to provide documentation confirming that corrective work on the dry sprinkler system was being completed to ensure proper system function. 2. Inadequate documentation and maintenance of the dry sprinkler system may compromise the safety of residents, staff, and	6/2/2025

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	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 record review and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could affect approximately all occupants in the event of a fire. Findings Include: On April 3, 2025, at approximately 9:55 AM, record review of the annual dry sprinkler inspection dated 10-2-24, revealed the system failed inspection due to the dry system in the attic being capped and only 6 heads active. At the time of survey, no documentation was provided to indicate work on the system was being completed to correct the issue or state which portions of the system were operational. This finding was confirmed by the Maintenance Director at the time of record review. .		visitors in the event of a fire emergency. 3. Corrective actions have been implemented as follows: o Excel Fire Protection replaced the 3-inch and 4-inch piping in the system. o Superiorland Electronics installed a second air compressor and replaced 12 feet of main sprinkler piping. o The system was flooded and tested; two leaks were identified (above a resident room and in the boiler room) and have been repaired. o A trip test will be conducted to confirm proper system functionality. o Both Excel and Superiorland Electronics have submitted full documentation of all repair and maintenance work to the facility. o The Maintenance Director has received training on the importance of maintaining a functional dry sprinkler system and retaining documentation of all related work. o Superioland Electronics will complete the hydrostatic testing of the system by 5/23/25. 4. The Maintenance Director is responsible for ensuring the sprinkler system remains operational, for maintaining complete documentation of all service and repairs, and for reporting system status to the Quality Assurance (QA) Committee.	
K0354 SS= F	Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration	K0354	1. The facility failed to follow its fire watch policy and procedures when the dry sprinkler system was not functioning properly. Per	6/2/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	524041	A. BUILDING _____ B. WING _____	4/3/2025

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	of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure when the sprinkler system is out of service for more than 10 hours in a 24-hour period, the affected areas are evacuated or an approved Fire Watch is provided until the sprinkler system is returned to service as required by 19.3.5.1 and 9.7.5 of the LSC and 15.5.2 of NFPA 25. This deficient practice could affect all occupants in the event of a fire. Findings Include: 1) On April 3, 2025, at approximately 9:55 AM, record review of the annual dry sprinkler inspection dated 10-2-24, revealed the system failed inspection due to the dry system in the attic being capped and only 6 heads active. At the time of survey, the facility was not conducting fire watch throughout the unprotected areas of the building until the system is fully restored and approved. In addition, "out of service signage" was not posted throughout the building as required by the facility fire watch policy.		policy, the facility must either evacuate or initiate a fire watch if the system is non-operational for 10 or more hours within a 24-hour period. 2. Failure to implement fire watch procedures as required could have endangered the safety of all residents, staff, and visitors during a fire emergency. 3. Corrective actions have been taken as follows: o The facility promptly initiated fire watch procedures once the system malfunction was identified, including posting Out of Service signage and conducting regular monitoring rounds. o Excel Fire Protection replaced the 3-inch and 4-inch system piping. o Superiorland Electronics installed a second air compressor, replaced 12 feet of main sprinkler piping, and conducted a system water test. Two leaks (above a resident room and in the boiler room) were identified and repaired. o A trip test will be performed to confirm the full functionality of the system. o Documentation of all system repairs has been received from Excel and Superiorland. o All staff have been re-educated on the fire watch policy, including the requirement for timely implementation when the sprinkler system is out of service. o Superioland Electronics will complete the hydrostatic testing of the system by 5/23/25. 4. The Administrator is responsible for ensuring fire watch policies and procedures are implemented without delay during any future system outage and for reporting compliance status to the Quality Assurance (QA) Committee.	

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	2) On April 3, 2025, at approximately 1:32 PM, interview with CNA1 revealed she was not aware a portion of their sprinkler system was not operational and not working. CNA 1 stated, she felt it was important to know, as it may change how they respond during a fire. 3) On April 3, 2025, at approximately 3:00 PM, interview with the ADON revealed she was not aware a portion of their sprinkler system was not operational and not working. When ADON was asked if she knew a portion of their system was not working, she responded "No".			
K0711 SS= F	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure there is a written plan for the protection of all residents and for their evacuation in the event of an emergency, employees are periodically instructed in their duties under the plan as required by 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2 and 19.7.2.3. This deficient practice could affect all occupants in the event of	K0711	1. The facility failed to adequately communicate to staff that the dry sprinkler system was not functioning properly throughout the building and did not clearly define emergency evacuation procedures in the event of system failure. 2. Lack of communication regarding system malfunction and absence of defined evacuation procedures could place all residents, staff, and visitors at risk during a fire emergency. 3. Corrective actions taken include: o All facility staff were immediately notified that the dry sprinkler system was not functioning and responded appropriately by initiating fire watch procedures. o The Fire Watch policy has been revised to include specific evacuation protocols. The updated policy now requires immediate evacuation of the affected fire/smoke compartment upon any detection of smoke or fire. o The Maintenance Director was educated on the importance of prompt and clear communication to all staff regarding emergency system failures. o All staff have been re-educated on the	6/2/2025

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	a fire. Findings Include: On April 3, 2025, at approximately 9:55 AM, record review of the annual dry sprinkler inspection dated 10-2-24, revealed the system failed inspection due to the dry system in the attic being capped and only 6 heads active. At the time of survey, CNA1 and ADON were both interviewed and asked if they were aware a portion of their sprinkler system was not operation and not working as designed and installed. Both staff were unaware of this. No education was provided to facility staff to indicate how their response to a fire will change now that their sprinkler system is not operating as intended. This finding was confirmed by the Maintenance Director at the time of discovery.		updated Fire Watch policy and the emergency evacuation procedures. 4. The Maintenance Director is responsible for timely communication of any emergency system failures to facility staff and will report compliance and communication actions to the Quality Assurance (QA) Committee.	