Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001062	09/08/2026
Name of Provider or Supplier	**Street Address, City, State**	
Sacramento Eye Surgicenter	3150 J Street, Sacramento, CA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 416.54, Condition for Coverage for Ambulatory Surgical Centers (ASCs). CENSUS: 17
E0004	Develop EP Plan, Review and Update Annually CFR(s): 416.54(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, 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 STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to maintain and update the EPP. This could result in a delay in protecting the health and safety of 16 of 16 patients . Findings: During document review and interview with staff on 9/8/26, the EPP was reviewed. At 11:01 a.m., there were no documents provided to indicate that the EPP had been updated and reviewed at least every 2 years. The date of the last EPP review was 4/15 /20. During a concurrent interview, Staff 1 stated that the EPP had been updated annually but the most recent review had not been documented.
E0013	Development of EP Policies and Procedures CFR(s): 416.54(b) 403.748(b), 416.54(b), 418.113(b), 441.184(b), 460.84(b), 482.15(b), 483.73(b), 483. 475(b), 484.102(b), 485.68(b), 485.542(b), 485.625(b), 485.727(b), 485.920(b), 486. 360(b), 491.12(b), 494.62(b). (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 at least every 2 years. *[For LTC facilities at 483.73(b):] Policies and procedures. The LTC facility 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 at least annually. *Additional

	Requirements for PACE and ESRD Facilities: *[For PACE at 460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at 494.62(b):] Policies and procedures. The dialysis facility 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 at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to maintain and update the Emergency Preparedness (EP) Policies and Procedures. This could result in a delay in protecting the health and safety of 16 of 16 patients. Findings: During document review and interview with staff on 9/8/26, the EPP was reviewed. At 11:03 a.m., there were no documents provided to indicate that the EPP had been updated and reviewed at least every 2 years. The date of the last EPP review was 4/15 /20. During a concurrent interview, Staff 1 stated that the EP Policies and Procedures had been updated annually but the most recent review had not been documented.
E0029	Development of Communication Plan

	CFR(s): 416.54(c) 403.748(c), 416.54(c), 418.113(c), 441.184(c), 460.84(c), 482.15(c), 483.73(c), 483.475(c), 484.102(c), 485.68(c), 485.542(c), 485.625(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c). (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]. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to maintain and update the Communication Plan. This could result in a delay in protecting the health and safety of 16 of 16 patients. Findings: During document review and interview with staff on 9/8/26, the EPP was reviewed. At 11:04 a.m., there were no documents provided to indicate that the EPP's Communication Plan had been updated and reviewed at least every two years. The date of the last Communication Plan review date was 4/15/20. During a concurrent interview, Staff 1 stated that the Communication Plan had been updated annually but the most recent review had not been documented.
E0036	EP Training and Testing CFR(s): 416.54(d) 403.748(d), 416.54(d), 418.113(d), 441.184(d), 460.84(d), 482.15(d), 483.73(d), 483.475(d), 484.102(d), 485.68(d), 485.542(d), 485.625(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d). *[For RNCHIs at 403.748, ASCs at 416.54, Hospice at 418.113, PRTFs at 441.184, PACE at 460.84, Hospitals at 482.15, HHAs at 484.102, CORFs at 485.68, REHs at 485.542, CAHs at 486.625, "Organizations" under 485.727, CMHCs at 485.920, OPOs at 486.360, and RHC/FHQs at 491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at 483.73

	(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at 483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at 483.470(i). *[For ESRD Facilities at 494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Preparedness Plan (EPP). This was evidenced by the failure to review and update the Emergency Preparedness (EP) training. This could result in a delay in protecting the health and safety of 16 of 16 patients. Findings: During document review and interview with staff on 9/8/26, the EPP training was reviewed. At 11:05 a.m., there were no documents provided to indicate that the EP training and testing program for new and existing staff had been updated at least every two years. The date of the last training and testing review was 4/15/20. During a concurrent interview, Staff 1 stated that the EP training had been updated annually but the most recent review had not been documented.
K0000	K3 BUILDING: 01

	K6 PLAN APPROVAL: 1987 K7 SURVEY UNDER: 2012EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during a*recertificationLife Safety Code survey.The findings arein accordance with42 Code of Federal Regulations (CFR) 416.44(b)(c)(f),National Fire Protection Association (NFPA) 101 - Life Safety Code,2012 Edition, and NFPA 99 - Health Care Facilities Code,2012 Edition.
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by obstructed corridor doors. This can increase the passage of smoke through smoke compartments. This affected 16 of 16 patients and four of four smoke compartments.

	Findings: During a tour of the facility and interview with the staff on 9/8/26, the corridor doors were observed. 1. At 11:50 a.m., the corridor door to the Visual Field-Testing Room was observed with a self-closing mechanism. The corridor door was observed obstructed from closure by a yellow wedge-style doorstop. The doorstop was observed at the base of the door. During a concurrent interview, Staff 1 confirmed the finding and stated that she was unaware of the use of the doorstop. 2. At 11:50 a.m., the corridor door to the Storage Room by the Employee Break Room was observed with a self-closing mechanism. The corridor door was observed obstructed from closure by a wedge-style doorstop. The doorstop was observed at the base of the door. During a concurrent interview, Staff 1 confirmed the finding and stated that she was unaware of the use of the doorstop.
K0342	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 feet travel distance is not exceeded. 20.3.4.2, 21.3.4.2, 9.6.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by initiating devices that failed to activate the FAS. This could result in delayed notification in the event of a fire. This affected 16 of 16 patients and four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 21.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.4. 21.3.4.2 Initiation. Initiation of the required fire alarm systems shall be by manual

means in accordance with 9.6.2 and by means of any detection devices or detection systems required.

9.6.2 Signal Initiation.

9.6.2.1 Where required by other sections of this Code, actuation of the complete fire alarm system shall be initiated by, but shall not be limited to, any or all of the following means:

(1) Manual fire alarm initiation

(2) Automatic detection

(3) Extinguishing system operation

9.6.5 Fire Safety Functions.

9.6.5.1 Fire safety functions shall be installed in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code.

NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition

17.14 Manually Actuated Alarm-Initiating Devices.

17.14.1 Manual fire alarm boxes shall be used only for fire alarm initiating purposes.

Findings:

During a tour of the facility and interview with the staff on 9/8/26, the smoke detectors and manual pull stations were observed and tested.

1. At 12:22 p.m., the smoke detector protecting the post-operation area was tested with a can of smoke. The smoke detector failed to activate any strobe or chime notification devices in the facility. The Fire Alarm Control Panel (FACP) displayed illuminated LED lights signaling Alarm and Trouble signals for Zone 4. During a concurrent interview, Staff 1 confirmed the finding and stated that the smoke detector likely failed to activate the FAS since it was part of the devices connected to Zone 4. Staff 1 confirmed with the monitoring company that the activation signal for the smoke detector had not been received. Staff 1 acknowledged that the Alarm signal on the FACP was unable to be cleared after the activation of the waterflow alarm earlier at approximately 12:15 p.m., likely preventing the smoke detector signal from being received.

The facility had initiated fire watch at 1:30 p.m. on 9/8/26.

	2. At 12:27 p.m., the manual pull station in the Lobby was tested. The pull station failed to activate any strobe or chime notification devices in the facility. The FACP displayed illuminated LED lights signaling Alarm and Trouble signals for Zone 4. During a concurrent interview, Staff 1 confirmed the finding and stated that the manual pull station likely failed to activate the FAS since it was part of the devices connected to Zone 4. Staff 1 confirmed with the monitoring company that the activation signal for the pull station had not been received. Staff 1 acknowledged that the Alarm signal on the FACP was unable to be cleared after the activation of the waterflow alarm earlier at approximately 12:15 p.m., likely preventing the pull station signal from being received. The facility had initiated fire watch at 1:30 p.m. on 9/8/26.
K0343	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per 9.6.4. Smoke detection devices or systems equipped with reconfirmation features shall not be required to automatically notify the fire department, unless the alarm condition is reconfirmed within 120 seconds (2 minutes). 21.3.4.3 through 21.3.4.3.2.2, 9.6.3, 9.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by notification devices that failed to activate during the testing period. This could result in a delay in response from staff in the event of a fire. This affected 16 of 16 patients and four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 21.3.4.4 Fire Safety Functions. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically, without delay, any control functions required to be performed by that device. (See 9.6.5.) 9.6.5 Fire Safety Functions. 9.6.5.1 Fire safety functions shall be installed in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition

	10.7.2 Audible alarm notification appliances for a fire alarm system shall produce signals that are distinctive from other similar appliances used for other purposes in the same area that are not part of the fire alarm or emergency communications system. 10.7.3 * Audible signals on a control unit, or on multiple control units that are interconnected to form a system, or at a remote location, shall be permitted to have the same audible characteristics for all alerting functions including, but not limited to, alarm, trouble, and supervisory, provided that the distinction between signals shall be by other appropriate means, such as visible annunciation. 10.9.2 Actuation of alarm notification appliances or emergency voice communications, emergency control functions, and annunciation at the protected premises shall occur within 10 seconds after the activation of an initiating device Findings: During a tour of the facility and interview with the staff on 9/8/26, the FAS was tested. At 12:15 p.m., the facility's inspector test valve (ITV) was initiated. After approximately 80 seconds, the waterflow alarm bell along the southwest side of the building was activated. The notification devices inside the facility failed to emit an audible or visual signal once the FAS was activated. The Fire Alarm Control Panel (FACP) in the hallway by the Lobby was observed with illuminated LED lights displaying "Alarm" and "Trouble" signals. During a concurrent interview, Staff 1 confirmed the finding and stated that she was unaware of the condition of the notification devices. Staff 1 confirmed with the monitoring company that the waterflow alarm signal had been successfully received. The "Alarm" signal on the FACP was eventually cleared at approximately 1:20 p.m. The facility had initiated fire watch at approximately 1:30 p.m. on 9/8/26.
K0344	Fire Alarm - Control Functions CFR(s): NFPA 101 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 20.3.4.4, 21.3.4.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by a trouble signal on the Fire Alarm Control Panel (FACP). This could result in a malfunction in the FAS. This affected 16 of 16 patients and four of four smoke compartments.

NFPA 101: Life Safety Code, 2012 Edition

21.3.4.4 Fire Safety Functions. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically, without delay, any control functions required to be performed by that device. (See 9.6.5.)

9.6.5 Fire Safety Functions.

9.6.5.1 Fire safety functions shall be installed in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code.

NFPA 72: National Fire Alarm and Signaling Code

26.3.6.1.2 Circuit-adjusting means for emergency operation shall be permitted to be automatic or to be provided through manual operation upon receipt of a trouble signal.

26.3.7.4 Trouble Signals.Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the alarm systems, the central station shall perform the following actions:

(1) *Communicate immediately with persons designated by the subscriber

(2) Dispatch personnel to arrive within 4 hours to initiate maintenance, if necessary

(3) When the interruption is more than 8 hours, provide notice to the subscriber and the fire department if so required by the authority having jurisdiction as to the nature of the interruption, the time of occurrence, and the restoration of service

Findings:

During a tour of the facility and interview with the staff on 9/8/26, the FACP was observed.

At 11:20 a.m., the FACP in the corridor by the front desk was observed with an illuminated LED signaling a "Trouble" signal on Zone 4. A switch on the FACP labeled "Trouble Silence" was observed pressed into the face of the panel. Staff 1 pressed the Trouble Silence switch back out which caused the panel to emit a constant buzzing sound. During a concurrent interview, Staff 1 confirmed the finding and stated that she was unaware the FACP contained a trouble signal. Staff 1 stated that

	the Trouble Silence switch was likely pressed down to silence the buzzing sound.
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - 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 document review and interview, the facility failed to maintain the Fire Alarm System (FAS). This was evidenced by the failure to conduct the required inspections and tests for the FAS and the Fire Alarm Control Panel (FACP) batteries. This affected 16 of 16 patients and four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 21.3.4.4 Fire Safety Functions. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically, without delay, any control functions required to be performed by that device. (See 9.6.5.) 9.6.5 Fire Safety Functions. 9.6.5.1 Fire safety functions shall be installed in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.3.1 Testing Frequencies 9.Initiating devices (a) Air sampling; Semiannually (b) Duct detectors; Semiannually (c) Electromechanical releasing devices; Semiannually (d) Fire extinguishing system(s) or suppression system(s) switches; Semiannually

(e) Manual fire alarm boxes; Semiannually

(f) Heat detectors; Semiannually

(g) Radiant energy fire detectors: Semiannually

(h) Smoke detectors (excluding one- and two-family dwellings); Semiannually

(i) Supervisory signal devices; Semiannually

(j) Waterflow devices; Semiannually

14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.

Table 14.4.5 Testing Frequencies

1. Control equipment systems connected to supervising station

(a) Functions-Initial/Reacceptance, Annually

(b) Fuses-Initial/Reacceptance, Annually

(c) Interfaced equipment-Initial/Reacceptance, Annually

(d) Lamps and LEDs-Initial/Reacceptance, Annually

(e) Primary (main) power supply-Initial/Reacceptance, Annually

(f) Transponders-Initial/Reacceptance, Annually

Table 14.4.5 Testing Frequencies

6. Batteries-fire alarm systems

(d) Sealed lead-acid type

(1) Charger test (Replace battery as needed.) - Initial/Reacceptance; Annually

(2) Discharge test (30 minutes) - Initial/Reacceptance; Annually

(3) Load voltage test - Initial/Reacceptance; Semiannually

Findings:

During document review and interview with staff on 9/8/26, the FAS inspection and

	testing records were requested and reviewed. 1. At 9:55a.m., the facility failed to provide records to show that a semi-annual FAS inspection had been conducted. The date of the last semi-annual FAS inspection was unknown. During a concurrent interview, Staff 1 stated that she was under the impression that the FAS inspection had been conducted and that the facility would request records from their vendor. The facility was given until 5 p.m. on 9/8/26 to submit the according inspection records. No inspection records were received. 2. At 10 a.m., the facility failed to provide records to show that a annual FAS test had been conducted. The date of the last annual FAS test was 1/10/25. During a concurrent interview, Staff 1 stated that she was under the impression that FAS testing had been conducted and that the facility would request testing records from their vendor. The facility was given until 5 p.m. on 9/8/26 to submit the according inspection records. No testing records were received. 3. At 10:02 a.m., the facility failed to conduct two of two annual load voltage tests for the FACP batteries. The date of the last load voltage test was 1/10/25. During a concurrent interview, Staff 1 stated she was unsure if the battery testing had been conducted and that the facility would request testing records from their vendor. The facility was given until 5 p.m. on 9/8/26 to submit the according testing records. No testing records were received. 4. At 10:03 am, the facility failed to conduct the annual discharge test for the FACP batteries. The date of the last discharge test was 1/10/25. During a concurrent interview, Staff 1 stated she was unsure if the battery testing had been conducted and that the facility would request testing records from their vendor. The facility was given until 5 p.m. on 9/8/26 to submit the according testing records. No testing records were received. 5. At 10:04 a.m., the facility failed to conduct the annual charger test for the FACP batteries. The date of the last charger test was 1/10/25. During a concurrent interview, Staff 1 stated she was unsure if the battery testing had been conducted and that the facility would request testing records from their vendor. The facility was given until 5 p.m. on 9/8/26 to submit the according testing records. No testing records were received.
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101

Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25

This STANDARD is not met as evidenced by:
Based on document review, observation, and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by missing records to show that the required test to the sprinkler system had been conducted and by the failure to maintain sprinkler system components. This could result in a malfunction to the automatic sprinkler system in the event of a fire. This affected 16 of 16 patients and four of four smoke compartments.

NFPA 101, Life Safety Code, 2012 Edition

21.3.7.6 Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating,and air-conditioning systems where adjacent smoke compartments are protected throughout by an approved, supervisedautomatic sprinkler system in accordance with Section 9.7.

9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition

5.1.1.2

Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.

Gauges (dry, preaction, and deluge systems) - Weekly/monthly 5.2.4.2, 5.2.4.3, 5.2.4.4

Control valves Table 13.1

Waterflow alarm devices - Quarterly 5.2.5

Valve supervisory alarm devices - Quarterly 5.2.5

Supervisory signal devices (except valve supervisory switches) - Quarterly 5.2.5

Gauges (wet pipe systems) - Monthly 5.2.4.1

Hydraulic nameplate - Quarterly 5.2.6

Buildings - Annually (prior to freezing weather) 4.1.1.1

Hanger/seismic bracing - Annually 5.2.3

Pipe and fittings - Annually 5.2.2

Sprinklers - Annually 5.2.1

Spare sprinklers - Annually 5.2.1.4

Information sign - Annually 5.2.6.1

Fire department connections Table 13.1

Valves (all types) Table 13.1

Obstruction, internal inspection of piping -5 years 14.2

13.3.2.2* The valve inspection shall verify that the valves are in the following condition:

(1) In the normal open or closed position

(2)*Sealed, locked, or supervised

(3) Accessible

(4) Provided with correct wrenches

(5) Free from external leaks

(6) Provided with applicable identification

13.3.3 Testing.

13.3.3.1 Each control valve shall be operated annually through its full range and returned to its normal position.

13.3.3.2* Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve.

Findings:

	During document review, observation, and interview with staff on 9/8/26, the sprinkler system testing records were requested, and the sprinkler system components were observed. 1. At 10:40 a.m., the facility failed to provide records to show that the annual sprinkler system test had been conducted. The riser in the Riser Room along the southwest side of the building was observed with a tag for an annual sprinkler system test dated 1/10/25. During a concurrent interview, Staff 1 confirmed the finding and stated that she was under the impression that an annual test had been conducted. Staff 1 stated the facility would request records from their vendors. The facility was given until 5 p.m. on 9/8/26 to submit the according testing records. No sprinkler system testing records were received. 2. At 12:32 p.m., the facility's publicly accessible Post Indicator Valve (PIV) along the southeast side of the facility was observed secured with a lock. The facility was missing a key that would open the lock to access the valve for testing. During a concurrent interview, Staff 1 confirmed the finding and stated that she was unaware if there was a key in the facility that would open the lock. The PIV was unable to be tested before the end of the survey.
K0521	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the HVAC system. This was evidenced by missing records for the required test and inspection for the facility's smoke dampers. This could result in the spread of smoke throughout smoke compartments in the event of a fire. This affected 16 of 16 patients and four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition 21.5.2 Heating, Ventilating, and Air-Conditioning. 21.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 21.5.2.2. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in

accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 Edition

5.4.8 Maintenance.

5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.

NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition

19.4* Periodic Inspection and Testing.

19.4.1 Each damper shall be tested and inspected 1 year after installation.

19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.

19.4.3 Full unobstructed access to the fire or combination fire/ smoke damper shall be verified and corrected as required.

19.4.4 If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-inplace if so equipped.

19.4.5 The operational test of the damper shall verify that there is no damper interference due to rusted, bent, misaligned, or damaged frame or blades, or defective hinges or other moving parts.

19.4.6 The damper frame shall not be penetrated by any foreign objects that would affect fire damper operations.

19.4.7 The damper shall not be blocked from closure in any way.

19.4.8 The fusible link shall be reinstalled after testing is complete.

19.4.8.1 If the link is damaged or painted, it shall be replaced with a link of the same size, temperature, and load rating.

19.4.9 All inspections and testing shall be documented, indicating the location of the fire damper or combination fire/ smoke damper, date of inspection, name of inspector, and

deficiencies discovered.

19.4.9.1 The documentation shall have a space to indicate when and how the

	deficiencies were corrected. 19.4.10 All documentation shall be maintained and made available for review by the AHJ. Findings: During document review and interview with staff on 9/8/26, the smoke damper inspection and testing records were requested. At 10:54 a.m., the facility failed to provide records to show that the four-year smoke damper testing had been conducted. The date of the last smoke damper testing was unknown. During a concurrent interview, Staff 1 confirmed the finding and stated that she was under the impression that the damper testing had been conducted during the annual fire alarm system (FAS) test. The annual FAS testing record dated 1/10/25 failed to show damper testing being conducted.