PRINTED: 10/19/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 06 - MAIN LIC B MING 111339 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N TREASURE DRIVE TREASURE ISLE CARE CENTER NORTH BAY VILLAGE, FL 33141 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS. K 000 A complaint investigation survey for complaint number 2020014701 was conducted 09/22/2020 at Treasure Isle Care Center, a nursing home in North Bay Village, Florida.

The complaint contained one (1) allegation, of which one (1) was substantiated. Treasure Isle Care Center is not in compliance with requirements for nursing homes. K 511 NEPA 101 Utilities - Gas and Electric K 511 10/22/20 SS=F Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54. National Fuel Gas Code. electrical wiring and equipment complies with NEPA 70. National Electric Code, Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it Preparation and/or execution of this Plan was determined that the facility failed to maintain of Corrections does not constitute equipment using gas as required as evidenced by admission or agreement by the Provider of lack of documentation. This deficiency could the items alleged or conclusion set forth in affect all occupants of the facility in case of a fire the Statement of Deficiencies. The Plan or other emergency. of Corrections is prepared and/or executed solely because the provision of Findings included: federal and state laws requires it. During the records review process of the facility on 09/22/2020 at 3:00 PM with the Administrator. ACTION TAKEN TO CORRECT THE it was revealed that (1) there was a gas leak investigation by the local Fire Department on DEFICIENCY: 08/25/2020; (2) there was a gas leak investigation by equipment servicing company on 08/26/2020; The Maintenance Assistant immediately (3) there was repair work completed by an checked the pilot lights to ensure that they

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 10/12/20

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Agency for Health Care Administration
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

AND PLAN OF CO

| | | 111339 | B. WING | | 09/22/2020 | | |
|---|---|--|---------------------|---|--|--|--|
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATE, ZIP CODE | | | |
| 1735 N TREASURE DRIVE | | | | | | | |
| TREASURE ISLE CARE CENTER NORTH BAY VILLAGE, FL 33141 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | | |
| K 511 | Continued From page | 1 | K 511 | | Land de la constitución de la co | | |
| | and (4) there was no equipment testing and | d certification by a certified company after the repair These findings were wledged by the he exit conference. | | were working properly. The grid pan assembly, located underneath the pilot lights, was raised in order to ensure the the pilot lights would not be blown out is sudden gush of wind. All staff was in-serviced/educated on the importance of immediate reporting of a and all gas odors in the facility to the Maintenance Director and/or designee well as to the Administrator. HOW OTHER RESIDENTS HAVING T POTENTIAL TO BE AFFECTED WILL IDENTIFIED: All residents have the potential to be affected by this deficient practice. Vendor was called in to check all gas lin order to ensure that there was no potential gas leak. MEASURES PUT INTO PLACE TO ENSURE THE SAME DEFICIENT PRACTICE DOES NOT RECUR. Dietary Cook was in-serviced/educated the importance of checking the pilot tip throughout the day in order to ensure the if a pilot tight goes out it is immediately identified and turned back on with notification to the NHA and Maintenand Director and/or designee. | at py a land and a land a land and a land a land and a land and a land and a land a | | |
| AUGA 5 | 1000 | | | BE MONITORED: | | | |
| AHCA Form S | | | | POTENTIAL TO BE AFFECTED WILL IDENTIFIED: All residents have the potential to be affected by this deficient practice. Vendor was called in to check all gas li in order to ensure that there was no potential gas leak. MEASURES PUT INTO PLACE TO ENSURE THE SAME DEFICIENT PRACTICE DOES NOT RECUR: Dietary Cook was in-serviced/educated the importance of checking the pilot light roughout the day in order to ensure tif a pilot light goes out it is immediately identified and turned back on with notification to the NHA and Maintenand Director and/or designee. HOW THE CORRECTIVE ACTION WI | nes fon hts hat | | |

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| STATEMENT | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 96 - MAIN LIC | | (X3) DATE SURVEY COMPLETED | |
| 111339 | | 111339 | B. WING | | 09/22/2020 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | ITE, ZIP CODE | | |
| TREASUR | RE ISLE CARE CENTER | | EASURE DRIV Y VILLAGE, F | - | | |
| (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) COMPLETE DATE |
| K 511 | Continued From page | s 2 | K 511 | Dietary Cook will perform hourly auditsivisual checks of all pilot lights tensure that they are turned on and working properly. CDM will conduct random weekly auditsivisual checks of all pilot lights tensure that they are turned on and working properly. Findings of audits will be submitted/presented by the CDM and designee during monthly QA&A Committee meeting x 3 months, then quarterly for three consecutive quarter | o Vor | |

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| STATEMENT | FOR DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | CONSTRUCTION 6 - MAIN LIC | (X3) DATE SURVEY COMPLETED | | | |
| | | 111339 | B. WING | | 09/22/2020 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | | |
| TREASUR | E ISLE CARE CENTER | | ASURE DRIV | | | | |
| | | | Y VILLAGE, F | | | | |
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| N 000 | INITIAL COMMENTS | | N 000 | | | | |
| | Control was conducted is le Care Center, a mu Village, Florida in acc Administrative Code E has the ability to trans what Heating, Ventilae (HVAC) equipment is or the effectiveness o verified. The conclusivatements and HVAC cooled are discounted in the conductive the confection of | spa.4.1265. ces have a generator and fer power, verification of ing, and Air-Conditioning connected to the generator, fool zones was not ons are based on he facility staff and ed by the facility. by the facility staff and ed by the facility staff and ed by the facility. control of the facility as of 5,546 square feet are feet and Section sided in the back of the Room, powers HVAC | | | | | |

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE 10/12/20 Electronically Signed

09/22/2020

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 06 - MAIN LIC

NAME OF PROVIDER OR SUPPLIER

B. WING_ STREET ADDRESS, CITY, STATE, ZIP CODE

TREASURE ISLE CARE CENTER

111339

1735 N TREASURE DRIVE

| TREASUR | E ISLE CARE CENTER N | ORTH BAY VILLAGE, F | L 33141 | |
|--------------------------|--|---------------------|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| K 000 | INITIAL COMMENTS | K 000 | | |
| | A complaint investigation survey for complaint number 2020014701 was conducted 09/22/202 at Treasure Isle Care Center, a nursing home i North Bay Village, Florida. | | | and a management of the state o |
| | The complaint contained one (1) allegation, of which one (1) was substantiated. | | | and and and and and and |
| | Treasure Isle Care Center is not in compliance with requirements for nursing homes. | • | | on one of the other othe |
| K 511 SS=F | NFPA 101 Utilities - Gas and Electric | K 511 | | 10/22/20 |
| | Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Cod electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided in hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 | | | |
| | This Statute or Rule is not met as evidenced b Based on records review and staff interview, it was determined that the facility failed to mainta equipment using gas as required as evidenced lack of documentation. This deficiency could affect all occupants of the facility in case of a fil or other emergency. | ain I by | | |
| | Findings included: | | | |
| | During the records review process of the facility on 09/22/2020 at 3:00 PM with the Administratit was revealed that (1) there was a gas leak investigation by the local Fire Department on 08/25/2020; (2) there was a gas leak investigate by equipment servicing company on 08/26/202 (3) there was repair work completed by an | or, | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE Electronically Signed 10/12/20

| PRINTED: 10/19/2020 Agency for Health Care Administration | | | | | | | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: 1 | 06 - MAIN LIC | COMPLI | ETED | |
| | | 111339 | B. WING | | 09/2 | 09/22/2020 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ITE, ZIP CODE | | | |
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| MERODI | | | AY VILLAGE, F | | | | |
| (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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | SHOULD BE COM | | |
| K 511 | Continued From page | 1 | K 511 | | | | |
| | equipment servicing of | company on 09/03/2020; | | | | | |
| | and (4) there was no | documentation for | | | | | |
| | | d certification by a certified company after the repair | | | | | |
| | work was completed. | | | | | | |
| | discussed and acknow | | | | | | |
| | Administrator during t | he exit conference. | | | | | |
| | NFPA 101 (2015 Editi NFPA 54 (2015) Chap | | | | | | |
| | Class III | | | | | | |
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| STATEMENT | FOR DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | CONSTRUCTION 6 - MAIN LIC | (X3) DATE SURVEY COMPLETED | | | |
| | | 111339 | B. WING | | 09/22/2020 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | | |
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| N 000 | INITIAL COMMENTS | | N 000 | | | | |
| | Control was conducted is le Care Center, a mu Village, Florida in acc Administrative Code E has the ability to trans what Heating, Ventilae (HVAC) equipment is or the effectiveness o verified. The conclusivatements and HVAC cooled are discounted in the conductive the confection of | spa.4.1265. ces have a generator and fer power, verification of ing, and Air-Conditioning connected to the generator, fool zones was not ons are based on he facility staff and ed by the facility. by the facility staff and ed by the facility staff and ed by the facility. control of the facility as of 5,546 square feet are feet and Section sided in the back of the Room, powers HVAC | | | | | |

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