Agency for Health Care Adminis	tration				01/06/2021 1 APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	CONSTRUCTION 15 - MAIN LIC	(X3) DATE S COMPLI	
	55225	B. WING		12/0	9/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BOCA CIEGA CENTER	1414 59TH	f ST S RT, FL 33707			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 000 INITIAL COMMENTS		K 000			
survey was conducted Ciego Center, a nursi in accordance with N Association (NFPA) 1 applicable requireme Marshafs Rules and Administrative Code 1 69A-53, F.A.C. 59A-4 400 Part II, and F.S. 1 Fire Protection Assoc (2015 edition) Assown Prevention Code and standards and requiri 101, Chapter 2. The following is described for the time of the SS=D Market SS=D Fire Alarm System - 1 A fire alarm system is accordance with an a with the requirements Electric Code, and NI and Signaling Code.	and 101 (2015 edition) and this of Florida State Fire Regulations, Florida F.A.C.) 69A-3, F.A.C., and Florida Statutes (F.S.) 330.0215, adopting National lation (NFPA) 1 and 101 as the Florida Fire all NFPA referenced ements adopted per NFPA ription of the deficiencies, se visit. System - Testing and destination of the deficiencies of the defi	K 345			1/10/21

of a deleted alarm activation under hazardous LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Statute or Rule is not met as evidenced by: Based on review of the facility records and

interview with the Administrator and Maintenance Director, the facility failed to maintain the Fire

Alarm System. Maintaining the Fire Alarm System

ensures proper operation and lessens the chance

TITLE (X6) DATE Electronically Signed 12/31/20

1) The facility has completed annual duct detector differential pressure test and the

bi-annual smoke detector sensitivity test

2) The Fire Alarm System testing and

per testing requirements on 12/15/20.

PRINTED: 01/06/2021 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: 05 - MAIN LIC B MING 55225 12/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1414 59TH ST S **BOCA CIEGA CENTER** GULFPORT, FL 33707 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 345 Continued From page 1 K 345 conditions maintenance is maintained to NFPA 101 standards Findings included: The maintenance director has On 12/09/2020 between 9:30 a.m. and 12:00 p.m. received education related to the during document review, the facility failed to requirements of maintaining the Fire Alarm provide evidence of the annual duct detector System to include, but not limited to, the differential pressure test and the biennial smoke requirement of annual duct detector detector sensitivity test per manufacturer's testing differential testing and biennial smoke requirements. detector sensitivity test. The findings were acknowledged by the 4) The Maintenance Director/Designee Administrator and Maintenance Director at the will audit the duct detector differential 3:00 p.m. exit conference. pressure testing and the smoke detector sensitivity test documentation monthly to per NFPA 101 (2015 Edition) 19.3.4.1, 9.6, validate tests are conducted timely. The 9.6.1.3 results of the audit will be reviewed at the QA&A Committee meeting for four months per NFPA 72 (2013 Edition) 14.4.4, 14.4.3.2(17) for recommendations or until substantial (a)(5), 14,4,3,2(17)(h) compliance is met. Class III K 918 NFPA 99 Electrical Systems - Essential Electric K 918 1/10/21 ss=D Syste Electrical Systems - Essential Electric System Maintenance and Testing

with NFPA 110.

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

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40

STATE FORM cnso 814521 If continuation sheet 2 of 4

Agency f	or Health Care Adminis	stration): 01/06/2021 1 APPROVEE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION D5 - MAIN LIC	(X3) DATE S COMPL	
		55225	B. WING		12/0	9/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	ATE, ZIP CODE		
BOCA CIE	GA CENTER	1414 59T				
		GULFPO	RT, FL 33707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 918	Continued From page	2	K 918			
	under load conditions simulated cold start a transfer of all EES for competent personnel stored energy power accordance with NFF circuit breakers are in program for periodica components is established and program for periodica components is established and program for periodica components is established and program for periodical program for pr	ous hours. Scheduled test include a complete and automatic or manual ads, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A111. Main and feeder spected annually, and a lily exercising the ished according to ments. Written records of img are maintained and S electrical panels and and readity identifiable. It will be a supported to the readity in the readity identifiable. It will be a supported by the readity in the latter of the readity in		The facility has completed and received documentation of the annual quality test sample on 12/10/20 for the control of th		
	generator. Written rec testing are required to available. Findings included:	ords of maintenance and be maintained and readily and readily liew on 12/09/2020 between		emergency generator and documenta of the monthly conductance testing of generator maintenance free sealed br is complete. 2) The facility generator is in compli- with fuel testing and conductance test	tion the attery ance	

2) That there was no documentation of monthly AHCA Form 3020-0001

11:30 a.m. and 12:00 p.m. with the Maintenance

1) That there was no documentation of the annual

fuel quality test per American Society for Testing

and Materials (ASTM) standards for the

Director, it was revealed:

emergency generator.

requirements.

3) The maintenance department has

requirements of annual fuel quality test per

received education related to the

American Society for Testing and

emergency generator as well as

Materials (ASTM) standards for the

Agency f	or Health Care Adminis	tration				: 01/06/2021 I APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC		(X3) DATE SURVEY COMPLETED	
		55225	B. WING		12/0	9/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
BOCA CIE	GA CENTER	1414 59TH GULFPORT	ST S F, FL 33707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 918	Continued From page	3	K 918			
	conductance testing of maintenance free sea An interview was con Director concurrent w confirmed the findings per NFPA 99 (2015 E 6.4.4.1.3, 6.4.1.1.16	of the generator sled battery. ducted with the Maintenance ith the observations and		documenting monthly conductance te of the generator maintenance free set battery. 4) The Maintenance Director/Design will audit generator fuel test completio and documentation and monthly conductance testing monthly to valida compliance. The results of the audit wreivewed at the QASA Committee me for four months for recommendations until substantial compliance is met.	aled nee on ite vill be eting	

AHCA Form 3020-0001

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0	<u>/938-0391</u>
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED		
		105271	B. WING		12/09	/2020
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
BOCA CIE	GA CENTER		1	114 59TH ST S ULFPORT, FL 33707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000			
	survey was conducte Ciega Center, a nursi Florida. Boca Ciega Center is CFR 483 Subpart B, National Fire Protecti	not in compliance with 42 42 CFR 488.307, and on Association (NFPA) 101 ments for nursing homes.				
K 345 SS=D	Fire Alarm System - 1 CFR(s): NFPA 101 Fire Alarm System - 1 A fire alarm system is accordance with an a with the requirements Electric Code, and NI and Signaling Code, acceptance, mainten available. 9.6.1.3, 9.6.1.5, NFP, This REQUIREMENT by: Based on review of I interview with the Adf	ance and testing are readily A 70, NFPA 72 is not met as evidenced the facility records and ininistrator and Maintenance titled to maintain the Fire	K 345	The facility has completed annual duct detector differential pressure tes the bi-annual smoke detector sensitive.	al st and rity	10/21
	ensures proper opera	aining the Fire Alarm System tion and lessens the chance livation under hazardous		The Fire Alarm System testing a maintenance is maintained to NFPA.	nd	

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

(X6) DATE

Electronically Signed 12/31/2020 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.

PRINTED: 01/06/2021

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES	1				0. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION PT - MAIN FED	(X3) DATE COMP	PLETED
	ļ	105271	B. WING	_		12/	/09/2020
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
POCA CIE	GA CENTER			1.	414 59TH ST S		
BUCA CIL	GACENIER			G	SULFPORT, FL 33707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 345	Continued From page	· 1	к	345	standards.		
	Findings included:						
	On 12/09/2020 betwe during document revie provide evidence of the differential pressure to	een 9:30 a.m. and 12:00 p.m. ew, the facility falled to he annual duct detector est and the biennial smoke st per manufacturer's testing			3) The maintenance director has received education related to the requirements of maintaining the Fire Alarm System to include, but not limite to, the requirement of annual duct detector differential testing and biennia smoke detector sensitivity test.		
	3:00 p.m. exit confere per NFPA 101 (2012 I	aintenance Director at the ence.			The Maintenance Director/Designs will audit the duct detector differential pressure testing and the smoke detect sensitivity test documentation monthly validate tests are conducted timely. The	or to ne	
	9.6.1.3 per NFPA 72 (2010 E- 14.4.2.2(14)(g)(1), 14	dition) 14.4.5, 14.4.2.2, 4.4.2.2(14)(g)(6)			results of the audit will be reviewed at to QA&A Committee meeting for four more for recommendations or until substantial compliance is met.	nths	
K 918 SS≂D	Electrical Systems - E CFR(s): NFPA 101	Essential Electric Syste	к	918			1/10/21
	Maintenance and Tes The generator or oth and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life s Maintenance and test transfer switches are with NFPA 110. Generator sets are in under load 30 minuter day intervals, and exe	Essential Electric System titing er alternate power source ment is capable of supplying onds. If the 10-second uring the monthly test, a ridded to annually confirm this safety and critical branches. ting of the generator and performed in accordance spected weekly, exercised s 12 times a year in 20-40 ercised once every 36 bus hours. Scheduled test					

under load conditions include a complete

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CENTERS FOR MEDICARE & MEDICAID SERVICES C							
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED	(X3) DATE SURVEY COMPLETED				
	105271	B. WING	12/09/2020				

		105271	B. WING_			12/0	09/2020
	ROVIDER OR SUPPLIER			14	REET ADDRESS, CITY, STATE, ZIP CODE 114 59TH ST S ULFPORT, FL 33707	1270	372020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 918	simulated cold start a transfer of all EES los competent personnel. stored energy power: accordance with NFP circuit breakers are in program for periodica components is establi manufacturer require maintenance and test readily available. EES circuits are marked, re separate from normal the possibility of dams source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (NF 111, 700.10 (NFPA 77 This REQUIREMENT by: Based on review of the interview with the Mairevealed that the facil generator. Written rec testing are required to available. Findings included: During document revi 11:30 a.m. and 12:00 Director, it was reveal of that there was no fuel quality test per Ar and Materials (ASTM).	nd automatic or manual ds, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder spected annually, and a ly exercising the shed according to heats. Withen records of ing are maintained and electrical panels and aduly identifiable, and power circuits. Minimizing gee of the emergency power insideration for new (PA 99). NFPA 110, NFPA) is not met as evidenced the facility records and intenance Director, it was ty failed to maintain the ords of maintenance Director, it was ty failed to maintain the ords of maintenance and be maintained and readily ew on 12/09/2020 between p.m. with the Maintenance ed: documentation of the annual nerican Society for Testing standards for the	K9	918	1) The facility has completed and received documentation of the annual foult to the annual foult to the more apple on 12/10/20 for the emergency generator and documentation of the monthly conductance testing of the generator maintenance free sealed battery is complete. 2) The facility generator is in compliar with fuel testing and conductance testin requirements. 3) The maintenance department has received education related to the reguirements of annual fuel quality test per American Society for Testing and Materials (ASTM) standards for the emergency generator as well as documenting monthly conductance test	on he nce	

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	105271	B. WING	12/09/2020		
D DI AN OF CODDECTION DO DESCRIPTION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED	(X3) DATE SURVEY COMPLETED		
ENTERS FOR MEDICARE & MEDICAID SERVICES					

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1414 59TH ST S		
ROCY CIE	GA CENTER	0	GULFPORT, FL 33707		
(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	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	DST DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105271	B. WING			12/	09/2020
	ROVIDER OR SUPPLIER		•	١,	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 59TH ST S GULFPORT, FL 33707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	home, Emergency Pr Boca Ciega Center is Emergency Prepared	Ciega Center, a nursing eparedness was reviewed. not in compliance with ness per Code of Federal 2, Part 483.73, Requirement					
E 004 SS=D	The following is a des noncompliance. Develop EP Plan, Re CFR(s): 483.73(a)	scription of the view and Update Annually	E	004			1/10/21
	Federal, State and lo preparedness require develop establish and	ments. The [facility] must d maintain a comprehensive ness program that meets the					
	The emergency preprinclude, but not be lin elements:	aredness program must nited to, the following					
	and maintain an eme	The [facility] must develop rgency preparedness plan d], and updated at least lan must do all of the					
	CAH] must comply we State, and local emer requirements. The [h develop and maintain	ency Plan. The [hospital or ith all applicable Federal, gency preparedness lospital or CAH] must					

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

(X6) DATE

Electronically Signed

12/31/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105271	B. WING		12/09/2020
NAME OF P	ROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE	
BOCA CIE	GA CENTER		- 1	414 59TH ST S GULFPORT, FL 33707	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 004	Plan. The LTC facility an emergency prepar reviewed and update * [For ESRD Facilities Plan. The ESRD facilities plan. This REQUIREMENT by: Based on record rev. failed to provide the a their Emergency Preg Annual review and up required to address it the community, the fapopulations. Findings included: On 12/09/2020 betwee while reviewing the fat to provide evidence or policy and procedure annual review must be date of the review an emergency plan base. Concurrent with the n	ection, utilizing an 1 §483.73(a):] Emergency must develop and maintain edness plan that must be d at least annually. 2 at §494.62(a):] Emergency thy must develop and cy preparedness plan that and updated at least every 2 id is not met as evidenced ew and interview, the facility nnual review and update of paredness Program (EP). dating of the program is ne changing environments of cility and the facility ent 10:00 AM and 12:00 PM cility's EP, the facility failed of the annual review of all s contained in their EP. The e documented to include the d any updates made to the	E 004	1) A review of the policies and procedures contained in the Emerg Preparedness Program (EP) was conducted by the facility Inter-disciple team (IDT). 2) The EP has been updated to nannual review with no corrections cadditions to policies in place. 3) IDT received education relater maintaining the EP updated, at lea nannually, and/or upon indication of changing environments of the com the facility, and the facility population. 4) The Maintenance Director/IDE will audit the EP monthly to validate updates are needed related to changing environments of the community, far or the community, far or the community.	neet the or to
	and updated to meet	ould need to be reviewed the Federal requirements ion that verifies the policies		facility populations or changes in pa and procedure. The results of the will be reviewed at the QA&A Com-	audit

and procedures have been reviewed and updated

meeting for four months for

Facility ID: 55225

PRINTED: 01/06/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 105271 B. WING 12/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1414 59TH ST S BOCA CIEGA CENTER GULFPORT, FL 33707 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 004 | Continued From page 2 E 004 on an annual basis. recommendations or until substantial compliance is met.