DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105910	A. BUILDING _____ B. WING _____	11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL REEF NURSING & REHABILITATION CENTER	**9869 SW 152ND STREET MIAMI, FL 33157**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments During an unannounced Fire & Life Safety recertification survey conducted on 11/23/2020-11/24/2020 at Coral Reef Nursing & Rehabilitation Center, a nursing home in Miami, Florida, Emergency Preparedness was reviewed. Coral Reef Nursing & Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E 000		

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

Electronically Signed | 12/26/2020

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.

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	105910	A. BUILDING **01 - MAIN FED** B. WING _____	**11/24/2020**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 11/23/2020 to11/24/2020 at Coral Reef Nursing & Rehabilitation Center, a nursing home in Miami, Florida. Coral Reef Nursing & Rehabilitation Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes. Initial Plan Review: 1995 with addition in 2010 Existing NFPA 220 Construction Type: Type II (111) Number of beds: 180 Census: 135 The following is description of the noncompliance.	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on records reviewed and staff interview, it was determined that the facility failed to perform fire alarm testing and maintenance as required as evidenced by lack of documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. This	K 345		12/31/20

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Electronically Signed		12/26/2020

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.

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K 345	Continued From page 1 deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. The report dated 05/09/2019 was provided during survey. During the Staff Interview between 10:30 am and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. They provided a report dated 05/09/2019 during survey. NFPA 101 (2012 Edition) 19.3.4.1, 9.6 NFPA 72 (2010 Edition) Chapter 14 Table 14.4.2.2	K 345		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		12/31/20

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K 363	Continued From page 2 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to properly maintain the smoke / fire doors as required as evidenced by a door not latching and a door held open. This deficiency could affect all occupants of	K 363		

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K 363	Continued From page 3 the facility in case of a fire or other emergency. Findings included: During the Life Safety Survey tour of the facility between 2:00 PM and 6:00 PM on 11/24/2020 with the Maintenance Director, it was observed as follows: On 11/24/2020 at 2:41 pm Patient Room N21: door was not latching properly. It was repaired during survey. On 11/24/2020 at 2:46 PM Hospice Team Room next to Patient Room N23: door had a self-closing device, and it was held open with a wood wedge. The wood wedge was removed during survey. On 11/24/2020 during the Staff Interview between 2:00 PM and 6:00 PM, the Maintenance Director acknowledged that (1) Patient Room N21 door was not latching properly; and (2) Hospice Team Room next to Patient Room N23 door had a self-closing device, and it was held open with a wood wedge. The Maintenance Director repaired the door and removed the wood wedge during survey. These findings were also acknowledged by the Administrator during the exit conference. NFPA 101 (2012 Edition) 19.3.6.3.5	K 363		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		12/31/20

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K 712	Continued From page 4 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on records reviewed and staff interview, it was determined that the facility failed to perform fire drills as required as evidenced by lack of documentation. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. NFPA 101 (2012 Edition) 19.7.1.4 through 19.7.1.7	K 712		

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K 771	Continued From page 5	K 771		
K 771 SS=D	Engineer Smoke Control Systems CFR(s): NFPA 101 Engineer Smoke Control Systems 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 This REQUIREMENT is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform fire dampers testing and maintenance as required as evidenced by lack of documentation for the performance of fire dampers test. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire dampers test within the last 4 years. A report dated 08/20/2016 was provided during survey. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire dampers test within the last 4 years. They provided a report dated 08/20/2016.	K 771		12/31/20

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K 771	Continued From page 6	K 771		
K 921 SS=D	NFPA 101 (2012 Edition) 19.7.7.1 Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff	K 921		12/31/20

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K 921	Continued From page 7 interview, it was determined that the facility failed to maintain electrical equipment as required as evidenced by lack of testing documentation. This deficiency could affect occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. NFPA 99 (2012 Edition) 10.5.2.1	K 921		

Agency for Health Care Administration

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	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 11/23/2020 to11/24/2020 at Coral Reef Nursing & Rehabilitation Center, a nursing home in Miami, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015 edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is description of the deficiencies found at the time of the survey.	K 000		
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform fire alarm testing and maintenance as required as evidenced by lack of documentation for the performance of fire alarm duct detector airstream	K 345		12/31/20

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K 345	Continued From page 1 sampling using a method acceptable to the manufacturer or published instructions. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. The report dated 05/09/2019 was provided during survey. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. They provided a report dated 05/09/2019 during survey. NFPA 101 (2015 Edition) 19.3.4.1, 9.6 NFPA 72 (2013 Edition) Chapter 14 Table 14.4.3.2 Class III	K 345		
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors	K 363		12/31/20

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K 363	Continued From page 2 2015 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations (only for Federal survey citation) only on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 2015 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor	K 363		

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K 363	Continued From page 3 covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with self-latching and positive latching hardware. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations (only for Federal survey citation) on corridor doors and rooms containing flammable or combustible materials. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This Statute or Rule is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to properly maintain the smoke / fire doors as required as evidenced by a door not latching and a door held open. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the Life Safety Survey tour of the facility between 2:00 PM and 6:00 PM on 11/24/2020 with the Maintenance Director, it was observed as follows: On 11/24/2020 at 2:41 PM Patient Room N21: door was not latching properly. It was repaired during survey. On 11/24/2020 at 2:46 PM Hospice Team Room	K 363		

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K 363	Continued From page 4 next to Patient Room N23: door had a self-closing device, and it was held open with a wood wedge. The wood wedge was removed during survey. During the Staff Interview between 2:00 PM and 6:00 PM on 11/24/2020, the Maintenance Director acknowledged that (1) Patient Room N21 door was not latching properly; and (2) The Hospice Team Room next to Patient Room N23 door had a self-closing device, and it was held open with a wood wedge. He repaired the door and removed the wood wedge during survey. These findings were also acknowledged by the Administrator during the exit conference. NFPA 101 (2015 Edition) 19.3.6.3.5 Class III	K 363		
K 712 SS=D	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1, 19.7.1, 4.7 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform	K 712		12/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 712	Continued From page 5 fire drills as required as evidenced by lack of documentation. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. NFPA 101 (2015 Edition) 19.7.1.4 through 19.7.1.7 Class III	K 712		
K 771 SS=D	NFPA 101 Engineer Smoke Control Systems Engineer Smoke Control Systems 2015 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.	K 771		12/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

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K 771	Continued From page 6 19.7.7 2015 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, Standard for Smoke Control Systems. Test documentation is maintained on the premises. 18.7.7 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform fire dampers testing and maintenance as required as evidenced by lack of documentation for the performance of fire dampers test. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire dampers test within the last 4 years. A report dated 08/20/2016 was provided during survey. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire dampers test within the last 4 years. They provided a report dated 08/20/2016. NFPA 101 (2015 Edition) 19.7.7.1	K 771		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

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K 771	Continued From page 7 Class III	K 771		
K 921 SS=D	NFPA 99 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on record review, observations, and staff	K 921		12/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 921	Continued From page 8 interview, it was determined that the facility failed to maintain electrical equipment as required as evidenced by lack of testing documentation. This deficiency could affect occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. NFPA 99 (2015 Edition) 10.5.2.1.2 Class III	K 921		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105910	A. BUILDING _____ B. WING _____	11/24/2020

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E 000	Initial Comments During an unannounced Fire & Life Safety recertification survey conducted on 11/23/2020-11/24/2020 at Coral Reef Nursing & Rehabilitation Center, a nursing home in Miami, Florida, Emergency Preparedness was reviewed. Coral Reef Nursing & Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E 000		

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

Electronically Signed | 12/26/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105910	A. BUILDING **01 - MAIN FED** B. WING _____	**11/24/2020**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 11/23/2020 to11/24/2020 at Coral Reef Nursing & Rehabilitation Center, a nursing home in Miami, Florida. Coral Reef Nursing & Rehabilitation Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes. Initial Plan Review: 1995 with addition in 2010 Existing NFPA 220 Construction Type: Type II (111) Number of beds: 180 Census: 135 The following is description of the noncompliance.	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on records reviewed and staff interview, it was determined that the facility failed to perform fire alarm testing and maintenance as required as evidenced by lack of documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. This	K 345	K345 Corrective action: Differential pressure testing on all smoke duct detectors was conducted on November 25, 2020. Identification of residents having potential	12/31/20

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

Electronically Signed | 12/26/2020

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.

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K 345	Continued From page 1 deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. The report dated 05/09/2019 was provided during survey. During the Staff Interview between 10:30 am and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. They provided a report dated 05/09/2019 during survey. NFPA 101 (2012 Edition) 19.3.4.1, 9.6 NFPA 72 (2010 Edition) Chapter 14 Table 14.4.2.2	K 345	to be affected: All residents have the potential to be affected when smoke duct detector differential are nor conducted. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance director to ensure that the duct detector differential testing will be conducted annually as required by NFPA. Monitoring of corrective action: Maintenance director will ensure that the duct detector differential testing will be conducted annually. All findings will be discussed in the next QAPI meetings.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		12/31/20

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K 363	Continued From page 2 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to properly maintain the smoke / fire doors as required as evidenced by a door not latching and a door held open. This deficiency could affect all occupants of	K 363	K363 Corrective Action: On November 24, 2020 N21 door was not latching properly, it was immediately	

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K 363	Continued From page 3 the facility in case of a fire or other emergency. Findings included: During the Life Safety Survey tour of the facility between 2:00 PM and 6:00 PM on 11/24/2020 with the Maintenance Director, it was observed as follows: On 11/24/2020 at 2:41 pm Patient Room N21: door was not latching properly. It was repaired during survey. On 11/24/2020 at 2:46 PM Hospice Team Room next to Patient Room N23: door had a self-closing device, and it was held open with a wood wedge. The wood wedge was removed during survey. On 11/24/2020 during the Staff Interview between 2:00 PM and 6:00 PM, the Maintenance Director acknowledged that (1) Patient Room N21 door was not latching properly; and (2) Hospice Team Room next to Patient Room N23 door had a self-closing device, and it was held open with a wood wedge. The Maintenance Director repaired the door and removed the wood wedge during survey. These findings were also acknowledged by the Administrator during the exit conference. NFPA 101 (2012 Edition) 19.3.6.3.5	K 363	repaired. On November 24, 2020 the hospice team room had a self-closing device and it was held open with a wood wedge. The wood wedge was removed immediately. Identification of residents having potential to be affected: All residents have the potential to be affected when doors are not latching properly and self-closing doors are held open with wood wedge. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance department to ensure that all doors are latching properly and self-closing doors are not held open with door wedge. Corrective action: Maintenance director/designee will conduct random weekly audits for the next three month to ensure that all doors properly latch and that self-closing doors are not held open with a door wedge. All findings will be discussed in the next two QAPI meetings.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		12/31/20

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K 712	Continued From page 4 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on records reviewed and staff interview, it was determined that the facility failed to perform fire drills as required as evidenced by lack of documentation. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. NFPA 101 (2012 Edition) 19.7.1.4 through 19.7.1.7	K 712	F712 Corrective Action: Fire drills were conducted and on all three shifts. The fire drill documentation was updated tor reflect the fire drills conducted. Identification of residents having potential to be affected: All residents have the potential to be affected fire drills are not conducted and there is lack of documentation Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance department to ensure that all fire drills are conducted during their appropriate time frame and all documentation regarding fire drills is updated accordingly. Corrective action: Maintenance director/designee performed fire drills during scheduled time and all fire drills are documented accordingly. All findings will be discussed in the next two QAPI meetings.	

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K 771	Continued From page 5	K 771		
K 771 SS=D	Engineer Smoke Control Systems CFR(s): NFPA 101 Engineer Smoke Control Systems 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 This REQUIREMENT is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform fire dampers testing and maintenance as required as evidenced by lack of documentation for the performance of fire dampers test. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire dampers test within the last 4 years. A report dated 08/20/2016 was provided during survey. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire dampers test within the last 4 years. They provided a report dated 08/20/2016.	K 771	K771 Corrective action: The fire dampers testing and maintenance was conducted on November 25, 2020. Identification of residents having potential to be affected: All residents have the potential to be affected when the fire damper testing and maintenance are not conducted every four years. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance director to ensure that the fire dampeners are tested and maintained every four years. Monitoring of corrective action: Maintenance director will ensure that the fire dampeners and maintenance will be conducted every four years. . All findings will be discussed in the next QAPI meetings.	12/31/20

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K 771	Continued From page 6	K 771		
K 921 SS=D	NFPA 101 (2012 Edition) 19.7.7.1 Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff	K 921	K921	12/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105910	A. BUILDING **01 - MAIN FED** B. WING _____	**11/24/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL REEF NURSING & REHABILITATION CENTER	**9869 SW 152ND STREET** **MIAMI, FL 33157**

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K 921	Continued From page 7 interview, it was determined that the facility failed to maintain electrical equipment as required as evidenced by lack of testing documentation. This deficiency could affect occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. NFPA 99 (2012 Edition) 10.5.2.1	K 921	Corrective Action: On December 9, 2020 the electrical testing of both fixed and portable medical equipment was conducted. Binders located in the maintenance office. Identification of residents having potential to be affected: All residents have the potential to be affected when electrical testing and maintenance are not conducted. Medical equipment both fixed and portable test will be kept in binders located in the maintenance office. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance director to ensure that the electrical testing of fixed and portable medical equipment will be conducted annually. Monitoring of corrective action: Maintenance director will ensure that electrical testing of fixed and portable medical equipment will be conducted annually. . All findings will be discussed in the next QAPI meetings.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL REEF NURSING & REHABILITATION CENTER	**9869 SW 152ND STREET MIAMI, FL 33157**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 11/23/2020 to11/24/2020 at Coral Reef Nursing & Rehabilitation Center, a nursing home in Miami, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015 edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is description of the deficiencies found at the time of the survey.	K 000		
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform fire alarm testing and maintenance as required as evidenced by lack of documentation for the performance of fire alarm duct detector airstream	K 345	K345 Corrective action: Differential pressure testing on all smoke duct detectors was conducted on November 25, 2020.	12/31/20

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/26/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

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K 345	Continued From page 1 sampling using a method acceptable to the manufacturer or published instructions. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. The report dated 05/09/2019 was provided during survey. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire alarm duct detector airstream sampling using a method acceptable to the manufacturer or published instructions. They provided a report dated 05/09/2019 during survey. NFPA 101 (2015 Edition) 19.3.4.1, 9.6 NFPA 72 (2013 Edition) Chapter 14 Table 14.4.3.2 Class III	K 345	Identification of residents having potential to be affected: All residents have the potential to be affected when smoke duct detector differential are nor conducted. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance director to ensure that the duct detector differential testing will be conducted annually as required by NFPA. Monitoring of corrective action: Maintenance director will ensure that the duct detector differential testing will be conducted annually. . All findings will be discussed in the next QAPI meetings.	
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors	K 363		12/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

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K 363	Continued From page 2 2015 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations (only for Federal survey citation) only on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 2015 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111356	A. BUILDING: **05 - MAIN LIC** B. WING _____	**11/24/2020**

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K 363	Continued From page 3 covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with self-latching and positive latching hardware. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations (only for Federal survey citation) on corridor doors and rooms containing flammable or combustible materials. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This Statute or Rule is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to properly maintain the smoke / fire doors as required as evidenced by a door not latching and a door held open. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the Life Safety Survey tour of the facility between 2:00 PM and 6:00 PM on 11/24/2020 with the Maintenance Director, it was observed as follows: On 11/24/2020 at 2:41 PM Patient Room N21: door was not latching properly. It was repaired during survey. On 11/24/2020 at 2:46 PM Hospice Team Room	K 363	K363 Corrective Action: On November 24, 2020 N21 door was not latching properly, it was immediately repaired. On November 24, 2020 the hospice team room had a self-closing device and it was held open with a wood wedge. The wood wedge was removed immediately. Identification of residents having potential to be affected: All residents have the potential to be affected when doors are not latching properly and self-closing doors are held open with wood wedge. Measures/systems changes to prevent reoccurrence:	

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K 363	Continued From page 4 next to Patient Room N23: door had a self-closing device, and it was held open with a wood wedge. The wood wedge was removed during survey. During the Staff Interview between 2:00 PM and 6:00 PM on 11/24/2020, the Maintenance Director acknowledged that (1) Patient Room N21 door was not latching properly; and (2) The Hospice Team Room next to Patient Room N23 door had a self-closing device, and it was held open with a wood wedge. He repaired the door and removed the wood wedge during survey. These findings were also acknowledged by the Administrator during the exit conference. NFPA 101 (2015 Edition) 19.3.6.3.5 Class III	K 363	An in-service was conducted by the administrator with the maintenance department to ensure that all doors are latching properly and self-closing doors are not held open with door wedge. Corrective action: Maintenance director/designee will conduct random weekly audits for the next three month to ensure that all doors properly latch and that self-closing doors are not held open with a door wedge. All findings will be discussed in the next two QAPI meetings.	
K 712 SS=D	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1, 19.7.1, 4.7 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform	K 712	F712 Corrective Action:	12/31/20

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K 712	Continued From page 5 fire drills as required as evidenced by lack of documentation. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for fire drills performed in 2020 2nd Quarter / 3rd Shift, 3rd Quarter / 1st Shift, and in 2019 4th Quarter / 1st Shift. NFPA 101 (2015 Edition) 19.7.1.4 through 19.7.1.7 Class III	K 712	Fire drills were conducted and on all three shifts. The fire drill documentation was updated tor reflect the fire drills conducted. Identification of residents having potential to be affected: All residents have the potential to be affected fire drills are not conducted and there is lack of documentation Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance department to ensure that all fire drills are conducted during their appropriate time frame and all documentation regarding fire drills is updated accordingly. Corrective action: Maintenance director/designee performed fire drills during scheduled time and all fire drills are documented accordingly. All findings will be discussed in the next two QAPI meetings.	
K 771 SS=D	NFPA 101 Engineer Smoke Control Systems Engineer Smoke Control Systems 2015 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.	K 771		12/31/20

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K 771	Continued From page 6 19.7.7 2015 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, Standard for Smoke Control Systems. Test documentation is maintained on the premises. 18.7.7 This Statute or Rule is not met as evidenced by: Based on records review and staff interview, it was determined that the facility failed to perform fire dampers testing and maintenance as required as evidenced by lack of documentation for the performance of fire dampers test. This deficiency could affect all occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for the performance of fire dampers test within the last 4 years. A report dated 08/20/2016 was provided during survey. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for the performance of fire dampers test within the last 4 years. They provided a report dated 08/20/2016. NFPA 101 (2015 Edition) 19.7.7.1	K 771	K771 Corrective action: The fire dampers testing and maintenance was conducted on November 25, 2020. Identification of residents having potential to be affected: All residents have the potential to be affected when the fire damper testing and maintenance are not conducted every four years. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance director to ensure that the fire dampeners are tested and maintained every four years. Monitoring of corrective action: Maintenance director will ensure that the fire dampeners and maintenance will be conducted every four years. . All findings will be discussed in the next QAPI meetings.	

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K 771	Continued From page 7 Class III	K 771		
K 921 SS=D	NFPA 99 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on record review, observations, and staff	K 921	K921	12/31/20

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K 921	Continued From page 8 interview, it was determined that the facility failed to maintain electrical equipment as required as evidenced by lack of testing documentation. This deficiency could affect occupants of the facility in case of a fire or other emergency. Findings included: During the records review process of the facility between 10:30 AM and 4:30 PM on 11/23/2020 with the Administrator and between 10:30 AM and 2:00 PM on 11/24/2020 with the Maintenance Director, it was revealed that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. During the Staff Interview between 10:30 AM and 4:30 PM on 11/23/2020 and between 10:30 AM and 2:00 PM on 11/24/2020, both, the Administrator and the Maintenance Director acknowledged that there was no documentation for electrical equipment testing since Annual Report dated 04/11/2019. NFPA 99 (2015 Edition) 10.5.2.1.2 Class III	K 921	Corrective Action: On December 9, 2020 the electrical testing of both fixed and portable medical equipment was conducted. Binders located in the maintenance office. Identification of residents having potential to be affected: All residents have the potential to be affected when electrical testing and maintenance are not conducted. Medical equipment both fixed and portable test will be kept in binders located in the maintenance office. Measures/systems changes to prevent reoccurrence: An in-service was conducted by the administrator with the maintenance director to ensure that the electrical testing of fixed and portable medical equipment will be conducted annually. Monitoring of corrective action: Maintenance director will ensure that electrical testing of fixed and portable medical equipment will be conducted annually. . All findings will be discussed in the next QAPI meetings.	