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 |
|---|---|---|---|
| | 55229 | A. BUILDING: **05 - MAIN LIC**<br>B. WING _____ | **03/04/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BALANCED HEALTHCARE** | **4250 66TH ST N**<br>**SAINT PETERSBURG, FL 33709** |

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| K 000 | INITIAL COMMENTS<br><br>A re-licensure survey was conducted from 03/03/2021 to 03/04/2021 at Balanced Health Care, a nursing home in St. Petersburg, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2018 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 (2018 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2.<br><br>Date Opened: 1975<br>Bldg. Type: II (000)<br>Square Footage: 175,000<br>Smoke Compartments: 16<br>Floor Levels: 2<br>Generator: 450 kW<br>Licensed Bed: 299<br>Census: 215<br>Fully Sprinklered: Yes<br>Fire Alarm: Yes, monitored<br><br>The following is description of the deficiencies, found at the time of the visit. | K 000 | | |
| K 222 SS=D | NFPA 101 Egress Doors<br><br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: | K 222 | | 4/5/21 |

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| K 222 | Continued From page 1<br><br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br><br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br><br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | K 222 | | |

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| K 222 | Continued From page 2<br><br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br><br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview with the Maintenance Director, the facility failed to maintain delayed egress doors.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director and the Maintenance Director between 03/03/2021 and 03/04/2021, and between 9:00 a.m. and 3:30 p.m., the facility failed to properly identify the delayed egress doors with required signage on the doors throughout the facility. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2018 Edition) 19.2.2.2.1, 7.2.1.6.1.1(4)(a)<br><br>Class III | K 222 | A. On 3/10/21 delayed egress doors were identified, and delayed egress signage placed on doors.<br>B. Maintenance Director/designee conducted a quality monitor of egress doors for signage on 3/10/21 and identified doors were provided delayed egress signage.<br>C. On 03/15/21 Administrator re-educated maintenance department on delayed egress signage for egress doors.<br>D. Maintenance Director/designee to conduct quality monitors for delayed egress signage on egress doors weekly for 4 weeks, then monthly for 2 months. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |

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| K 223 SS=D | NFPA 101 Doors with Self-Closing Devices<br><br>Doors with Self-Closing Devices<br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview with the Regional Maintenance Director and the Maintenance Director, the facility failed to maintain doors with self closing devices.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director and the Maintenance Director from 03/03/2021 to 03/04/2021 between 9:00 a.m. and 3:00 p.m., it was observed that the following self closing doors failed to close and latch when tested:<br>1) Exit door from Lifestyle soiled utility room<br>2) Private office door in Lifestyle 1 dining room<br>3) Men's restroom door by elevator<br>4) Lifestyle 1 dining room stairwell exit door<br>5) Housekeeping door in Lifestyle 2<br>6) 1 of 2 door leafs of the 2nd floor dining room entry doors<br>7) 2-West exit door from stairwell at ground level | K 223 | A. Self-closing doors on Lifestyle soiled utility room exit door scheduled to be replaced on 4/28/21, private office door Lifestyle 1 dining room was repaired on 03/08/21, men's restroom door by elevator door closure removed on 3/5/21, Lifestyle 1 dining room stairwell exit door replaced key pad latch on 03/11/21, housekeeping door in Lifestyle 2 repaired 03/05/21, door leafs of the 2nd floor dining room entry doors adjusted 03/09/21, and 2 west exit door from stairwell at ground level new door closure installed 03/25/21.<br>B. On 3/24/21 Maintenance Director conducted quality monitor of self-closing doors for closing and latching. Any identified concerns were repaired on 3/24/21.<br>C. On 3/15/21 Administrator re-educated maintenance staff on preventative maintenance of self-closing doors for | 4/5/21 |

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| K 223 | Continued From page 4<br><br>An interview was conducted with the Regional Maintenance Director and the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>Per NFPA 101 (2018 Edition) 19.7.6, 4.6.12, 8.5.4.1<br>Per NFPA 80 (2016 Edition) 6.1.3.2.1<br><br>Class III | K 223 | proper closing and latching.<br>D. Maintenance Director/designee to conduct quality monitors for proper closing and latching of self-closing doors two times a week for 4 weeks, then weekly for 12 weeks. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 291 SS=D | NFPA 101 Emergency Lighting<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review, and interview with the Regional Maintenance Director, the facility failed to maintain emergency battery backup lighting.<br><br>Findings included:<br><br>During the facility record review with the Regional Maintenance Director on 03/03/2021 between 9:30 a.m. and 12:00 p.m., the facility failed to provide evidence of monthly and annual testing of emergency lights equipped with battery backups.<br>During the facility tour with the Regional Maintenance Director on 03/03/2021 between 12:50 p.m. and 3:00 p.m., the emergency lights located in the generator room failed to operate when tested. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings. | K 291 | A. On 3/8/21 The emergency lights located in the generator room were replaced.<br>B. On 3/3/21 Maintenance Director conducted quality monitor on emergency back up lighting for function. There were no other emergency back-up lights identified.<br>C. On 03/15/21 Administrator re-educated maintenance staff on preventative maintenance monitoring of emergency back-up lighting monthly and annually.<br>D. Maintenance Director/designee will conduct quality monitors of operation of emergency back-up lighting weekly for 4 weeks, then monthly for 2 months, with follow-up initiated as needed to ensure substantial compliance with K291. | 4/5/21 |

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| K 291 | Continued From page 5<br><br>per NFPA 101 (2018 Edition) 19.2.9.1, 7.9.2.6, 7.9.2.7, 7.9.3.1.1(1)(3)(5)<br><br>Class III | K 291 | Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 325 SS=D | NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)<br><br>Alcohol Based Hand Rub Dispenser (ABHR)<br>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:<br>* Corridor is at least 6 feet wide<br>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols<br>* Dispensers shall have a minimum of 4-foot horizontal spacing<br>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room<br>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30<br>* Dispensers are not installed within 1 inch of an ignition source<br>* Dispensers over carpeted floors are in sprinklered smoke compartments<br>* ABHR does not exceed 95 percent alcohol<br>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)<br>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview with the Regional Maintenance Director, the facility failed to maintain the maximum storage limits of alcohol | K 325 | A. On 03/04/21 alcohol based hand rub was removed and stored to not exceed number of gallons per storage area. | 4/5/21 |

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| K 325 | Continued From page 6<br><br>based hand rub (ABHR) per compartment.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director between 03/03/2021 to 03/04/2021, and between 9:00 a.m. and 3:30 p.m., it was observed that the facility had 40 gallons of ABHR stored in Room 107. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2018 edition) 19.4.3(7)<br><br>Class III | K 325 | B. On 3/5/21 Housekeeping Director/designee completed quality monitor of alcohol-based hand rub for required storage amounts. No other issues identified.<br>C. Housekeeping Director/designee will re-educate housekeeping staff on storage of alcohol-based hand rub by 04/01/21.<br>D. Housekeeping Director/designee to conduct quality monitors of storage of alcohol-based hand rub 3 times a week for 4 weeks, then weekly for 8 weeks, then monthly to ensure substantial compliance of K325. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 541 SS=D | NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu<br><br>Rubbish Chutes, Incinerators, and Laundry Chutes<br><br>2015 EXISTING<br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and | K 541 | | 4/5/21 |

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| K 541 | Continued From page 7<br><br>protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82<br><br>2015 NEW<br>Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2.<br>*The fire resistance rating of chute charging room shall not be required to exceed one hour.<br>*Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7.<br>*Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7.<br>18.5.4.2, 8.7, 9.5, 9.7, NFPA 82<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview with the Maintenance Director, the facility failed to maintain the laundry chute intake doors.<br><br>Findings included:<br><br>During the facility tour with the Maintenance Director from 03/03/2021 - 03/04/2021 between 9:00 a.m. and 3:30 p.m., it was observed that 4 of 4 laundry chute fire rated intake doors failed to be self-closing, as they were found in the open position secured by non-approved methods. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. | K 541 | A. On 3/5/21 latches were removed from laundry chutes to ensure closing.<br>B. On 3/5/21 Maintenance Director completed quality monitor of laundry chutes for proper closing and no other concerns identified.<br>C. On 03/15/21.Administrator re-educated maintenance staff on maintaining laundry chutes closure.<br>D. Maintenance Director/designee to complete quality monitors for proper closing of laundry chutes daily for 2 weeks, then 3 times a week for 10 weeks, then monthly to ensure substantial compliance of K541. Findings and trends will be brought to QAPI for review. Quality | |

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| K 541 | Continued From page 8<br><br>(Photographic evidence obtained)<br><br>per NFPA 101 (2018 edition) 19.3.1, 8.6.1, 8.6.2, 9.5.2<br>per NFPA 82 (2014 edition) 6.2.3.3.1.1, 6.2.3.3.2.1<br><br>Class III | K 541 | Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 712 SS=D | NFPA 101 Fire Drills<br><br>Fire Drills<br>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.<br>18.7.1, 19.7.1, 4.7<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview with the Regional Maintenance Director and the Maintenance Director, the facility failed to conduct fire drills as required by NFPA 101.<br><br>Findings included:<br><br>During the facility record review with the Regional Maintenance Director between 03/03/2021 and 03/04/2021, and between 9:30 a.m. and 3:30 p.m., the facility failed to conduct fire drills for:<br>1) 2nd and 3rd shifts for Q2 2020 | K 712 | A. On 3/26/21 fire drills were conducted for each shift.<br>B. Current residents had the potential to be affected.<br>C. On 3/24/21 Administrator re-educated Maintenance Director on conducting fire drills once a shift per quarter and maintaining documentation of such drills. On 3/25/21 Maintenance Director created yearly calendar of fire drills to ensure fire drills to be conducted once a shift per quarter. | 4/5/21 |

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| K 712 | Continued From page 9<br><br>2) 1st and 3rd shifts for Q3 2020<br>3) All shifts for Q4 2020<br><br>An interview was conducted with the Regional Maintenance Director and the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>Per NFPA 101 (2018 Edition) 19.7.1.6, 19.7.1.7<br><br>Class III | K 712 | D. Administrator/designee to conduct quality monitors of fire drills conducted and documented monthly for 3 months, to ensure substantial compliance of K712. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 741 SS=D | NFPA 101 Smoking Regulations<br><br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. | K 741 | | 4/5/21 |

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| (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 |
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| K 741 | Continued From page 10<br><br>18.7.4, 19.7.4<br>(Note smoking tower disposal receptacles are not ashtrays)<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview with the Regional Maintenance Director, the facility failed to maintain the required equipment in the resident and employee smoking areas.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director between 03/03/2021 to 03/04/2021, and between 9:00 a.m. and 3:30 p.m., it was found in the resident and employee smoking areas that:<br>1) The facility failed to provide ashtrays of non-combustible material and of safe design<br>2) The facility failed to provide metal containers equipped with self-closing cover devices to empty ashtrays into<br>3) Cigarette butts were also observed in combustible trash cans in both smoking areas<br><br>An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2018 edition) 197.4(5)(6)<br><br>Class III | K 741 | A. 1. On 3/22/21 non-combustible material self-closing ashtrays were purchased and provided for resident and staff smoking areas. 2. Self-closing metal containers clearly marked for cigarette butts only to empty ashtrays into will be provided for resident and staff smoking areas by 4/2/21. 3. On 3/25/21 combustible trash cans were clearly marked for trash only in resident and staff smoking areas.<br>B. Current smoking residents and staff have the potential to be affected.<br>C. SDC/designee will re-educate staff by 04/01/21 on use of proper self-closing non-combustible ashtrays, self-closing metal containers to empty ashtrays into, and combustible trash cans to be used for trash only.<br>D. Maintenance Director/designee to complete quality monitors for noncombustible material self-closing ashtrays, self-closing metal containers for cigarette butts, and combustible trash cans for trash only daily Monday – Friday for 2 weeks, then weekly for 10 weeks, then monthly to ensure substantial compliance of K741. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |

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|---|---|---|---|
| | 55229 | A. BUILDING: **05 - MAIN LIC** B. WING _____ | **03/04/2021** |

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| **BALANCED HEALTHCARE** | **4250 66TH ST N SAINT PETERSBURG, FL 33709** |

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| K 761 | Continued From page 11 | K 761 | | |
| K 761 SS=D | NFPA 101 Maintenance Inspection & Testing - Doors<br><br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (NFPA 101)<br>5.2, 5.2.3 (NFPA 80)<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview with the Maintenance Director during document review and the facility tour, it was observed that the facility failed to maintain the fire rated attic access doors.<br><br>Findings included:<br><br>During the facility record review, and interview with the Regional Maintenance Director and the Maintenance Director between 03/03/2021 to 03/04/2021, and between 09:00 a.m. and 3:30 p.m., it was observed that the facility provided no evidence for the annual inspection of the fire rated attic access doors. In an interview with the Maintenance Director, they had said there were a total of 30 doors in the building.<br><br>per NFPA 1 (2018 edition) 12.4.6.8.4.1, 12.4.6.8.4.2, 12.4.6.8.4.3 | K 761 | A. On 03/25/21 the fire rated attic access doors were inspected and documented.<br>B. Current residents had the potential to be affected.<br>C. On 03/24/21 Administrator re-educated Maintenance Director on requirement for annual inspection of fire rated attic access doors.<br>D. Maintenance Director/designee to conduct quality monitor of documentation of inspection of fire rated attic access doors monthly for 3 months to ensure substantial compliance of L761. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | 4/5/21 |

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| | 55229 | A. BUILDING: **05 - MAIN LIC** B. WING _____ | **03/04/2021** |

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| K 761 | Continued From page 12<br><br>Class III | K 761 | | |
| K 914 SS=D | NFPA 99 Electrical Systems - Maintenance and Testing<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview with the Regional Maintenance Director, the facility failed to test receptacles and or provide documented performance data for receptacles located in patient care rooms and bed locations.<br><br>Findings included:<br><br>During the facility record review with the Regional | K 914 | A. On 3/25/21 annual receptacle testing completed and documented.<br>B. Current residents had the potential to be affected.<br>C. On 3/24/21 Administrator re-educated Maintenance Director on requirement for electric receptacles to be tested annually and documented.<br>D. Maintenance Director to conduct | 4/5/21 |

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| | 55229 | A. BUILDING: **05 - MAIN LIC**<br>B. WING _____ | **03/04/2021** |

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| K 914 | Continued From page 13<br><br>Maintenance Director between 03/03/2021 to 03/04/2021, and between 09:30 a.m. and 3:30 p.m., the facility failed to provide evidence of annual no evidence of annual receptacle inspection and testing was provided. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 99 (2018 Edition) 6.3.3.2, 6.3.4.1.1<br><br>Class III | K 914 | quality monitoring of annual testing of electric receptacle and documentation monthly for 3 months to ensure substantial compliance of K914. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |

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| | 105390 | A. BUILDING _____ B. WING _____ | 03/04/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BALANCED HEALTHCARE | 4250 66TH ST N SAINT PETERSBURG, FL 33709 |

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| E 000 | Initial Comments<br><br>During the recertification survey conducted from 03/03/2021 to 03/04/2021 at Balanced Health Care, a nursing home, Emergency Preparedness was reviewed. Balanced Health Care is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.<br><br>The following is a description of the noncompliance. | E 000 | | |
| E 004 SS=D | Develop EP Plan, Review and Update Annually<br>CFR(s): 483.73(a)<br><br>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.<br><br>The emergency preparedness program must include, but not be limited to, the following elements:<br><br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive | E 004 | | 4/5/21 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/26/2021 |

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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| | 105390 | A. BUILDING _____ B. WING _____ | 03/04/2021 |

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| E 004 | Continued From page 1<br>emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.<br><br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview with the Regional Maintenance Director, the facility failed to update and review their Emergency Preparedness Program (EPP) on an annual basis.<br><br>Findings included:<br><br>During the facility record review with the Regional Maintenance Director on 03/03/2021 between the hours of 09:30 a.m. and 12:00 p.m., it was observed that the facility failed to provide the annual review and update of their EPP, as the most recent update and review was performed on 01/17/2019. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per 42 CFR 483.73(a) | E 004 | A. The Emergency Preparedness Program will be updated and reviewed by 04/05/21.<br>B. No other concerns identified.<br>C. On 03/15/21 Administrator re-educated Maintenance Director on policy to update and review Emergency Preparedness Program annually.<br>D. Administrator/designee will conduct quality monitors for the update and review of the Emergency Preparedness Program monthly for three months to ensure compliance with E004. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |

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| | 105390 | A. BUILDING **01 - MAIN FED**<br>B. WING _____ | **03/04/2021** |

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| K 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted 03/03-04/2021 at Balanced Health Care, a nursing home in St. Petersburg, Florida. Balanced Health Care is not in compliance with 42 CFR 483.90(a) and National Fire Protection Association (NFPA) 101(2012 edition) requirements for nursing homes.<br><br>Initial Plan Review: 1975<br>Existing<br>NFPA 220 Construction Type: II (111)<br>Number of beds: 299<br>Census: 215<br><br>The following is a description of the noncompliance. | K 000 | | |
| K 222 SS=D | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS | K 222 | | 4/5/21 |

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| K 222 | Continued From page 1<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. | K 222 | | |

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| | 105390 | A. BUILDING **01 - MAIN FED**<br>B. WING _____ | **03/04/2021** |

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| K 222 | Continued From page 2<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the Maintenance Director, the facility failed to maintain delayed egress doors.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director and the Maintenance Director between 03/03/2021 and 03/04/2021, and between 9:00 a.m. and 3:30 p.m., the facility failed to properly identify the delayed egress doors with required signage on the doors throughout the facility. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2012 edition) 19.2.2.2.1, 7.2.1.6.1.1(4) | K 222 | A. On 3/10/21 delayed egress doors were identified, and delayed egress signage placed on doors.<br>B. Maintenance Director/designee conducted a quality monitor of egress doors for signage on 3/10/21 and identified doors were provided delayed egress signage.<br>C. On 03/15/21 Administrator re-educated maintenance department on delayed egress signage for egress doors.<br>D. Maintenance Director/designee to conduct quality monitors for delayed egress signage on egress doors weekly for 4 weeks, then monthly for 2 months. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 223 SS=D | Doors with Self-Closing Devices<br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and | K 223 | | 4/5/21 |

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| K 223 | Continued From page 3<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the Regional Maintenance Director and the Maintenance Director, the facility failed to maintain doors with self closing devices.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director and the Maintenance Director from 03/03/2021 to 03/04/2021 between 9:00 a.m. and 3:00 p.m., it was observed that the following self closing doors failed to close and latch when tested:<br>1) Exit door from Lifestyle soiled utility room<br>2) Private office door in Lifestyle 1 dining room<br>3) Men's restroom door by elevator<br>4) Lifestyle 1 dining room stairwell exit door<br>5) Housekeeping door in Lifestyle 2<br>6) 1 of 2 door leafs of the 2nd floor dining room entry doors<br>7) 2-West exit door from stairwell at ground level<br><br>An interview was conducted with the Regional Maintenance Director and the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2012 Edition) 19.7.6, 4.6.12, 8.3.3.1, 8.5.4.1<br>per NFPA 80 (2010 Edition) 6.1.4.2.1 | K 223 | A. Self-closing doors on Lifestyle soiled utility room exit door scheduled to be replaced on 4/28/21, private office door Lifestyle 1 dining room was repaired on 03/08/21, men's restroom door by elevator door closure removed on 3/5/21, Lifestyle 1 dining room stairwell exit door replaced key pad latch on 03/11/21, housekeeping door in Lifestyle 2 repaired 03/05/21, door leafs of the 2nd floor dining room entry doors adjusted 03/09/21, and 2 west exit door from stairwell at ground level new door closure installed 03/25/21.<br>B. On 3/24/21 Maintenance Director conducted quality monitor of self-closing doors for closing and latching. Any identified concerns were repaired on 3/24/21.<br>C. On 3/15/21 Administrator re-educated maintenance staff on preventative maintenance of self-closing doors for proper closing and latching.<br>D. Maintenance Director/designee to conduct quality monitors for proper closing and latching of self-closing doors two times a week for 4 weeks, then weekly for 12 weeks. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 291<br>SS=D | Emergency Lighting<br>CFR(s): NFPA 101 | K 291 | | 4/5/21 |

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| | 105390 | A. BUILDING **01 - MAIN FED**<br>B. WING _____ | **03/04/2021** |

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| K 291 | Continued From page 4<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview with the Regional Maintenance Director, the facility failed to maintain emergency battery backup lighting.<br><br>Findings included:<br><br>During the facility record review with the Regional Maintenance Director on 03/03/2021 between 9:30 a.m. and 12:00 p.m., the facility failed to provide evidence of monthly and annual testing of emergency lights equipped with battery backups. During the facility tour with the Regional Maintenance Director on 03/03/2021 between 12:50 p.m. and 3:00 p.m., the emergency lights located in the generator room failed to operate when tested. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2012 Edition) 19.2.9.1, 4.5.8, 7.9.2.6, 7.9.3.1.1(1)(3)(5) | K 291 | A. On 3/8/21 The emergency lights located in the generator room were replaced.<br>B. On 3/3/21 Maintenance Director conducted quality monitor on emergency back up lighting for function. There were no other emergency back-up lights identified.<br>C. On 03/15/21 Administrator re-educated maintenance staff on preventative maintenance monitoring of emergency back-up lighting monthly and annually.<br>D. Maintenance Director/designee will conduct quality monitors of operation of emergency back-up lighting weekly for 4 weeks, then monthly for 2 months, with follow-up initiated as needed to ensure substantial compliance with K291. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 325 SS=D | Alcohol Based Hand Rub Dispenser (ABHR)<br>CFR(s): NFPA 101<br><br>Alcohol Based Hand Rub Dispenser (ABHR)<br>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:<br>* Corridor is at least 6 feet wide | K 325 | | 4/5/21 |

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| | 105390 | A. BUILDING **01 - MAIN FED**<br>B. WING _____ | **03/04/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BALANCED HEALTHCARE** | **4250 66TH ST N**<br>**SAINT PETERSBURG, FL 33709** |

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| K 325 | Continued From page 5<br>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols<br>* Dispensers shall have a minimum of 4-foot horizontal spacing<br>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room<br>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30<br>* Dispensers are not installed within 1 inch of an ignition source<br>* Dispensers over carpeted floors are in sprinklered smoke compartments<br>* ABHR does not exceed 95 percent alcohol<br>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)<br>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the Regional Maintenance Director, the facility failed to maintain the maximum storage limits of alcohol based hand rub (ABHR) per compartment.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director between 03/03/2021 to 03/04/2021, and between 9:00 a.m. and 3:30 p.m., it was observed that the facility had 40 gallons of ABHR stored in Room 107. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings. | K 325 | A. On 03/04/21 alcohol based hand rub was removed and stored to not exceed number of gallons per storage area.<br>B. On 3/5/21 Housekeeping Director/designee completed quality monitor of alcohol-based hand rub for required storage amounts. No other issues identified.<br>C. Housekeeping Director/designee will re-educate housekeeping staff on storage of alcohol-based hand rub by 04/01/21.<br>D. Housekeeping Director/designee to conduct quality monitors of storage of alcohol-based hand rub 3 times a week for 4 weeks, then weekly for 8 weeks, then monthly to ensure substantial | |

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| K 325 | Continued From page 6<br>per NFPA 101 (2012 edition) 19.3.2.6, 8.7.3.1 | K 325 | compliance of K325. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 541 SS=D | Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101<br><br>Rubbish Chutes, Incinerators, and Laundry Chutes<br>2012 EXISTING<br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.<br>19.5.4, 9.5, 8.4, NFPA 82<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the Maintenance Director, the facility failed to maintain the laundry chute intake doors. | K 541 | A. On 3/5/21 latches were removed from laundry chutes to ensure closing.<br>B. On 3/5/21 Maintenance Director completed quality monitor of laundry | 4/5/21 |

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| K 541 | Continued From page 7<br>Findings included:<br><br>During the facility tour with the Maintenance Director from 03/03/2021 - 03/04/2021 between 9:00 a.m. and 3:30 p.m., it was observed that 4 of 4 laundry chute fire rated intake doors failed to be self-closing, as they were found in the open position secured by non-approved methods. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>(Photographic evidence obtained)<br><br>per NFPA 101 (2012 edition) 19.3.1, 8.6.1, 8.6.2, 9.5.2<br>per NFPA 82 (2009 edition) 5.2.3.3.1.1, 5.2.3.3.2.1 | K 541 | chutes for proper closing and no other concerns identified.<br>C. On 03/15/21.Administrator re-educated maintenance staff on maintaining laundry chutes closure.<br>D. Maintenance Director/designee to complete quality monitors for proper closing of laundry chutes daily for 2 weeks, then 3 times a week for 10 weeks, then monthly to ensure substantial compliance of K541. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 712 SS=D | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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 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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview with the Regional Maintenance Director and the Maintenance Director, the facility failed to conduct | K 712 | A. On 3/26/21 fire drills were conducted for each shift.<br>B. Current residents had the potential to | 4/5/21 |

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| K 712 | Continued From page 8<br>fire drills as required by NFPA 101 or provide evidence of documented orientation training related to the current fire plan in lieu of conducting fire drills as per CMS QSO-20-31-All.<br><br>Findings included:<br><br>During the facility record review with the Regional Maintenance Director between 03/03/2021 and 03/04/2021, and between 9:00 a.m. and 3:30 p.m., the facility failed to conduct fire drills or orientation training for:<br>1) 2nd and 3rd shifts for Q2 2020<br>2) 1st and 3rd shifts for Q3 2020<br>3) All shifts for Q4 2020<br><br>An interview was conducted with the Regional Maintenance Director and the Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 101 (2012 Edition) 19.7.1.6, 19.7.1.7<br>CMS QSO-20-31-All | K 712 | be affected.<br>C. On 3/24/21 Administrator re-educated Maintenance Director on conducting fire drills once a shift per quarter and maintaining documentation of such drills. On 3/25/21 Maintenance Director created yearly calendar of fire drills to ensure fire drills to be conducted once a shift per quarter.<br>D. Administrator/designee to conduct quality monitors of fire drills conducted and documented monthly for 3 months, to ensure substantial compliance of K712. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 741<br>SS=D | Smoking Regulations<br>CFR(s): NFPA 101<br><br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all | K 741 | | 4/5/21 |

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| K 741 | Continued From page 9<br>major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the Regional Maintenance Director, the facility failed to maintain the required equipment in the resident and employee smoking areas.<br><br>Findings included:<br><br>During the facility tour with the Regional Maintenance Director between 03/03/2021 to 03/04/2021, and between 9:00 a.m. and 3:30 p.m., it was found in the resident and employee smoking areas that:<br>1) The facility failed to provide ashtrays of non-combustible material and of safe design<br>2) The facility failed to provide metal containers equipped with self-closing cover devices to empty ashtrays into<br>3) Cigarette butts were also observed in combustible trash cans in both smoking areas<br><br>An interview was conducted with the Regional Maintenance Director concurrent with the | K 741 | A. 1. On 3/22/21 non-combustible material self-closing ashtrays were purchased and provided for resident and staff smoking areas. 2. Self-closing metal containers clearly marked for cigarette butts only to empty ashtrays into will be provided for resident and staff smoking areas by 4/2/21. 3. On 3/25/21 combustible trash cans were clearly marked for trash only in resident and staff smoking areas.<br>B. Current smoking residents and staff have the potential to be affected.<br>C. SDC/designee will re-educate staff by 04/01/21 on use of proper self-closing non-combustible ashtrays, self-closing metal containers to empty ashtrays into, and combustible trash cans to be used for trash only.<br>D. Maintenance Director/designee to complete quality monitors for noncombustible material self-closing | |

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| K 741 | Continued From page 10<br>observations and confirmed the findings.<br><br>per NFPA 101 (2012 edition) 19.7.4(5)(6) | K 741 | ashtrays, self-closing metal containers for cigarette butts, and combustible trash cans for trash only daily Monday – Friday for 2 weeks, then weekly for 10 weeks, then monthly to ensure substantial compliance of K741. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 761 SS=D | Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the Maintenance Director during document review and the facility tour, it was observed that the facility failed to maintain the fire rated attic access doors.<br><br>Findings included: | K 761 | A. On 03/25/21 the fire rated attic access doors were inspected and documented.<br>B. Current residents had the potential to be affected.<br>C. On 03/24/21 Administrator re-educated Maintenance Director on requirement for annual inspection of fire rated attic access doors. | 4/5/21 |

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| K 761 | Continued From page 11<br>During the facility record review, and interview with the Regional Maintenance Director and the Maintenance Director between 03/03/2021 to 03/04/2021, and between 09:00 a.m. and 3:30 p.m., it was observed that the facility provided no evidence for the annual inspection of the fire rated attic access doors. In an interview with the Maintenance Director, they had said there were a total of 30 doors in the building.<br><br>per NFPA 1 (2012 edition) 12.4.6.6, 12.4.6.9 | K 761 | D. Maintenance Director/designee to conduct quality monitor of documentation of inspection of fire rated attic access doors monthly for 3 months to ensure substantial compliance of L761. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |
| K 914<br>SS=D | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by: | K 914 | | 4/5/21 |

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| K 914 | Continued From page 12<br>Based on record review and interview with the Regional Maintenance Director, the facility failed to test receptacles and or provide documented performance data for receptacles located in patient care rooms and bed locations.<br><br>Findings included:<br><br>During the facility record review with the Regional Maintenance Director between 03/03/2021 to 03/04/2021, and between 09:30 a.m. and 3:30 p.m., the facility failed to provide evidence of the annual receptacle inspection and testing. An interview was conducted with the Regional Maintenance Director concurrent with the observations and confirmed the findings.<br><br>per NFPA 99 (2012 edition) 6.3.3.2, 6.3.4.1.3 | K 914 | A. On 3/25/21 annual receptacle testing completed and documented.<br>B. Current residents had the potential to be affected.<br>C. On 3/24/21 Administrator re-educated Maintenance Director on requirement for electric receptacles to be tested annually and documented.<br>D. Maintenance Director to conduct quality monitoring of annual testing of electric receptacle and documentation monthly for 3 months to ensure substantial compliance of K914. Findings and trends will be brought to QAPI for review. Quality Monitoring and schedule modified based on findings and trends to ensure compliance is achieved and maintained. | |