

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

PRINTED: 06/23/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105520</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01, 05</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/13/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>CONSULATE HEALTH CARE OF BRANDON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>701 VICTORIA ST BRANDON, FL 33510</b>	
(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 the Recertification survey conducted on 05/13/2021 at Consulate Health Care of Brandon, a nursing home, Emergency Preparedness was reviewed. Consulate Health Care of Brandon is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73 Requirement for Long-Term Care Facilities.  The following is a description of the noncompliance.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)  §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:  (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015		6/11/21

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

TITLE

(X6) DATE

Electronically Signed

06/07/2021

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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E 015	<p>Continued From page 1</p> <p>safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and interview, the facility failed to incorporate into their Emergency Preparedness Program (EP) the policy and procedures for subsistence needs for staff and patients. The program did not completely incorporate provisions for maintaining temperatures in the event of the loss of the local utility.</p>	E 015	<p>The facility's Federal Emergency Preparedness Plan (Fed EPP) will be updated with documentation identifying the new 60kW generator that powers the Heating, Ventilation, and Air Conditioning (HVAC) for the 100 &amp; 200 hall resident rooms.</p> <p>There is only one required Fed EPP,</p>		

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E 015	Continued From page 2  Findings include: On 05/13/2021 at 9:15 a.m. during record review, the facility failed to identify the new 60 kW generator that powers the Heating, Ventilation, and Air Conditioning (HVAC) for the 100 & 200 hall resident rooms into their emergency power plan. An interview was conducted with the maintenance director concurrent with the record review and confirmed the findings.  per CFR 42, part 483.73(1)(a)	E 015	therefore no additional reviews were needed.  The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73(b)(1)- Subsistence Needs for Staff and Patients specific to including documentation identifying the new 60kW generator that powers the Heating, Ventilation, and Air Conditioning (HVAC) for the 100 & 200 hall resident rooms., and will continue to monitor in accordance with the standard.  Any findings will be reported to the monthly QAPI Committee for further review.	
E 023 SS=F	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5)  §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).  [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the	E 023		6/11/21

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E 023	<p>Continued From page 3</p> <p>policies and procedures must address the following:]</p> <p>[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.</p> <p>*[For RNHCs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following:</p> <p>(i) Preserves patient information.</p> <p>(ii) Protects confidentiality of patient information.</p> <p>(iii) Secures and maintains the availability of records.</p> <p>*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview with the maintenance director, the facility failed to incorporate Emergency Preparedness Program (EPP) policies and procedures for the preservation, protection, and transfer of patient records including the security and availability of those records. This in the event of an emergency including an emergency requiring an evacuation would leave caregivers without the information necessary to provide for the medical needs of the patient and would leave the patients personal health information vulnerable to unauthorized access.</p> <p>Findings included:</p>	E 023	<p>The facility's Fed EPP will be updated with documentation of a plan that preserves patient information, protects confidentiality, and secures and maintains availability of records.</p> <p>There is only one required Fed EPP, therefore no additional reviews were needed.</p> <p>The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73(b)(5)- Policies/ Procedures for Medical Documentation specific to</p>	

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E 023	Continued From page 4  On 05/13/2021 at 9:15 a.m. while reviewing the facility's EPP, there was no plan for preserving patient information, confidentiality, and providing for the availability of records. An interview was conducted with the maintenance director concurrent with the record review and confirmed the findings.  per 42 CFR 483.73(b)(5)	E 023	maintaining documentation of a plan that preserves patient information, protects confidentiality, and secures and maintains availability of records, and secures and maintains availability of records, and will continue to monitor in accordance with the standard.  Any findings will be reported to the monthly QAPI Committee for further review.	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1)  §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).  [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]  (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.  *[For Hospitals at §482.15(c) and CAHs at	E 030		6/11/21

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E 030	<p>Continued From page 5</p> <p>§485.625(c)] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians</p> <p>(iv) Other [hospitals and CAHs].</p> <p>(v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Next of kin, guardian, or custodian.</p> <p>(iv) Other RNHCIs.</p> <p>(v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Hospice employees.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p>	E 030			

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E 030	<p>Continued From page 6</p> <p>(iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p> <p>(2) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Volunteers.</p> <p>(iv) Other OPOs.</p> <p>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview with the maintenance director, the facility failed to provide a communication plan in their Emergency Preparedness Program (EPP) that included the names and contact information of staff and residents' physicians. This in the event of an emergency would leave residents vulnerable from the lack of medical and support staffing particularly during a transfer of the residents to other facilities.</p> <p>Findings included:</p> <p>On 05/13/2021 at 9:15 a.m. while reviewing the facility's EPP, there was no list of staff and physician contact information. An interview was</p>	E 030	<p>The facility's Fed EPP will be updated with documentation of staff and physician contact information.</p> <p>There is only one required Fed EPP, therefore no additional reviews were needed.</p> <p>The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- Names and Contact Information specific to maintaining documentation of staff and physician contact information, and will continue to monitor in accordance with the standard.</p>	

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E 030	Continued From page 7 conducted with the maintenance director concurrent with the record review and confirmed the findings.	E 030	Any findings will be reported to the monthly QAPI Committee for further review.	6/11/21	
K 000	per 42 CFR 483.73(c)(1)(i)(iii) INITIAL COMMENTS  An unannounced Fire & Life Safety recertification survey was conducted 05/13/2021 at Consulate Health Care of Brandon, a nursing home in Brandon, Florida. The Facility is not in compliance with 42 CFR 483.90 (a), and National Fire Protection Association (NFPA) 101 (2012 edition), NFPA 99 (2012 edition) requirements for nursing homes.  Initial Plan Review: 2005 New or Existing: Existing NFPA 220 Construction Type: II (211) Number of beds: 120 Census: 113  The following is a description of the noncompliance.	K 000			
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101  Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	K 200			



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K 200	Continued From page 8  This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain exit doors in accordance with NFPA 101. Failure to maintain exit doors in an emergency could allow smoke/fire to enter the building.  The findings include: On 05/13/2021 between the hours of 12:45 p.m. and 4:15 p.m. during the facility tour with the maintenance director, it was found that exit doors located by rooms 114, 216, and the administrator's office were found with the door latch locked in the open position preventing the doors from latching when in the closed position.  An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.  per NFPA 101 (2012 Edition) 19.2.2.2.1, 7.2.1.5.10  (Photographic Evidence Obtained)	K 200	The exit doors located by rooms 114, 216, and the administrator's office noted to not be latching when in the closed position will be corrected.  Additional exit doors will be reviewed for proper latching in the closed position.  The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Means of Egress Requirements- Other specific to maintaining exit doors to properly latch in the closed position, and will continue to monitor in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.	
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101  Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		6/11/21

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K 211	Continued From page 9 by: Based on observation and interview, the facility failed to maintain egress pathways free from obstructions in accordance with NFPA 101. Barriers placed in exit corridors could impede the egress of building occupants in an emergency.  Findings include: 1) On 05/13/2021 between the hours of 12:45 p.m. and 4:15 p.m. overgrown vegetation was observed blocking the clear means of egress from the west Victoria exit. 2) It was also observed that the 300 corridor was obstructed by plastic barriers attached to the corridor walls and ceiling with duct tape.  An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. In addition, the maintenance director stated that the facility did not have interim life safety measures in place and did not know if the plastic barrier was of fire rated material.  per NFPA 101 (2012 Edition) 19.2.1, 7.1.10.1, 7.5.1.1, 4.6.10  (Photographic Evidence Obtained)	K 211	The overgrown vegetation observed blocking the clear means of egress from the west Victoria exit will be corrected. The plastic barriers noted to be obstructing the 300 corridor were removed.  Additional means of egress will be reviewed for blockage by vegetation, and additional corridors will be reviewed for being obstructed by plastic barriers.  The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Means of Egress- General specific to maintaining means of egress and corridors free of obstructions, and will continue to monitor in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.	
K 224 SS=D	Horizontal Sliding Doors CFR(s): NFPA 101  Horizontal-Sliding Doors Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of	K 224		6/11/21

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K 224	<p>Continued From page 10</p> <p>the following criteria are met:</p> <ul style="list-style-type: none"> <li>o Area served by the door has no high hazard contents.</li> <li>o Door is operable from either side without special knowledge or effort.</li> <li>o Force required to operate the door in the direction of travel is less than or equal to 30 lbf to set the door in motion and less than or equal to 15 lbf to close or open to the required width.</li> <li>o Assembly is appropriately fire rated, and where rated, is self-closing or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80.</li> <li>o Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound.</li> </ul> <p>19.2.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain horizontal sliding doors in accordance with NFPA 101.</p> <p>Findings include: On 05/13/2021 between the hours of 12:45 p.m. and 4:15 p.m. the right leaf of the front horizontal sliding doors failed to open without excessive force when the emergency release function was demonstrated by the Maintenance Director.</p> <p>An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2012 Edition) 19.2.2.2.1, 7.2.1, 7.2.1.5, 7.2.1.4.5.1</p>	K 224	<p>The right leaf of the front horizontal sliding doors that failed to open without excessive force when the emergency release function was demonstrated will be corrected.</p> <p>The facility only has one set of horizontal sliding doors, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Horizontal Sliding Doors specific to maintaining proper function of the front horizontal sliding doors, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further</p>	

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K 224	Continued From page 11	K 224		
K 353 SS=D	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the automatic sprinkler system in accordance with NFPA 101.</p> <p>Findings include: On 05/13/2021 during the facility tour between the hours of 12:45 p.m. and 4:15 p.m. it was observed that:</p> <p>1) 6 of 6 sprinklers were loaded with foreign material in the drive through canopy and front porch entry</p> <p>2) 3 of 5 sprinklers were loaded with lint in the laundry area</p>	K 353	<p>review.</p> <p>The sprinklers noted to be loaded with foreign material in the drive through canopy, front porch entrance, in the laundry area, and on the Victoria lobby porch will be corrected.</p> <p>Additional sprinkler heads will be reviewed for loading.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Sprinkler System- Maintenance and Testing specific</p>	6/11/21

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K 353	Continued From page 12 3) 4 of 4 sprinklers loaded foreign materials on the Victoria lobby porch  An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.  per NFPA 101 (2012 Edition) 19.3.5, 19.3.5.1, 9.7, 9.7.5 per NFPA 25 (2011 Edition) 5.2.1, 5.2.1.1.1, 5.2.1.1.2 (5), 5.2.1.1.4	K 353	to maintaining sprinkler heads free of loading, and will continue to monitor in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the continuity of smoke barrier construction in accordance with NFPA 101.  Findings include: On 05/13/2021 during the facility tour between the hours of 12:45 p.m. and 4:15 p.m. smoke barrier penetrations were observed in the following	K 372	The smoke barrier penetrations noted in the wall in Social Services, the 400 hall medication room, the nurses charting room penetration by doorknob, Dietary dry storage, the Maintenance office storage room, and in the ceiling above the generator annunciator panel will be corrected utilizing listed and rated fire	6/11/21

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K 372	Continued From page 13 areas: 1) Wall in Social Services 2) 400 hall medication room 3) Nurses charting room penetration by door knob 4 Dietary dry storage 5) Maintenance office storage room 6) Employee lounge had a recessed electrical outlet with no cover with refrigerator plugged into it 7) In ceiling above generator annunciator panel - unsealed penetrations  An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.  Per NFPA 101 (2012 Edition) 19.3.7.3, 8.5, 8.5.1, 8.5.2	K 372	stopping materials. The missing outlet cover noted on the recessed outlet in the Employee lounge with refrigerator plugged into it will be replaced.  Additional smoke barriers will be reviewed for unsealed penetrations and outlets missing covers.  The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Subdivision of Building Spaces- Smoke Barrier Construction specific to properly sealing smoke barrier penetrations, and maintaining proper covers on electrical outlets, and will continue to monitor in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.		
K 521 SS=D	HVAC CFR(s): NFPA 101  HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2  This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility	K 521	The improperly vented portable spot	6/11/21	

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K 521	<p>Continued From page 14</p> <p>failed to maintain the Heating, Ventilation, and Air Conditioning (HVAC) system in accordance with NFPA 101.</p> <p>The findings include:</p> <p>On 05/13/2021 between 12:45 p.m. and 4:15 p.m. during the facility tour with the maintenance director, it was observed that the facility had installed a portable spot cooler in the facility maintenance office. Further investigation revealed the facility attached the air duct to exhaust the air through the suspended ceiling into the interstitial space between the suspended ceiling and the drywall.</p> <p>An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2012 Edition) 19.5.2, 9.2, 4.6.12.1 per NFPA 90A (2012 Edition) 4.2.4, 4.3.1, 4.3.11.2.1 per NFPA 90B (2012 Edition) 4.3.7</p> <p>(Photographic evidence obtained)</p>	K 521	<p>cooler noted in the Maintenance office was removed.</p> <p>There was only one portable spot cooler in use at the facility, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 HVAC specific to properly venting portable spot coolers when in use, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>		
K 914 SS=D	<p>Electrical Systems - Maintenance and Testing</p> <p>CFR(s): NFPA 101</p> <p>Electrical Systems - Maintenance and Testing</p> <p>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</p>	K 914			6/11/21

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K 914	<p>Continued From page 15</p> <p>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.</p> <p>6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain the electrical receptacles in accordance with NFPA 101.</p> <p>Findings include:</p> <p>On 05/13/2021 between the hours of 9:15 a.m. and 11:30 p.m., record review revealed that the last annual receptacle test was completed sometime in 2019, no actual date noted.</p> <p>An interview was conducted with the maintenance director concurrent with the record review and confirmed the findings.</p> <p>per NFPA 99 (2012 Edition) 6.3.4.1, 6.3.4.1.3</p> <p>(Photographic evidence obtained)</p>	K 914	<p>The annual receptacle test will be completed and properly dated.</p> <p>There is only one required annual receptacle test, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Electrical Systems- Maintenance and Testing specific to completing and properly dating the receptacle testing annually. This item will be added to the facility's TELS Preventative Maintenance (PM) Calendar, and will continue to be monitored in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>	



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N 132 SS=I	<p>59A-4.1265 FAC Emergency Environmental Control</p> <p>59A-4.1265 Emergency Environmental Control for Nursing Homes.</p> <p>(1) DETAILED NURSING HOME EMERGENCY POWER PLAN. Each nursing home shall prepare a detailed plan ("plan"), to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency power in the event of the loss of primary electrical power in that nursing home, which includes the following information:</p> <p>(a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the nursing home, to ensure that current licensees of nursing homes will be equipped to ensure the protection of resident health, safety, welfare, and comfort for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. Safe indoor air temperatures in resident occupied areas shall be determined by the licensee to meet the clinical needs of residents, but shall not exceed eighty-one (81) degrees Fahrenheit.</p> <p>1. The required temperature must be maintained in an area or areas determined by the nursing home of sufficient size to maintain all residents safely at all times and is appropriate for the care needs and life safety requirements. For planning purposes, no less than thirty (30) net square feet per resident must be provided. This may include areas that are less than the entire nursing home if the nursing home's comprehensive emergency management plan includes relocating residents to portions of the building where the health, safety, welfare, and comfort of the residents will be maintained as required by this rule. The plan shall include information regarding the area(s) within the nursing home where the required temperature will be maintained.</p> <p>2. The alternate power source for the equipment necessary to maintain the safe indoor air</p>	N 132		6/11/21

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Electronically Signed

06/07/21

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N 132	<p>Continued From page 1</p> <p>temperature required by this rule may be provided by the essential electrical system required by the Florida Building Code for Nursing Home design and construction or onsite optional standby system as defined by NFPA 70 National Electrical Code supplying normal power to the nursing home maintained onsite at all times when the building is occupied. If an optional standby system is used, it must be connected and maintained in accordance with the manufacturer's recommendations. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.</p> <p>3. Each nursing home is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to maintain the safe indoor air temperature required by this rule for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the nursing home required to operate the systems and equipment.</p> <p>a. A nursing home in an evacuation zone pursuant to Chapter 252, F.S., must maintain an alternative power source and fuel as required by this subsection at all times when the facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.</p> <p>b. Facilities located on a single campus with other facilities licensed by the Agency under common ownership, may share fuel, alternative power resources, and resident space available on the</p>	N 132		

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N 132	<p>Continued From page 2</p> <p>campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan.</p> <p>c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage.</p> <p>(b) The acquisition of sufficient fuel, and safe maintenance of that fuel onsite at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source required in paragraph (1)(a), to power life safety systems, critical systems, and equipment necessary to maintain safe indoor air temperatures as described in this rule for ninety-six (96) hours after the loss of electrical power during a declared state of emergency. The plan shall include information regarding fuel source and fuel storage.</p> <p>1. A nursing home located in an area in a declared state of emergency area pursuant to Section 252.36, F.S., that may impact primary power delivery must secure ninety-six (96) hours of fuel. The nursing home may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency.</p> <p>2. A nursing home must store a minimum of seventy-two (72) hours of fuel onsite.</p> <p>3. Piped natural gas is an allowable fuel source and meets the onsite fuel requirement under this rule.</p>	N 132		

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N 132	<p>Continued From page 3</p> <p>4. If local ordinances or other regulations that limit the amount of onsite fuel storage for the nursing home's location and the nursing home does not have access to piped natural gas, then the nursing home must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel.</p> <p>(c) The acquisition of services necessary to install, maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source installed in the nursing home.</p> <p>(2) SUBMISSION OF THE PLAN.</p> <p>(a) Each nursing home licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review and approval within thirty (30) days of the effective date of the rule. Nursing Home plans previously received and approved under Emergency Rule 59AER17-1, F.A.C., will require resubmission only if changes are made.</p> <p>(b) Each new nursing home shall submit the plan required under this rule prior to obtaining a license.</p> <p>(c) Each existing nursing home that undergoes additions, modifications, alterations, refurbishment, reconstruction or renovations that require modification of the systems or equipment affecting the nursing home's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval.</p> <p>(3) PLAN REVIEW. Architectural and engineering plans are subject to review by the Agency's Office of Plans and Construction. The local emergency management agency shall review the emergency power plan for compliance with the subsection</p>	N 132		

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N 132	<p>Continued From page 4</p> <p>and may rely on the technical review of the Office of Plans and Construction. Once the review is complete, the local emergency management agency shall:</p> <p>(a) Report deficiencies in the plan to the nursing home for resolution. The nursing home must resubmit the plan within ten (10) business days.</p> <p>(b) Report approval or denial of the plan to the Agency and the nursing home.</p> <p>(4) APPROVED PLANS.</p> <p>(a) Each nursing home must maintain a copy of its plan in a manner that makes the plan readily available at the licensee's physical address for review by the authority having jurisdiction. If the plan is maintained in an electronic format, nursing home staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request.</p> <p>(b) Within two (2) business days of the approval of the plan from the local emergency management agency, the nursing home shall submit in writing proof of the approval to the Agency for Health Care Administration.</p> <p>(c) The nursing home shall submit a consumer friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the nursing home emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation.</p> <p>(5) IMPLEMENTATION OF THE PLAN.</p> <p>(a) Each nursing home licensed prior to the effective date of this rule shall, no later than June 1, 2018 have implemented the plan required under this rule.</p>	N 132		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CONSULATE HEALTH CARE OF BRANDON**

**701 VICTORIA ST  
BRANDON, FL 33510**

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N 132	<p>Continued From page 5</p> <p>(b) The Agency shall grant an extension up to January 1, 2019 to providers in compliance with paragraph (c), below, and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Nursing homes granted an extension must keep the Agency apprised of progress on a monthly basis to ensure there are no unnecessary delays.</p> <p>(c) During the extension period, a nursing home must make arrangements pending full implementation of its plan that the residents are housed in an area that meets the safe indoor air temperature requirements of paragraph (1)(a), for a minimum of ninety-six (96) hours.</p> <p>1. A nursing home not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the nursing home, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite.</p> <p>2. A nursing home located in an evacuation zone pursuant to Chapter 252, F.S., must either:</p> <p>a. Fully and safely evacuate its residents prior to the arrival of the event, or</p> <p>b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the nursing home,</p> <p>(d) Each new nursing home shall implement the plan prior to obtaining a license.</p> <p>(e) Each nursing home that undergoes any additions, modifications, alterations, refurbishment, reconstruction or renovations that</p>	N 132		

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N 132	<p>Continued From page 6</p> <p>require modification of the systems or equipment affecting the nursing home's compliance with this rule shall implement its amended plan subsequent with the completion of construction.</p> <p>(f) The Agency may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule.</p> <p>(6) POLICIES AND PROCEDURES.</p> <p>(a) Each nursing home shall develop and implement written policies and procedures to ensure that each nursing home can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall be resident-focused to ensure that residents do not experience complications from heat exposure, and shall include a contingency plan to transport residents to a safe facility if the current nursing home's plan to keep the residents in a safe and comfortable location within the nursing home at or below the indoor air temperature required by this rule becomes compromised.</p> <p>(b) Each nursing home shall maintain its written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by the authority having jurisdiction. If the policies and procedures are maintained in an electronic format, nursing home staff must be readily available to access the policies and procedures and produce the requested information.</p> <p>(c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and all parties authorized in writing or by law.</p>	N 132			

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N 132	<p>Continued From page 7</p> <p>(7) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency may seek any remedy authorized by Chapter 400, Part II, or Chapter 408, Part II, F.S., including but not limited to, license revocation, license suspension, and the imposition of administrative fines.</p> <p>(8) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.</p> <p>(a) Nursing homes whose comprehensive emergency management plan is to evacuate must comply with this rule.</p> <p>(b) Once the plan has been approved, the nursing home shall submit the plan as an addendum with any future submissions for approval of its Comprehensive Emergency Management Plan.</p> <p>(9) NOTIFICATION.</p> <p>(a) Within three (3) business days, each nursing home must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative:</p> <ol style="list-style-type: none"> <li>1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval;</li> <li>2. Upon final implementation of the plan by the nursing home following review by the State Fire Marshal or the Agency's Office of Plans and Construction.</li> </ol> <p>(b) The nursing home shall keep a copy of each written or electronic notification sent by the nursing home to the resident and resident's representative on file.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview with the maintenance director and administrator, it was revealed that the facility failed to provide a</p>	N 132	<p>The Emergency Environmental Control Plan (EECP) section of the facility's Comprehensive Emergency Management</p>	



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N 132	<p>Continued From page 8</p> <p>detailed plan, to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency power in the event of the loss of primary electrical power in facility.</p> <p>Findings included:</p> <p>On 05/13/2021 between 9:15 a.m. and 11:30 a.m., a review of the facility's Comprehensive Emergency Management Plan (CEMP) and the generator/cooling plan revealed the following:</p> <ol style="list-style-type: none"> <li>1) The facility failed to provide documentation that identified the cool zones in the building, and the net square footage of the areas to be used as cool zones for the residents and staff.</li> <li>2) The facility failed to provide documentation of how residents will be relocated to and within the cool zones.</li> <li>3) The facility failed to identify the use of spot coolers, the number of spot coolers required to cool the 300 and 400 patient areas.</li> <li>4) The facility failed to have spot coolers onsite.</li> <li>5) The facility failed to incorporate infectious control measures into their emergency power plan.</li> <li>6) The facility failed to ensure an on-site and trained individual was available during all shifts, to be able transfer power to the generator, to enable the HVAC cool zones via the manual transfer of power during an emergency.</li> </ol> <p>An interview was conducted with the maintenance director and administrator concurrent with the observations and confirmed the findings.</p> <p>per F.A.C. 59A-4.1265</p> <p>Class II</p>	N 132	<p>Plan (CEMP) will be updated with documentation to identify the cool zones in the building, the net square footage of the areas to be used as cool zones for the residents and staff, how residents will be relocated to and within the cool zones, the newly installed alternate power source for emergency heating and cooling, incorporation of infectious control measures, and trained on-site individuals available during all shifts to be able transfer power to the generator, to enable the HVAC cool zones via the manual transfer of power during an emergency.</p> <p>There is only one requirement for new generator project F.A.C. 59A-4.1265, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of F.A.C. 59A-4.1265 Emergency Environmental Control specific to properly maintaining documentation of the facility's EECOP and updating when needed. Annual Review of the facility's EECOP will be added to the facility's TELS PM Calendar, and will continue to be monitored in accordance with the standard.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>

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K 000 K 000	Continued From page 9  INITIAL COMMENTS  A re-licensure survey was conducted on 05/13/2021 at Consulate Health Care of Brandon, a nursing home in Brandon, 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.  Date Opened: 2005 Bldg. Type: II (211) Square Footage: 39,000 Smoke Compartments: 8 Floor Levels: 1 Generator: 80 kW, 60kW Licensed Bed: 120 Census: 113 Fully Sprinklered: Yes Fire Alarm: Yes, monitored  The following is description of the deficiencies found at the time of the visit.	K 000  K 000		
K 200 SS=D	NFPA 101 Means of Egress Requirements - Other  Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are	K 200		6/11/21

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K 200	<p>Continued From page 10</p> <p>deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included. 18.2, 19.2</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain exit doors in accordance with NFPA 101. Failure to maintain exit doors in an emergency could allow smoke/fire to enter the building.</p> <p>The findings include: On 05/13/2021 between the hours of 12:45 p.m. and 4:15 p.m. during the facility tour with the maintenance director, it was found that exit doors located by rooms 114, 216, and the administrator's office were found with the door latch locked in the open position preventing the doors from latching when in the closed position.</p> <p>An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2018 Edition) 19.2.2.2.1, 7.2.1.5.10</p> <p>Class III</p> <p>(Photographic Evidence Obtained)</p>	K 200	<p>The exit doors located by rooms 114, 216, and the administrator's office noted to not be latching when in the closed position will be corrected.</p> <p>Additional exit doors will be reviewed for proper latching in the closed position.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Means of Egress Requirements- Other specific to maintaining exit doors to properly latch in the closed position, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>		
K 211 SS=D	<p>NFPA 101 Means of Egress - General</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to</p>	K 211			6/11/21

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K 211	Continued From page 11  full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1  This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure egress pathways were free from obstructions in accordance with NFPA 101. Barriers placed in exit corridors could impede the egress of building occupants in an emergency.  Findings include: On 05/13/2021 between the hours of 12:30 p.m. and 4:15 p.m. the 300 corridor was found obstructed by plastic barriers attached to the corridor walls and ceiling with duct tape. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. In addition, the maintenance director stated that the facility did not have interim life safety measures in place and did not know if the plastic barrier was of fire rated material.  Per NFPA 101 (2018 Edition) 19.2.1, 7.1.10.1, 7.5.1.1, 4.6.10 Florida Administrative Code 59A-4.134(1)-(4) & Florida Building Code (2020) 7th edition Section 450.1.  Class III  (Photographic Evidence Obtained)	K 211	The overgrown vegetation observed blocking the clear means of egress from the west Victoria exit will be corrected. The plastic barriers noted to be obstructing the 300 corridor were removed.  Additional means of egress will be reviewed for blockage by vegetation, and additional corridors will be reviewed for being obstructed by plastic barriers.  The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Means of Egress- General specific to maintaining means of egress and corridors free of obstructions, and will continue to monitor in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.	
K 224 SS=D	NFPA 101 Horizontal Sliding Doors  Horizontal-Sliding Doors Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single	K 224		6/11/21

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K 224	<p>Continued From page 12</p> <p>leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>* Area served by the door has no hazards.</li> <li>* Door is operable from either side without special knowledge or effort.</li> <li>* Force required to operate the door in the direction of travel is less than or equal to 30 lbf to set the door in motion and less than or equal to 15 lbf to close or open to the required width.</li> <li>* Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80.</li> <li>* Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound.</li> </ul> <p>18.2.2.2.10, 19.2.2.2.10</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain horizontal sliding doors in accordance with NFPA 101.</p> <p>Findings include: On 05/13/2021 between the hours of 12:45 p.m. and 4:15 p.m. the right leaf of the front horizontal sliding doors failed to open without excessive force when the emergency release function was demonstrated by the Maintenance Director.</p> <p>An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2018 Edition) 19.2.2.2.1, 7.2.1, 7.2.1.5, 7.2.1.4.5.1</p> <p>Class III</p>	K 224	<p>The right leaf of the front horizontal sliding doors that failed to open without excessive force when the emergency release function was demonstrated will be corrected.</p> <p>The facility only has one set of horizontal sliding doors, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Horizontal Sliding Doors specific to maintaining proper function of the front horizontal sliding doors, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the</p>	

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K 224	Continued From page 13	K 224		
K 353 SS=D	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This Statute or Rule is not met as evidenced by: Based on record review, observation and, interview, the facility failed to maintain the automatic sprinkler system in accordance with NFPA 101.</p> <p>Findings include: On 05/13/2021 during the record review and the facility tour between the hours of 9:45 p.m. and 4:15 p.m. it was observed that: 1) 6 of 6 sprinklers were loaded with foreign material in the drive through canopy and front porch entry</p>	K 353	<p>monthly QAPI Committee for further review.</p> <p>The sprinklers noted to be loaded with foreign material in the drive through canopy, front porch entrance, in the laundry area, and on the Victoria lobby porch will be corrected.</p> <p>Additional sprinkler heads will be reviewed for loading.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Sprinkler</p>	6/11/21

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K 353	Continued From page 14  2) 3 of 5 sprinklers were loaded with lint in the laundry area 3) 4 of 4 sprinklers loaded with foreign material on the Victoria lobby porch 4) No evidence was produced for the 5-year hydrostatic test of the fire department connection (FDC)  An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.  per NFPA 101 (2018 Edition) 19.3.5, 19.3.5.1, 9.7, 9.7.1.1, 9.11.1 per NFPA 25 (2017 Edition) 5.2.1, 5.2.1.1.1 (5)  Class III	K 353	System- Maintenance and Testing specific to maintaining sprinkler heads free of loading, and will continue to monitor in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie  Subdivision of Building Spaces - Smoke Barrier Construction  2015 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.  2015 NEW Smoke barriers shall be constructed to provide at	K 372		6/11/21

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K 372	<p>Continued From page 15</p> <p>least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the continuity of smoke barrier construction in accordance with NFPA 101.</p> <p>Findings include: On 05/13/2021 during the facility tour between the hours of 12:45 p.m. and 4:15 p.m. penetrations in smoke barriers were observed in the following areas:</p> <ol style="list-style-type: none"> <li>1) Wall in Social Services</li> <li>2) 400 hall medication room</li> <li>3) Nurses charting room penetration by door knob</li> <li>4) Dietary dry storage</li> <li>5) Maintenance office storage room</li> <li>6) Employee lounge had a recessed electrical outlet with no cover with refrigerator plugged into it</li> <li>7) In ceiling above generator annunciator panel - unsealed penetrations</li> </ol> <p>An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.</p> <p>Per NFPA 101 (2018 Edition) 19.3.7.3, 8.5, 8.5.1, 8.5.2, 8.5.2.1</p> <p>Class III</p> <p>(Photographic evidence obtained)</p>	K 372	<p>The smoke barrier penetrations noted in the wall in Social Services, the 400 hall medication room, the nurses charting room penetration by doorknob, Dietary dry storage, the Maintenance office storage room, and in the ceiling above the generator annunciator panel will be corrected utilizing listed and rated fire stopping materials. The missing outlet cover noted on the recessed outlet in the Employee lounge with refrigerator plugged into it will be replaced.</p> <p>Additional smoke barriers will be reviewed for unsealed penetrations and outlets missing covers.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Subdivision of Building Spaces- Smoke Barrier Construction specific to properly sealing smoke barrier penetrations, and maintaining proper covers on electrical outlets, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>	



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>62917</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01, 05</b>  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/13/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>CONSULATE HEALTH CARE OF BRANDON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>701 VICTORIA ST BRANDON, FL 33510</b>		
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K 521 SS=D	<p>NFPA 101 HVAC</p> <p>HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain the Heating, Ventilation, and Air Conditioning (HVAC) system in accordance with NFPA 101.</p> <p>The findings include:</p> <p>On 05/13/2021 between 12:45 p.m. and 4:15 p.m. during the facility tour with the maintenance director, it was observed that the facility had installed a portable spot cooler in the facility maintenance office. Further investigation revealed the facility attached the air duct to exhaust the air through the suspended ceiling into the interstitial space between the suspended ceiling and the drywall. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2018 Edition) 19.5.2, 9.2, 4.6.12.1 per NFPA 90A (2018 Edition) 4.2.4, 4.3.1, 4.3.11.2.1 per NFPA 90B (2018 Edition) 4.3.7</p> <p>Class III</p> <p>(Photographic evidence obtained)</p>	K 521	<p>The improperly vented portable spot cooler noted in the Maintenance office was removed.</p> <p>There was only one portable spot cooler in use at the facility, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 HVAC specific to properly venting portable spot coolers when in use, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>	6/11/21
K 761 SS=D	<p>NFPA 101 Maintenance Inspection &amp; Testing - Doors</p>	K 761		6/11/21

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K 761	<p>Continued From page 17</p> <p>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. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (NFPA 101) 5.2, 5.2.3 (NFPA 80)</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire door documentation in accordance with NFPA 101.</p> <p>Findings include:</p> <p>On 05/13/2021 between the hours of 09:15 a.m. and 11:30 a.m. it was observed that the Fire Door documentation presented dated 03/10/2021 did not meet NFPA 80 requirements. Missing components included:</p> <ol style="list-style-type: none"> <li>(1) Name of facility</li> <li>(2) Address of facility</li> <li>(3) Name of person(s) performing inspections and testing</li> <li>(4) Company name and address of inspecting company</li> <li>(5) Signature of inspector of record</li> </ol> <p>An interview was conducted with the maintenance director concurrent with the record review and confirmed the findings.</p>	K 761	<p>The required annual fire door inspection documentation will be updated to meet NFPA 80 requirements.</p> <p>There is only required annual fire door inspection, therefore no additional reviews were needed.</p> <p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Maintenance, Inspection, &amp; Testing- Doors specific to the annual fire door inspection documentation meeting NFPA 80 requirements. This item will be added to the facility's TELS PM Calendar, and will continue to be monitored in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>	

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K 761	Continued From page 18  per NFPA 101 (2018 Edition) 19.2.2.2, 19.2.2.2.1, 7.2.1, 7.2.1.15.2, 7.2.1.15.3, 7.1.2.15.4, 7.1.2.15.6, 7.2.1.15.7 per NFPA 80 2016 Edition) 5.2.1  Class III  (Photographic evidence was obtained)	K 761		
K 914 SS=D	NFPA 99 Electrical Systems - Maintenance and Testing  Electrical Systems - Maintenance and Testing 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. 6.3.4 (NFPA 99)  This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the electrical receptacles in	K 914	The annual receptacle test will be completed and properly dated.	6/11/21

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K 914	Continued From page 19  accordance with NFPA 101.  Findings include: On 05/13/2021 between the hours of 9:15 a.m. and 11:30 a.m., record review revealed that the last annual receptacle test was completed sometime in 2019, no actual date noted.  An interview was conducted with the maintenance director concurrent with the record review and confirmed the findings.  per NFPA 99 (2018 Edition) 6.3.3.2, 6.3.3.2.7  (Photographic evidence obtained)  Class III	K 914	There is only one required annual receptacle test, therefore no additional reviews were needed.  The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 101 Electrical Systems- Maintenance and Testing specific to completing and properly dating the receptacle testing annually. This item will be added to the facility's TELS Preventative Maintenance (PM) Calendar, and will continue to be monitored in accordance with NFPA standards.  Any findings will be reported to the monthly QAPI Committee for further review.	
K1150 SS=D	NFPA 99 (2015 Edition) Security Management  This chapter shall apply to new and existing health care facilities. A health care facility shall have a security management plan. The scope, objectives, performance, and effectiveness of the security plan shall be tested at a frequency shown to be necessary by review of the security vulnerability assessment (SVA) in accordance with Section 13.3. NFPA 99 (2015 Edition)  This Statute or Rule is not met as evidenced by: Based on record review and interview with the maintenance director and administrator, it was revealed that the facility failed to have a Security Vulnerability Assessment (SVA).  Findings included:	K1150	The facility's Security Vulnerability Assessment (SVA) will be properly documented.  There is only one required SVA, therefore no additional reviews were needed.	6/11/21

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K1150	<p>Continued From page 20</p> <p>On 05/13/2021 between 9:15 a.m. and 11:30 a.m., during record review with the Maintenance Director, no evidence was provided for a SVA.</p> <p>An interview was conducted with the maintenance director and administrator concurrent with the observations and confirmed the findings.</p> <p>per NFPA 99 (2018 Edition) 13.1, 13.2, 13.2.1, 13.3, 13.3.1, 13.3.2, 13.3.3, 13.4, 13.4.1, 13.4.2 (1-9)</p> <p>Class III</p>	K1150	<p>The Executive Director/ designee will educate the Maintenance Director on the importance of NFPA 99 Security Management specific to properly documenting the facility's SVA, and will continue to monitor in accordance with NFPA standards.</p> <p>Any findings will be reported to the monthly QAPI Committee for further review.</p>	