STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105723	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT MYERS	**1600 MATTHEW DRIVE** **FORT MYERS, FL 33907**

(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
K 000	INITIAL COMMENTS	K 000		

An unannounced Fire Life Safety recertification survey was conducted 7/18/16 at Heartland Health Care Center Fort Myers, a skilled nursing facility in Fort Myers, Florida.

Heartland Health Care Center Fort Myers is not in compliance with Code of Federal Regulations (CFR) 42, Section 483.70, Physical Environment Requirements for Long Term Care Facilities and the National Fire Protection Association (NFPA) 101 (2000 edition) Life Safety Code.

The following is a description of the noncompliance.

K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		8/21/16

Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.
8.3, 19.3.7.3, 19.3.7.5
This STANDARD is not met as evidenced by:
Based on observations made during life safety tour of the facility and interviews with the staff, the facility failed to ensure all penetrations of sensitive partitions, i.e. fire walls and smoke walls were properly protected with fire stop Underwriters Laboratory design schedules in accordance with NFPA 101 8.3.5.1. This would allow fire, smoke and toxic gases to migrate from one compartment to another by increasing the size of the affected area.

The findings included:

K025 NFPA 101 Life Safety Code Standard

The identified breaches above double doors in two compartments 4 & 5 will be sealed with approved fire caulk.

The Maintenance Director will conduct an audit of all fire class post barrier walls for breaches and penetrations and any identified breaches will be corrected in accordance NFPA Life Safety Code

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105723	A. BUILDING 01 - MAIN FED B. WING	07/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT MYERS	1600 MATTHEW DRIVE FORT MYERS, FL 33907

(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
K 025	Continued From page 1 On 7/18/16 at 1:35 p.m., observed above the double doors leading into fire/smoke compartments four and five, there was conduits and wires passing through the rated walls without the proper fire stop material as required. The Facility Director was unsure by whom or when these penetrations were made. Breaches and penetrations of all fire/smoke barrier walls were required to be appropriately repaired and the walls brought back to their original fire rated integrity. These penetrations must be resealed with a UL approved design and approved fire rated caulking or compound, on both sides of each penetration. NFPA 101, 19.3.7.3, 19.3.7.5, Chapter 8.3.	K 025	Standards. The Maintenance Director or designee will conduct random audits for 3 months fire/smoke barrier walls for breaches and penetrations. The results of the random audits will be reported to QA & A committee monthly by the Maintenance Director or designee and followed up as necessary to ensure ongoing compliance.	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain portable fire extinguishers as required by NFPA 10. This deficient practice could render the extinguishers inaccessible endangering the patients, staff, and other building occupants. The findings included: On 7/18/16 at 11:10 a.m., during tour with the	K 064	K064 NFPA 101-LSC 2012 Fire Extinguishers The Maintenance Director will correct the identified recessed extinguishers signage to be in compliance with NFPA Life Safety Code Standards. The Maintenance Director will review all	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105723	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT MYERS	**1600 MATTHEW DRIVE** **FORT MYERS, FL 33907**

(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
K 064	Continued From page 2 Facility Director it was observed the portable extinguishers were located in recessed cabinets. These extinguisher cabinets did not have the required signage. The Facility Director said he didn't know of this requirement. NFPA 101 Life Safety Code (2000) 18.3.5.12 & 19.3.5.12, 9.7.4.1. 6.1.3.10.2 6.1.3.3.2 shall be marked conspicuously.	K 064	recessed extinguishers signage and correct as necessary to ensure compliance with NFPA Life Safety Code Standards. The Maintenance Director or designee will conduct random audits of recessed extinguishers cabinets monthly for 3 months. The results of the random audits will be reported to QA & A committee monthly by the Maintenance Director or designee an followed up as necessary to ensure ongoing compliance.	
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not comply with specific provisions of NFPA 99, Standard for Health Care Facilities. Improper oxygen storage procedures were noted. The findings included: At 1:25 p.m., observed E-tank oxygen cylinders in the storage rooms failed to be marked as	K 076	K076 NFPA 101-LSC 2012 Medical Gas The identified O2 cylinders in the Oxygen Storage room have been segregated in accordance with NFPA Life Safety Code Standards. All Oxygen Storage rooms have been inspected to ensure appropriate oxygen	8/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105723	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2016**

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K 076	Continued From page 3 required. It was noted the full and empty cylinders were mixed in the same storage rack. The Facility Director said he was not aware of this requirement. NFPA 101-2000 NFPA 99 Per 9.7.5.2, if stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Per 9.7.5.3, empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 076	segregation in accordance with NFPA Life Safety Code Standards. All staff will be trained on proper segregation of Oxygen storage. The Maintenance Director or designee will conduct random audits of Oxygen storage for 3 months to ensure compliance in accordance with NFPA Life Safety Code Standards. The results of the random audits will be reported to the QA & A committee monthly by the Maintenance Director or designee and followed up as necessary to ensure ongoing compliance.	

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
	83610	A. BUILDING: **03 - MAIN LIC** B. WING _____	**07/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT M	**1600 MATTHEW DRIVE FORT MYERS, FL 33907**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	Initial Comments An unannounced Fire Life Safety relicensure survey was conducted 7/18/16 at Heartland Health Care Center Fort Myers, a skilled nursing facility (license # 12060961) in Fort Myers, Florida. Each nursing facility shall provide fire protection through the elimination of fire hazards. All portions of the existing facility shall comply with the requirements of Chapter 19 (Existing Health Care Occupancies), and all new portions comply with Chapter 18 (New Health Care Occupancies), as written in the Code for Safety to Life from Fire in Buildings and Structures, published by the National Fire Protection Association (NFPA), known as the Life Safety Code and its applicable referenced publications. The edition shall be described in F.A.C. 59A-4, known as NFPA 101 (2012 Edition). The following is description of the deficiencies.	K 000		
K 064 SS=F	NFPA 101- LSC 2012 FIRE EXTINGUISHERS Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. Extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10 (Standard for Portable Fire Extinguishers 2010 edition). NFPA 101 Life Safety Code (2012) 18.3.5.12 & 19.3.5.12, 9.7.4.1.	K 064		8/21/16

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/16

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
	83610	A. BUILDING: 03 - MAIN LIC B. WING	07/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT M	1600 MATTHEW DRIVE FORT MYERS, FL 33907

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K 064	Continued From page 1	K 064		

This Statute or Rule is not met as evidenced by:
Based on observations, the facility failed to maintain portable fire extinguishers as required by NFPA 10. This deficient practice could render the extinguishers inaccessible endangering the patients, staff, and other building occupants.

The findings included:

On 7/18/16 at 11:10 a.m., during tour with the Facility Director it was observed the portable extinguishers were located in recessed cabinets. These extinguisher cabinets did not have the required signage.

The Facility Director said he didn't know of this requirement.

NFPA 101 Life Safety Code (2000) 18.3.5.12 & 19.3.5.12, 9.7.4.1.
6.1.3.10.2
6.1.3.3.2 shall be marked conspicuously.

Class III

K064 NFPA 101-LSC 2012 Fire Extinguishers

The Maintenance Director will correct the identified recessed extinguishers signage to be in compliance with NFPA Life Safety Code Standards.

The Maintenance Director will review all recessed extinguishers signage and correct as necessary to ensure compliance with NFPA Life Safety Code Standards.

The Maintenance Director or designee will conduct random audits of recessed extinguishers cabinets monthly for 3 months.

The results of the random audits will be reported to QA & A committee monthly by the Maintenance Director or designee an followed up as necessary to ensure ongoing compliance.

K 076 SS=F	NFPA 101- LSC 2012 Medical Gas	K 076		8/21/16

Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Health Care Facilities Code. Existing shall also be in accordance with section 8.7.

NFPA 101 Life Safety Code (2012) 18.3.2.4 & 19.3.2.4, 8.7, & NFPA 99 (2012) Chapter 11.

This Statute or Rule is not met as evidenced by:
Based on observation and interview, the facility

K076 NFPA 101-LSC 2012 Medical Gas

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
	83610	A. BUILDING: **03 - MAIN LIC** B. WING	**07/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 076	Continued From page 2 did not comply with specific provisions of NFPA 99, Standard for Health Care Facilities. Improper oxygen storage procedures were noted. The findings included: At 1:25 p.m., observed E-tank oxygen cylinders in the storage rooms failed to be marked as required. It was noted the full and empty cylinders were mixed in the same storage rack. The Facility Director said he was not aware of this requirement. NFPA 101-2000 NFPA 99 Per 9.7.5.2, if stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Per 9.7.5.3, empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. Class III	K 076	The identified O2 cylinders in the Oxygen Storage room have been segregated in accordance with NFPA Life Safety Code Standards. All Oxygen Storage rooms have been inspected to ensure appropriate segregation in accordance with NFPA Life Safety Code Standards. All staff will be trained on proper segregation of Oxygen storage. The Maintenance Director or designee will conduct random audits of Oxygen storage for 3 months to ensure compliance in accordance with NFPA Life Safety Code Standards. The results of the random audits will be reported to the QA & A committee monthly by the Maintenance Director or designee and followed up as necessary to ensure ongoing compliance.	
K 318 SS=F	NFPA 101- 2012 LSC FIRESTOP SYSTEMS AND DEVICES Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop	K 318		8/21/16

Agency for Health Care Administration

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	83610	A. BUILDING: **03 - MAIN LIC** B. WING _____	**07/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 318	Continued From page 3	K 318		

system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly.

NFPA 101 Life Safety Code (2012) 8.3.5.1.

This Statute or Rule is not met as evidenced by:
Based on observations made during life safety tour of the facility and interviews with the staff, the facility failed to ensure all penetrations of sensitive partitions, i.e. fire walls and smoke walls were properly protected with fire stop Underwriters Laboratory design schedules in accordance with NFPA 101 8.3.5.1. This would allow fire, smoke and toxic gases to migrate from one compartment to another by increasing the size of the affected area.

The findings included:

On 7/18/16 at 1:35 p.m., observed above the double doors leading into fire/smoke compartments four and five, there was conduits and wires passing through the rated walls without the proper fire stop material as required.

The Facility Director was unsure by whom or when these penetrations were made.

Breaches and penetrations of all fire/smoke barrier walls were required to be appropriately repaired and the walls brought back to their

K318 NFPA 101-2012 LSC Firestop Systems and Devices

The identified breaches above double doors in 2 compartments 4 & 5 will be sealed with approved fire caulk.

The Maintenance Director will conduct an audit of all fire class post barrier walls for breaches and penetrations and any identified breaches will be corrected in accordance with NFPA Life Safety Code Standards.

The Maintenance Director or designee will conduct random audits for 3 months fire/smoke barrier walls for breaches and penetrations.

The results of the random audits will be reported to the QA & A Committee monthly by the Maintenance Director or designee and followed up as necessary to ensure ongoing compliance.

Agency for Health Care Administration

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K 318	Continued From page 4 original fire rated integrity. These penetrations must be resealed with a UL approved design and approved fire rated caulking or compound, on both sides of each penetration. NFPA 101, 19.3.7.3, 19.3.7.5, Chapter 8.3. Class III	K 318		

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 4, 2016

Administrator
Heartland Health Care Center Fort Myers
1600 Matthew Drive
Fort Myers, FL 33907

RE: Recertification, Licensure and Life Safety Code survey results

Dear Administrator:

On July 18, 2016-July 21, 2016, a Recertification, Licensure and Life Safety Code surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

You will not receive a copy of this letter and attachments in the mail; you will only receive this faxed or electronic report.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than August 21, 2016.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com

recur, i.e., what quality assurance program will be put into place.

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed October 21, 2016 if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on January 21, 2017 if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based

interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. If you have questions, please contact this office at (239) 335-1315.

Sincerely,

Cynthia Brandt RN for

Jon Seehawer, RN
Field Office Manager

JS/je
Enclosures: CMS-2567 and State (3020) Form

R6WB