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

PRINTED: 01/25/2017 FORM APPROVED

OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (V1) DROV/IDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - MAIN FED R WING 105439 12/12/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 12TH STREET N I AKESIDE PAVILION NAPLES, FL 34103 PROVIDER'S BLANCE CORRECTION SUMMARY STATEMENT OF DEFICIENCIES CVS (VA) ID COMPLETION (EACH DESICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREEIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS An unannounced Fire & Life Safety recertification : survey was conducted 12/12/16 at Lakeside Pavilion, a nursing home in Naples, Florida. Lakeside Pavilion is not in compliance with 42 CFR 483 Subpart B. 42 CFR 488,307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes. Initial Plan Review: 1968 Existing NFPA 220 Construction Type: V (000) Number of beds:120 Census: 106 The following is description of the noncompliance. 1/15/17 K 324 K 324 NFPA 101 Cooking Facilities SS=D Cooking Facilities Cooking equipment is protected in accordance with NFPA 96. Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18,3,2,5,2, 19,3,2,5,2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3. 19.3.2.5.3. O * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18 3 2 5 4 19 3 2 5 4 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safequards 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

Event ID: U4TM21

01/09/2017

PRINTED: 01/25/2017

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN FED R. WING 105439 12/12/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 12TH STREET N I AKESIDE PAVILION NAPLES, FL 34103 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (YALIF) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LISC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 324 K 324 Continued From page 1 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5. 9.2.3. TIA 12-2 This STANDARD is not met as evidenced by: 1. On 12/21/16, the maintenance Based on a record review and interview with the maintenance director, the facility failed to inspect supervisor conducted a kitchen hood the commercial cooking equipment and maintain inspection. the equipment in reliable operating condition. On 1/9/17, repair of the caulking to the seams of the kitchen hood was completed The findings included: by The Hood Guys. 1. On 12/12/16 at 12:40 p.m., a review of the kitchen hood system records revealed there was 2. No other issues were identified related no monthly inspection of the system in to inspecting and maintaining the cooking facilities in accordance with NFPA 96. accordance with NFPA 17 2009 edition 7.3.4. The maintenance director acknowledged he was not currently performing this inspection. 3. Re-education was provided to the maintenance supervisor on 12/12/16 by 2. On 12/12/16 at 1:00 p.m., inspection of the the Regional Property Manager regarding NFPA 96, cooking facilities inspection and commercial cooking hood revealed the caulking maintenance. required for the seams of the hood to prevent grease laden vapors from penetrating was either The CED will audit the cooking facilities. missing or falling out in some areas. The inspection monthly to ensure compliance maintenance director acknowledged the deficiency and said he would repair it as soon as with NFPA 96 for 12 months. Results of the audit will be presented to the QAPI possible. committee for review and further recommendations K 345 1/15/17 K 345 NFPA 101 Fire Alarm System - Testing and ss=F Maintenance

Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National

Facility ID: 81103

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		AND HUMAN SERVICES				APPROVED . 0938-0391
STATEMENT O	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3) DAT	E SURVEY MPLETED
	ROVIDER OR SUPPLIER	105439	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/2016
	E PAVILION			29	100 12TH STREET N APLES, FL 34103	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
į	and Signaling Code	NFPA 72, National Fire Alarm a. Records of system enance and testing are readily	K	345		
	Based on a review with the r facility failed to tes accordance with X NFPA 72 2010 e mandatory testing unreliable. The findings include the same of t	45 a.m., a review of the fire ctor sensitivity report revealed ctors were tested except the emaintenance director learn testing company, then duct detectors were not tested			1.The duct detectors will be replaced by Cintas and sensitivity testing will be conducted for the new detectors by 1/15/17. 2. No other issues were identified related to smoke and duct detector testing in accordance with NFPA 101. 3. Re-education was provided to the maintenance supervisor by the Regional Property Manager regarding NFPA 101 or 12/12/16. 4. Center Executive Director will audit the maintenance supervisor s life safety book monthly for 3 months to ensure that fire alarm sensitivity testing is completed as required. Results of the audit will be presented to the QAPI committee for review and further recommendation.	
K 900 SS=F	Health Care Facili	Care Facilities Code - Other ties Code - Other IKS section any NFPA 99 luding Chapter 7, 8, 12, and 13		900		1/15/17

that are not addressed by the provided K-Tags, but are deficient. This information, along with the

Facility ID: 81103

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CENTERS FOR MEDICARE & MED				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		1 ' '	IPLE CONSTRUCTION NG 01 - MAIN FED	(X3) DATE SURVEY COMPLETED
	105439	B. WING		12/12/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKEODE DAMILION		- 1	2900 12TH STREET N	
LAKESIDE PAVILION		- 1	NAPLES, FL 34103	
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B' TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
K 900 Continued From page 3 applicable Health Care Fastandard citation, should b CMS-2567. This STANDARD is not m Based on a review of the interview with the mainten- facility failed to test the em generator dises fuel in acu 2012 edition 6.4.4.1.1.3. & 8.3.8. The findings included: On 12/12/16 at 12:12 p.m. documentation to show the been performed. The mail he was unaware of the rec	e included on Form et as evidenced by: facility records and ance director, the ergency back up pordance with NFPA 99 NFPA 110 2010 edition there was no annual fuel test had intenance director said		1.A generator diesel fuel samp conducted on 12/13/16. 2. No other issues were identifi to generator diesel fuel testing accordance with NFPA 99. 3. Re-education was provided maintenance supervisor by the Property Manager regarding N generator fuel testing on 12/12. 4. Center Executive Director w the maintenance supervisor s book monthly to ensure that the fuel testing is conducted as rec Results of the audit will be pret the QAPI committee for review recommendation.	ed related in to the Regional PPA 99, 716. Ill monitor life safety e generator guired, sented to

Facility ID: 81103

Agonov for H	ealth Care Admi	nietration			FORM APPROVED		
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CO	ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	03 - MAIN LIC	COMPLETED		
	!	81103	B. WING		12/12/2016		
NAME OF PROV	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
LAKESIDE PA	N/II ION	2900 12T	H STREET N				
LAKESIDE PA	AVILION	NAPLES,	FL 34103		***************************************		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL			
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO			
			İ	DEFICIENCY)			
K 000; Initi	ial Comments		K 000				
		ire & Life Safety re-licensure					
		ted on 12/12/16 at Lakeside home in Naples, Florida in					
		ational Fire Protection					
) 1 and 101 (2012 edition) and					
		nents of Florida State Fire					
		d Regulations, Florida e (F.A.C) 69A-3, F.A.C.	1				
69/	4-53, F.A.C. 59A	4-4, and Florida Statutes (F.S.)					
		6. 633.0215, adopting National	1		1		
		ociation (NFPA) 1 and 101 vn as the Florida Fire					
		nd all NFPA referenced					
		irements adopted per NFPA					
	1, Chapter 2.		i				
	e following is de ind at the time o	scription of the deficiencies,					
100	ind at the time o	The visit.					
K 054 N	FPA 101- LSC 20	012 SMOKE	K 054		1/15/17		
SS=F DE	TECTORS-INS	PECT, TEST, & MAINTAIN	!				
		detection in dealers there					
		detectors, including those d open devices, are approved,					
		ted, and tested in accordance					
wit	h the manufactu	re's specifications.	ļ				
	DA 404 LIE- C-E	-t. O-d- (2042) 4 6 42 NEDA					
	(2010) 14.4.5.3	ety Code (2012) 4.6.12, NFPA	1				
	(2010)						
l :							
		le is not met as evidenced by: of the facility records, and	1	1.The duct detectors will be repla	ced by		
		naintenance director, the		Cintas and sensitivity testing will			
fac	cility failed to tes	t the smoke detectors in	į	conducted for the new detectors			
ac	cordance with N	FPA 101 2012 edition 4.6.1.2.		1/15/17.			

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 01/09/17

Electronically Signed

STATE FORM If continuation sheet 1 of 9 U4TM21

				·	FORM A	PPROVED
Agency for Health Care Admir STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 03 - MAIN LIC	(X3) DATE S COMPL	
		81103	B. WING		12/12	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKESII	DE PAVILION		1 STREET N FL 34103			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE
K 054	Continued From pa	age 1	K 054			
		dition 14.4.5.3. A lack of rendered the equipment		No other issues were identified to smoke and duct detector testing accordance with NFPA 101.	g in	
	On 12/12/16 at 11:45 a.m., a review of the fire alarm smoke detector sensitivity report revealed all the smoke detectors were tested except the duct detectors. The maintenance director contacted the fire alarm testing company, then acknowledged the duct detectors were not tested for sensitivity. Class III			3. Re-education was provided to it maintenance supervisor by the Re Property Manager regarding NFPA 12/12/16. 4. Center Executive Director will a maintenance supervisor s life saf monthly for 3 months to ensure the alarm sensitivity testing is complet required. Results of the audit will presented to the QAPI committee review and further recommendatic further recommendations.	udit the fety book at fire ted as be for	
K 069 SS=D	Cooking facilities s accordance with 9	012 Cooking Equipment hall be protected in 2.3, unless otherwise	K 069	Teview and further recommendance	ni.	1/15/17
	Where residential food warming or lir shall not be require accordance with equipment shall no protected as a haz Within a smoke co or commercial coor commercial coor cooking facility sha	empartment, where residential sking equipment is used to 30 or fewer persons, one all be permitted to be open to	data constituti consti			
	conditions are met	ded that all of the following the health care facility served ility is limited to 30 beds and is	1			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING: 03 - MAIN LIC

(X3) DATE SURVEY
COMPLETED

B 1103

B WING

12/12/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

		2900 12TH NAPLES, F	STREET N L 34103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 069	Continued From page 2 separated from other portions of the heal facility by a smoke barrier constructed in accordance with 19.3.7.3, 19.3.7.6, and 1 (2) The cooktop or range is equipped with range hood of a width at least equal to the off the cooking surface, with grease baffle other grease-collecting and cleanout cap (3) The hood systems have a minimum a 500 cfm (14.000 L/min). (4) The hood systems that are not ducted exterior additionally have a charcoal filter remove smoke and odor. (5) The cooktop or range complies with a following: (a) The cooktop or range is protected with suppression system listed in accordance 300, Standard for Fire Testing of Fire Extinguishing Systems for Protection of Commercial Cooking Equipment, or is temeets all requirements of Ut. 300A, Extir System Units for Residential Range Top Surfaces, in accordance with the applica testing document 's scope. (b) A manual release of the extinguishing is provided in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Oper. Section 10.5. (c) An interlock is provided to turn off all of fuel and electrical power to the cookto range when the suppression system is a (6)*The use of solid fuel for cooking is profibiled. (8) Portable fire extinguishers in accordance (7)*Tobep-fat frying is prohibiled. (8) Portable fire extinguishers in accordance (9)*A switch meeting all of the following is provided: (9) A slocked switch, or a switch located in provided:	19.3.7.8. h a e width se or width se or ability. airflow of d to the all of the with UL steed and guishing Cooking blue or se or cooking blue or se or cooking se or cooki	К 069	DEFICIENCY)	
	restricted location, is provided within the	COUNTRY			

AHCA Form 3020-0001

Annan for House Co.				FORM APPROVED
Agency for Health Care Adm STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		,
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING:	03 - MAIN LIC	OOM CETED
	81103	B. WING		12/12/2016
NAME OF PROVIDER OR SUPPLIER	OTDECT AS			12/12/2010
THE STATISTICAL STATES		DRESS, CITY, S H STREET N	TATE, ZIP CODE	
		FL 34103		
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES			
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETE
K 069 Continued From pa	ne 3	K 069	DEFICIENCY)	
•	•	1, 009		·
	tes the cooktop or range.			
	ed to deactivate the cooktop			1
supervision.	the kitchen is not under staff			
	a timer, not exceeding a			
120-minute canacit	y, that automatically			1
	ktop or range, independent of			
staff action.	map or range, macpanacin or			İ
(10) Procedures for	the use, inspection, testing,	1		
and maintenance of	f the cooking equipment are in			
	apter 11 of NFPA 96 and the	1		
	tructions and are followed.			
(11) Not less than to	wo AC-powered photoelectric			
9.6.2.10.3 equippe	connected in accordance with d with a silence feature, and in	i l		
accordance with NE	PA 72, National Fire Alarm			
and Signaling Code	, are located not closer than			
20 ft (6.1 m) from th	e cooktop or range.			
(12) No smoke dete	ctor is located less than 20 ft			
(6.1 m) from the cod		. 1		
(13) The smoke cor	npartment is protected			:
throughout by an ap	proved, supervised automatic			
sprinkler system in	accordance with Section 9.7.			
Within a smoke con	partment, residential or			
commercial cooking	equipment that is used to			1
prepare meals for 3	0 or fewer persons shall be			
permitted, provided	that the cooking facility			
complies with all of	the following conditions:			
	ining the cooking equipment			i
is not a sleeping roo				. 1
shall be senarated 6	ining the cooking equipment rom the corridor by partitions			1
complying with 10.3	.6.2 through 19.3.6.5.			İ
(3) The requirement	s of 19.3.2.5.3(1) through			i
(10) and (13) are me	et.			
Where cooking facil				1

Agency	for Health Care Adm	inistration		ı	PRINTED: 01/25/2017 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION : 03 - MAIN LIC	(X3) DATE SURVEY COMPLETED
		81103	B. WING		12/12/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
LAKESI	DE PAVILION	2900 12TH NAPLES,	i STREET I FL 34103	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
K 069	Continued From pa	ige 4	K 069		
	cooking equipment space housing the a hazardous area requirements of 19 shall not be permitt NFPA 101 Life Safe 18.3.2.5.5 & 19.3.2 ***NOTE The kitch is applicable to lice requirement is mor has completed the	shall not cause the room or equipment to be classified as with respect to the 3.2.1, and the room or space ed to be open to the corridor. ety Code (2012) 18.3.2.5.1 thru. 5.1 thru 19.3.2.5.5. en open to a corridor provision shaure only. The CMS e stringent unless the Facility requirements for the sin accordance with S&C			
	Based on a record maintenance direct the commercial cod the equipment in re The findings include 1. On 12/12/16 at 1. Witchen hood system on on the performance direct currently performing 2. On 12/12/16 at 1. commercial cooking required for the seg grease laden vagor falling on falling on	2:40 p.m., a review of the m records revealed there was on of the system in FPA 17 2009 edition 7.3.4. The or acknowledged he was not given inspection. 3:00 p.m., inspection of the phood revealed the caulking ins of the hood to prevent strong penerating was either at in some areas. The		1. On 12/21/16, the maintenance supervisor conducted a kitchen ho inspection. On 1/9/17, repair of the caulking to seams of the kitchen hood was co by The Hood Guys. 2. No other issues were identified to inspecting and maintaining the cfacilities in accordance with NFPA 3. Re-education was provided to the maintenance supervisor on 12/12/ the Regional Property Manager rey NFPA 96, cooking facilities inspect maintenance. 4. The CED will audit the cooking 1	related sooking 96. he following sooking 16 by parding ion and facilities
		or acknowledged the		inspection monthly to ensure comp	

U4TM21

with NFPA 96 for 12 months. Results of

Agency	for Health Care Adm	injetration		•	FORM	APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION 03 - MAIN LIC	(X3) DATE COMP	SURVEY
		81103	B. WING		12/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKESIC	E PAVILION		1 STREET N FL 34103			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETE
K 069	Continued From pa	ge 5	K 069			
	possible.			the audit will be presented to the Q	API	
	Class III			committee for review and further recommendations		
	NFPA 101- 2012 LS GENERATOR FUE		K 316			1/15/17
	annually using tests standards. NFPA 101 Life Safe 19,51, 9.1.3 thru 9. This Statute or Rule Based on a review interview with the macility failed to test generator diesel fue 2012 edition 6.4.4.1 8.3.8. The findings include on 12/12/16 at 12:1 documentation to si	2 p.m., there was no how the annual fuel test had he maintenance director said		1.A generator diesel fuel sample te conducted on 12/13/16. 2. No other issues were identified in to generator diesel fuel testing in accordance with NFPA 99. 3. Re-education was provided to the maintenance supervisor by the Reg Property Manager regarding NFPA generator fuel testing on 12/12/16. 4. Center Executive Director will mit he maintenance supervisor is life took monthly to ensure that the get fuel testing is conducted as require Results of the audit will be presente the QAPI committee for review and recommendation.	elated e gjional 99, onitor safety nerator id. ed to	
K 317 SS=F	NFPA101-2012LSC REPAIR, RENO, M	FAC 58A-2.025,F.B.C-2011 DD, CHNG OF USE OR	K 317			1/15/17

6600

FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A RUILDING: 03 - MAIN LIC B. WING 81103 12/12/2016 NAME OF DROVINER OR SUDDILLED STREET ADDRESS, CITY, STATE, ZIP CODE 2900 12TH STREET N LAKESIDE PAVILION NAPLES, FL 34103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DDEELY COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

K 317

K 317 Continued From page 6

OCC. & ADD

buildings or for additions, conversions. renovations, or alterations to existing buildings. the plans and specifications for the contemplated construction shall be prepared by Florida-registered architects and engineers. (2) All contemplated additions, conversions, renovations, or alterations shall be submitted for approval or exemption from the plans review process.

(1) When construction is contemplated for new

- Rehabilitation work on existing buildings shall be classified as one of the following work categories in accordance with 43.2.2.1.
- (1) Repair
- (2) Renovation
- (3) Modification
- (4) Reconstruction
- (5) Change of use or occupancy classification
- (6) Addition

Rehabilitation work on existing buildings shall comply with Chapter 43 of NFPA 101, Life Safety Code

NFPA 101 Life Safety Code (2012) 4.6.7.1 & 4.6.7.2. Florida Administrative Code 58A-2 025 & Florida Building Code 2010 edition. ***NOTE ADD LANGUAGE FOR ICRA & ILSM*

This Statute or Rule is not met as evidenced by: Based on observations made during fire safety tour of the facility, and interview with the maintenance director and the administrator, the facility failed to submit a letter of intent and scope of work for a modification electrical upgrade, to the Agency for Health Care Administration (AHCA) Office of Plans and Construction (OPC)

K 317

On 12/23/16, facility retained the services of Burt Hill/ Pollok Krieg Architects, Inc.

On 1/4/17, electrical drawings from the

AHCA Form 3020-0001

6800

FORM APPROVED Agency for Health Care Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NI IMBED COMPLETED A BUILDING 03 - MAIN LIC 81103 B. WING 12/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE 7ID CODE 2900 12TH STREET N LAKESIDE PAVILION NAPLES, FL 34103 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (VE) DDEELY (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 317 Continued From page 7 K 317 for approval, prior to work being performed. facility's original construction and subsequent renovation and cut sheets for The findings included: quad outlet replacement parts were sent to Burt Hill/Pollock Krieg, Inc. for review. On 12/12/16 between 12:45 p.m. and 3:00 p.m.. the fire safety tour revealed the dupley electrical By 1/15/17, quad outlets in resident rooms outlets in all the resident rooms were removed will be altered to lock out use of 2 and upgraded to guad outlets. This expansion of receptacles per outlet (e.g. child safety house power outlets required a review for code plastic plugs covered with duct tape and compliance and to ensure the extra outlets did "no use" signage. not draw to much power and heat the wiring in the walls By 1/17/17, the electrical engineer from Burt Hill et al will provide an on-site review When questioned, the maintenance director said of the facility's existing electrical system this was the electrical arrangement when he and electrical load began employment 6 months ago. On 12/12/16 at 3:00 p.m., the administrator revealed the Following the outcome of the review. Burt outlets were changed out and expanded after the Hill et al will submit all required documents February 2016 annual survey. They were actually to AHCA Office of Plans and Construction.

installed after the fire safety revisit inspection on 4/8/16. The facility was cited for improper use of power strips. The power strips were removed and the deficiency cleared. The problem however remained that there were not enough outlets so the facility chose to modify and expand the outlets to solve their problem. The administrator acknowledged OPC should have been notified.

It was also noted the guad outlets were red indicating they are connected to the critical branch and the emergency back up generator. This was not verified.

Class III

Depending on the outcome of the review by Burt Hill et al and AHCA OPC, any additional work that needs to be done will be initiated and completed within 90 days of reply from AHCA OPC.

The CED will update the Area 8 AHCA office every 30 days on the status of the above review and recommendations

- 2. No other issues were identified regarding submission to AHCA Office of Plans and Construction for planned facility repair, renovation, modification, or additions
- On 12/12/17, the Regional Property Manager educated the CED and maintenance supervisor on submitting appropriate planned facility repairs.

Agency for Health Care Adm	inistration				APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 - MAIN LIC		SURVEY LETED
	81103	B. WING		12/1	2/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKESIDE PAVILION		TH STREET N 5, FL 34103			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICLENCY)	D BE	(X5) COMPLETE DATE
K 317 Continued From pa	ige 8	K 317			
÷			renovations, modifications, or add AHCA Office of Plans and Constru		
			By 1/15/17, the CED and/or her de will educate the staff on the "lock of the 2 receptacles per quad outlet i resident rooms. 4. Maintenance supervisor and/or designee will conduct daily rounds	out" of in his to	
			ensure no use of power strips, ext cords and/or use of the 'lock out' receptacles in the resident rooms. Executive Director will audit all pla facility repair, renovations, modific or additions monthly to ensure not to AHCA OPC is submitted as req Results of the audits will be prese the QAPI committee monthly for 3	Center inned sations, liftication uired. Inted to import in months	
			for review and further recommend	ation.	:
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JUSTIN M. SENIOR INTERIM SECRETARY

December 30, 2016

Administrator Lakeside Pavilion 2900 12th Street N Naples, FL 34103

RE: Recertification, Licensure and Life Safety Code survey results

Dear Administrator:

On December 12, 2016-December 15, 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.

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 January 15, 2017.

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

Recommended Remedies:

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



Lakeside Pavilion December 29, 2016 Page 2

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 March 15, 2017 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 June 15, 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

Phone number: (850) 412-4301 IDRCoordinator@ahca.mvflorida.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 Lakeside Pavilion December 29, 2016 Page 3

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 RNG poc

Jon Seehawer, RN Field Office Manager

JS/ie

Enclosures: CMS-2567 and State (3020) Form

R6WB