STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. BUILDING **01 - MAIN FED** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD REHABILITATION CENTER	**2839 S SEACREST BLVD** **BOYNTON BEACH, FL 33435**

(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 An unannounced Fire & Life Safety re-certification survey was conducted 09/18-19/2017 at Boulevard Rehabilitation Center, a nursing home in Boynton Beach, Florida. Boulevard Rehabilitation Center, is not in substantial compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012) requirements for nursing homes. Deficiencies were found at the time of the visit. Initial Plan Review: 1963/1999 Existing NFPA 220 Construction Type: II (000) Number of beds: 167 Census: 149 The following is description of the deficiencies, found at the time of the visit.	K 000		
K 211 SS=F	NFPA 101 Means of Egress - General 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 STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building exit egress. This deficient practice affects all smoke compartments, staff, visitors and all residents.	K 211	Corrective Action: We purchased "NO EXIT" signage and installed them on doors 1, 2 and 3. We have reinstalled the previous mag locks on the new fence to allow for proper	10/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 211	Continued From page 1 Findings include: On 09/18/2017 during the facility tour the following doors which have the appearance of exit doors were not signed as required by code to state NO EXIT so as to not cause confusion in an emergency. These doors are likely to be mistaken for an exit. Examples include: 1. At 9 A.M. the access corridor to the kitchen exterior door facing East. 2. At 10 A.M. the Private dining room to exterior courtyard. On 09/19/17 during the facility tour the following doors which have the appearance of exit doors were not signed as required by code. 3. At 9 A.M. smoking area exterior courtyard has 3 doors to interior egress, only 1 is accessible 24/7. 4. At 11 A.M. East courtyard gate is locked and can trap residents and staff in courtyard in an emergency. Based on interview at these same times, the Maintenance Director acknowledged that the required signage was not posted as required by code for areas that do not allow safe exit egress for yards, courts, open spaces, or other portions of the exit discharge, that shall be of the required width and size to provide all occupants with a safe access to a public way. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit	K 211	egress. Identifcation of others potentially affected: All of the doors were audited for proper signage throughout the facility. Systems to ensure compliance: The Maintenance Staff was in-serviced on ensuring that the proper signage is on all doors and that exit doors and patios have the proper egress mechanism. The Maintenance staff will conduct weekly reviews of the doors to ensure that the signage is in place and all egress is working proplerly. How the system will be monitored: The copies of the audits will be reviewed at the monthly QA meeting by the QA team to include the Administrator for 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. BUILDING **01 - MAIN FED** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD REHABILITATION CENTER	**2839 S SEACREST BLVD** **BOYNTON BEACH, FL 33435**

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K 211	Continued From page 2 conference on 09/19/2017. Actual NFPA Standards: NFPA LSC 101 (2012) 7.10.8.3.1 NO EXIT. 7.10.8.3.2 -7.7.1.1	K 211		
K 324 SS=F	NFPA 101 Cooking Facilities 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, or * 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. 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: Based on observation, written document review and staff interview, the facility failed to maintain the building kitchen cooking suppression system	K 324	Corrective Action: We contacted the vendor to adjust the chemical protection nozzles and they fixed	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. BUILDING **01 - MAIN FED** B. WING	**09/19/2017**

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BOULEVARD REHABILITATION CENTER	**2839 S SEACREST BLVD BOYNTON BEACH, FL 33435**

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K 324	Continued From page 3 suppression nozzles for protection of the cooking appliances. This deficient practice can affect all smoke compartments, all staff, visitors and all residents. Findings include: On 09/19/2017 at 9:15 A.M. accompanied by the Maintenance Director when touring the kitchen area the following issues were noted with the cooking appliance protection. Wet chemical protection system nozzles are not aligned to protect the appliances in the event of discharge for a fire. During interview with the Maintenance Director at these same times he acknowledged the discharge nozzles were improperly aligned. No additional paperwork was provided to substantiate compliance at the time of exit. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and record review additionally, at the exit conference on 09/19/17. Actual NFPA Standards: NFPA LSC 101 (2012) 9.2.3; 19.3.2.5 , NFPA 96 .	K 324	them on 9/22/17. Identification of other potentially affected: The Kitchen Manager and Maintenance Director will ensure that all other protection systems in the kitchen are working properly and in the proper place. Systems to ensure compliance: The Kitchen Manager or designee will inspect the chemical protection nozzles to ensure that they are directly over the stove. How the system will be monitored: A copy of the rounds will be reviewed by the QA team at the monthly QA meeting for 90 days for compliance.	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. BUILDING **01 - MAIN FED** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD REHABILITATION CENTER	**2839 S SEACREST BLVD** **BOYNTON BEACH, FL 33435**

(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 345	Continued From page 4 available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire alarm system to code requirements. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 09/18/2017 at 11:15 A.M. during the review of the facility documentation it was determined the facility was unable to substantiate and did not maintain the required fire alarm system functional documentation as required by code. Paperwork reviewed did not correctly indicate number of interface equipment (special locking arrangements- delayed egress locks) being tested or certified as functional. Based on the documentation provided the form indicated there are 25 devices connected as special locking arrangements of those 25 only 16 are indicated as passing, the other 9 are not indicated as failing or functional. The Maintenance Director acknowledged that the fire alarm company failed to properly test and document the required annual inspection testing of the electromechanical releasing devices which shall be tested annually. Documentation reviewed did not indicate required information. The facility did not produce any additional documentation at the exit conference to substantiate compliance.	K 345	Corrective Action: Our fire alarm contractor was called to complete the testing of the maglocks to include the 9 doors that were not tested. Identification: The Maintenance Director or designee to review all fire safety reports to ensure that the vendors are sending a complete report. System to ensure compliance: The Maintenance Director or designee will audit all reports received for life safety inspections for completeness monthly and report the results to the QA meeting monthly. How the system will be monitored: The Maintenance Director or designee will audit all reports received for life safety inspections for completeness monthly and report the results to the QA meeting monthly for 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. BUILDING **01 - MAIN FED** B. WING _____	**09/19/2017**

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K 345	Continued From page 5 The findings were acknowledged by the Administrator and verified by the Maintenance Director at the times of written document review and at the exit conference on 09/19/2017. Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.4 & 9.6. NFPA 72 (2010) 4.5.2.3 and 10.4.4.21 and 69 A-48.005 requires documentation.	K 345		
K 363 SS=F	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		10/19/17

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K 363	Continued From page 6 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on testing, observation and staff interview the facility failed to maintain the building corridor door opening assemblies. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 09/19/2017 accompanied by the Maintenance Director when touring the facility, when tested the following corridor doors did not close and latch in the door frame. Doors did not meet the code requirement of providing a means suitable to keep the door closed. (1) At 8:15 A.M. the staff break room corridor door. (2) At 8:30 A.M. the kitchen to dining rooms doors. (3) At 8:45 A.M. the kitchen chemical storage room doors. (4) At 10 A.M. the South wing janitor closet doors. (5) At 10:15 A.M. the South wing corridor fire/smoke doors. (6) At 10:30 A.M. the South wing corridor fire /smoke doors by the nursing station. (7) At 11:15 A.M. the East wing corridor fire/smoke doors. (8) At 11:30 A.M. the East linen corridor doors.	K 363	Corrective Action: 1. Staff break room door was adjusted to close. 2. The kitchen door leading into the dining room was adjusted to close. 3. The kitchen chemical storage room door was adjusted to close. 4. The south wing janitor closet door was adjusted to close. 5. The south wing corridor doors by the nursing station were adjusted to close. 6. The east wing corridor door was adjusted to close. 7. The east wing unit storage room corridor door was adjusted to close. Identification of others: All doors will be tested monthly by the Maintenance Director or designee to ensure that they close properly. System to ensure compliance: The Maintenance Director or designee will conduct a random audit of 50% of the doors monthly to ensure that they close properly. How the system will be monitored: The Maintenance Director or designee will present the audit to the QA	

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K 363	Continued From page 7 (9) At 11:45 A.M. the East unit storage room corridor door. An interview was conducted at this time with the Maintenance Director who acknowledged and witnessed that the corridor doors did not meet the code requirement of providing a means suitable to keep the door closed. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 09/19/2107. Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.6.3.3, 19-3.6.3.5	K 363	team at the monthly QA meeting for 90 days.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95004	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/19/2017**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 09/18-19/2017 at Boulevard Rehabilitation Center, State license: 1058096, a nursing home in Boynton Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2012) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is description of the deficiencies, found at the time of the visit.	K 000		
K 211 SS=F	NFPA 101 Means of Egress - General 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 Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building exit egress. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 09/18/2017 during the facility tour the	K 211	Corrective Action: We purchased "NO EXIT" signage and installed them on doors 1, 2 and 3. We have reinstalled the previous mag locks on the new fence to allow for proper egress. Identifcation of others potentially affected:	10/19/17

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	95004	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/19/2017**

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K 211	Continued From page 1 following doors which have the appearance of exit doors were not signed as required by code to state NO EXIT so as to not cause confusion in an emergency. These doors are likely to be mistaken for an exit. Examples include: 1. At 9 A.M. the access corridor to the kitchen exterior door facing East. 2. At 10 A.M. the Private dining room to exterior courtyard. On 09/19/17 during the facility tour the following doors which have the appearance of exit doors were not signed as required by code. 3. At 9 A.M. smoking area exterior courtyard has 3 doors to interior egress, only 1 is accessible 24/7. 4 At 11 A.M. East courtyard gate is locked and can trap residents and staff in courtyard in an emergency. Based on interview at these same times, the Maintenance Director acknowledged that the required signage was not posted as required by code for areas that do not allow safe exit egress for yards, courts, open spaces, or other portions of the exit discharge that shall be of the required width and size to provide all occupants with a safe access to a public way. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 09/19/2017. Class III	K 211	All of the doors were audited for proper signage throughout the facility. Systems to ensure compliance: The Maintenance Staff was in-serviced on ensuring that the proper signage is on all doors and that exit doors and patios have the proper egress mechanism. The Maintenance staff will conduct weekly reviews of the doors to ensure that the signage is in place and all egress is working properly. How the system will be monitored: The copies of the audits will be reviewed at the monthly QA meeting by the QA team to include the Administrator for 90 days.	

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	95004	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/19/2017**

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K 211	Continued From page 2 Actual NFPA Standards: NFPA LSC 101 (2012) 7.10.8.3.1 NO EXIT. 7.10.8.3.2 -7.7.1.1	K 211		
K 324 SS=F	NFPA 101 Cooking Facilities 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, or * 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. 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 Statute or Rule is not met as evidenced by: Based on observation, written document review and staff interview, the facility failed to maintain the building kitchen cooking suppression system suppression nozzles for protection of the cooking appliances. This deficient practice can affected all smoke compartments, all staff, visitors and all residents.	K 324	Corrective Action: We contacted the vendor to adjust the chemical protection nozzles and they fixed them on 9/22/17. Identification of other potentially affected: The Kitchen Manager and Maintenance Director will ensure that all	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 324	Continued From page 3 Findings include: On 09/19/2017 at 9:15 A.M. accompanied by the Maintenance Director when touring the kitchen area, following issues were noted with the cooking appliance protection: Wet chemical protection system nozzles are not aligned to protect the appliances in the event of discharge for a fire. During interview with the Maintenance Director at these same times he acknowledged the discharge nozzles were improperly aligned. No additional paperwork was provided to substantiate compliance at the time of exit. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time observation and record review additionally, at the exit conference on 09/19/17. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 9.2.3; 19.3.2.5 , NFPA 96 .	K 324	other protection systems in the kitchen are working properly and in the proper place. Systems to ensure compliance: The Kitchen Manager or designee will inspect the chemical protection nozzles to ensure that they are directly over the stove. How the system will be monitored: A copy of the rounds will be reviewed by the QA team at the monthly QA meeting for 90 days for compliance.	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72	K 345		10/19/17

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	95004	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD REHABILITATION CENTER	**2839 S SEACREST BLVD** **BOYNTON BEACH, FL 33435**

(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 345	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview the facility failed to maintain the building fire alarm system to code requirements. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 09/18/2017 at 11:15 A.M. during the review of the facility documentation it was determined the facility was unable to substantiate and did not maintain the required fire alarm system functional documentation as required by code. Paperwork reviewed did not correctly indicate number of interface equipment (special locking arrangements- delayed egress locks) being tested or certified as functional. Based on the documentation provided the form indicated there are 25 devices connected as special locking arrangements of those 25 only 16 are indicated as passing, the other 9 are not indicated as failing or functional. The Maintenance Director acknowledged that the fire alarm company failed to properly test and document the required annual inspection testing of the electromechanical releasing devices which shall be tested annually. Documentation reviewed did not indicate required information. The facility did not produce any additional documentation at the exit conference to substantiate compliance. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of written document review and at the exit conference on 09/19/2017. Class III	K 345	Corrective Action: Our fire alarm contractor was called to complete the testing of the maglocks to include the 9 doors that were not tested. Identification: The Maintenance Director or designee to review all fire safety reports to ensure that the vendors are sending a complete report. System to ensure compliance: The Maintenance Director or designee will audit all reports received for life safety inspections for completeness monthly and report the results to the QA meeting monthly. How the system will be monitored: The Maintenance Director or designee will audit all reports received for life safety inspections for completeness monthly and report the results to the QA meeting monthly for 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95004	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/19/2017**

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K 345	Continued From page 5 Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.4 & 9.6. NFPA 72 (2010) 4.5.2.3 and 10.4.4.21 and 69 A-48.005 requires documentation.	K 345		
K 363 SS=F	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations (only for Federal survey citation) only on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		10/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95004	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/19/2017**

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K 363	Continued From page 6 and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with self-latching and positive latching hardware. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations (only for Federal survey citation) on corridor doors and rooms containing flammable or combustible materials. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This Statute or Rule is not met as evidenced by: Based on testing, observation and staff interview the facility failed to maintain the building corridor door opening assemblies. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 09/19/2017 accompanied by the Maintenance Director when touring the facility, when tested the following corridor doors did not close and latch in	K 363	Corrective Action: 1. Staff break room door was adjusted to close. 2. The kitchen door leading into the dining room was adjusted to close. 3. The kitchen chemical storage room door was adjusted to close. 4. The south wing janitor closet door was adjusted to close. 5. The south wing corridor doors by the nursing station were adjusted to close.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 7 the door frame. Doors did not meet the code requirement of providing a means suitable to keep the door closed. (1) At 8:15 A.M. the staff break room corridor door. (2) At 8:30 A.M. the kitchen to dining rooms doors. (3) At 8:45 A.M. the kitchen chemical storage room doors. (4) At 10 A.M. the South wing janitor closet doors. (5) At 10:15 A.M. the South wing corridor fire/smoke doors. (6) At 10:30 A.M. the South wing corridor fire /smoke doors by the nursing station. (7) At 11:15 A.M. the East wing corridor fire/smoke doors. (8) At 11:30 A.M. the East linen corridor doors. (9) At 11:45 A.M. the East unit storage room corridor door. An interview was conducted at this time with the Maintenance Director who acknowledged and witnessed that the corridor doors did not meet the code requirement of providing a means suitable to keep the door closed. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 09/19/2107. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.6.3.3, 19-3.6.3.5	K 363	6. The east wing corridor door was adjusted to close. 7. The east wing unit storage room corridor door was adjusted to close. Identification of others: All doors will be tested monthly by the Maintenance Director or designee to ensure that they close properly. System to ensure compliance: The Maintenance Director or designee will conduct a random audit of 50% of the doors monthly to ensure that they close properly. How the system will be monitored: The Maintenance Director or designee will present the audit to the QA team at the monthly QA meeting for 90 days.	