CENTER STATEMENT O	DEPARTMENT OF HEALTH AND HUMAN SERVICES  ZENTERS FOR MEDICARE & MEDICAID SERVICES  ZENTERS FOR MEDICARE & MEDICAID SERVICES  (X2) PROVIDERSUPPLEPICIA DENTIFICATION NUMBER: A BUILDING 01, 04  105724  B. WING			FORM OMB NO (X3) DATE COMP	D: 11/08/2017 MAPPROVED D: 0938-0391 SURVEY LETED 19/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
OCALA O	AKS REHABILITATION C	ENTER	- 1	3930 E SILVER SPRINGS BLVD DCALA, FL 34470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000			
K 324 SS=E	survey was conducted Coala Oaks Rehabilit Silver Springs Blvd., a Florida 34470.  Ocala Oaks Rehabilit Compliance with 42 C 488.307, and Nationa (NFPA) 101 (2012 ed nursing homes.  Initial Plan Review: 11 New or Existing: Exis NFPA 220 Constructif Footage: 52.000 Number of beds: 120 Census: 104  The following is described at the time of the NFPA 101 Cooking Facilities Cooking Facilities Cooking Facilities Cooking Facilities and Fire Protection of Operations, unless: residential cooking appliances such as m toasters) are used for cooking in accordance "cooking in accordance" cooking in accordance "cooking in accordance" cooking in accordance "cooking facilities op compartments with 30 compositions of the NFPA 101 (1997) and 1997 (1997) and 1	FR 483 Subpart B, 42 CFR I fire Protection Association tion) requirements for 989 sing on Type: II (111) siption of the deficiencies, se visit: acilities  protected in accordance rd for Ventilation Control Commercial Cooking	K 324			10/19/17

\* cooking facilities in smoke compartments with LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE 10/05/2017

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.

Electronically Signed

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/08/2017 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01, 04		E SURVEY MPLETED
		105724	B. WING		or	9/19/2017
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIF 3930 E SILVER SPRINGS BLVD OCALA, FL 34470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
K 324	18.3.2.5.4, 19.3.2.5.4 Cooking facilities prol per 9.2.3 are not requ hazardous areas, but corridor.	comply with conditions under	К 3:	24		
	Based on records re facility failed to maint the facility in accorda 19.3.2.5.1, 9.2.3, NFI (2009). Failure to ma equipment endanger building occupants.  The findings include:  Observations on 9/15 from 9/30 am to 12/01  At 11:01 am during in produce documentaticheck inspection. Am	patients, staff, and other  1/17 during records review 0 pm revealed that: ecords review, facility fail to on for hood system "quick interview with the		The filing of this plan of not constitute an admissi deficiency. The plan of or comply with regulatory of the plan	on of this alleged orrection is to ompliance spected the spected the spectations a monthly "hood er findings."  I use the hood missure system is at with the NEPA see hood check it follow in the	
	96 (2011) 10.2.6 (4)., (1-8)	NFPA 17A (2009) 7.2.2. verified by Maintenance				

Director at the times of observation and the

PRINTED: 11/08/2017

		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 101, 04	(X3) DATE	
		105724	B. WING		09	19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
004140	AKS REHABILITATION (	CENTED	1	3930 E SILVER SPRINGS BLVD		
OCALA O	AKS KERABILITATION	SENIER	1	OCALA, FL 34470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JED BE	(X5) COMPLETION DATE
K 324	Administrator at the	e 2 exit conference on 9/19/17 at	K 32	4		
K 345 SS=E		System - Testing and	K 34	5		10/19/17
	A fire alarm system is accordance with an a with the requirements Electric Code, and N and Signaling Code.	ance and testing are readily				
	Based on records re facility failed to maint according with LSC Failure to maintain th for the travel of smok compartment to anot	her through the HVAC patients, staff, or other		The filing of this plan of correction not constitute an admission of this deficiency. The plan of correction is comply with regulatory compliance.  Maintenance Director contacted the vendor/fire monitoring system command had the necessary duct test of immediately.	alleged is to e e e pany	
	from 9:30 am to 12:0  At 10:25 am the facil documentation for a/	lity fail to produce		Maintenance Director has added t required duct testing to the list of mandatory testing to be done and appropriate frequency  Maintenance Director will follow al	with the	

Maintenance Director (MD) at the time of

observation revealed the MD was aware of the

identified fire safety inspections/testing via

the monthly QA meeting x 3 months

DEPARTI	FORM	PRINTED: 11/08/2017 FORM APPROVED OMB NO. 0938-0391				
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG 01, 04	(X3) DATE	
		105724	B. WING _		09/	19/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OCALA O	AKS REHABILITATION C	ENTER		3930 E SILVER SPRINGS BLVD OCALA, FL 34470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 345		3 ntial pressure test was not	кз	345		
K 353 SS=D	These findings were or Director at the times of Administrator at the education of the educa	cy 19.7.5., NFPA 72 (2010)  verified by Maintenance of observation and the xit conference on 9/19/17 at  System - Maintenance and	KS	353		10/19/17
	Automatic sprinkler a inspected, tested, and with NFPA 25, Standa Testing, and Maintain Protection Systems. I maintenance, inspect	ing of Water-based Fire Records of system design, ion and testing are e location and readily stem last checked				
	c) Water system sup					
	any non-required or p system. 9.7.5, 9.7.7, 9.7.8, an This STANDARD is in Based on observation facility failed to maintain the facility in accom-	Sinformation on coverage for hartial automatic sprinkler d NFPA 25 tot met as evidenced by: n and staff interview, the ain their fire sprinkler system dance with LSC Sections 13 (2010), NFPA 25 (2011).		The filing of this plan of correction do not constitute an admission of this all deficiency. The plan of correction is comply nit whe regulatory compliance	eged	

Failure to maintain fire sprinkler system increases the risk of injury to patients, staff, and other

Facility ID: 34208

PRINTED: 11/08/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND REAR OF CORRECTION COMPLETED. A BUILDING 01, 04 105724 R MING 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3930 E SILVER SPRINGS BLVD OCALA OAKS REHABILITATION CENTER OCALA, FL 34470 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY K 353 | Continued From page 4 K 353 building occupants. FDC signage was painted and a new sign was ordered to replace the identified sign. The findings include: All exterior fire safety signage will be Observations on 9/19/17 during the tour from inspected once a week x 3 weeks and 12:30 pm to 3:45 pm revealed that: once a month thereafter to ensure compliance with NFPA regulations At 12:35 pm on exterior/ north side of building, observed FDC location signage faded/ can't read Maintenance Director will follow all it. An interview with the Maintenance Director identified deficiencies via the monthly QA (MD) at the time of observation revealed the MD meeting x 3 months and reports all was aware of the FDC location signage was findings. faded Ref.: NFPA 101 (2012) 19.3.5., 9.7.5., NFPA 13 (2010) NFPA 25 (2011) These findings were verified by Maintenance Director at the times of observation and the Administrator at the exit conference on 9/19/17 at 4:00 pm. K 363 NEPA 101 Corridor - Doors K 363 10/19/17 SS=D 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

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/08/2017 MAPPROVED D: 0938-0391
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION 11, 04	(X3) DATE	
		105724	B. WING	_		09/	19/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	930 E SILVER SPRINGS BLVD		
OCALA O	AKS REHABILITATION C	ENTER		0	DCALA, FL 34470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
14 200		-					
K 363			K	363			
		oms containing flammable					
	or combustible mater						
		9 are permissible. Hold open					
		when the door is pushed or					
		Nonrated protective plates					
	meeting 19.3.6.3.6 at	e permitted. Dutch doors					
		labeled and made of steel					
		compliance with 8.3, unless					
		ent is sprinklered. Fixed fire					
	window assemblies a						
	sprinklered compartm						
	restrictions in area or	fire resistance of glass or					
	frames in window ass	emblies.					
	and 485	ts 403, 418, 460, 482, 483,					
		letails of doors such as fire					
		tomatics closing devices,					
	etc.						
		not met as evidenced by:					
		ns and interview, the facility			The filing of this plan of correction doe		
		proper operation of corridor			not constitute an admission of this alle	ged	
		cordance with LSC Section r assemblies to properly			deficiency. The plan of correction is to		
		pon release to maintain the			comply with regulatory compliance		
		porrier penetration. Failure to					
		sembly will allow for the			Identified door was immediately repair	ed	
	travel of fire and smo				so that it could be appropriately latche		
		ner endangering, patients,			and closed.		
	staff, or other building						
					Maintenance Director will inspect all		
	The findings include:				facility doors once a week x 3 weeks a	nd	
					then once a month thereafter for 3 mo	nths	
	Observations on 9/19	/17 during the tour from					
	12:30 pm to 3:45 pm	revealed that:			Maintenance Director will follow all the		
					identified deficiencies and report the		
	At 3:00 pm on 2nd flo	or/ Room 226, observed the			findings at the monthly QA meeting x 3	3	

corridor door would not fully close and latch. An

interview with the Maintenance Director (MD) at

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/08/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-035

STATEMENT OF DEFICIENCIES

(X) PROVIDERSUPPLERCIA

IDENTIFICATION NUMBER

AND PLAN OF CORRECTION

105724

NAME OF PROVIDER SUPPLER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

OCALA OAKS REHABILITATION CENTER

OCALA, FL 34470

SIMMARY STATEMENT OF DEFICIENCIES

OF DEPROVIDER OF AUGUST AND AS CONDECTION

DEPROVIDER OF AUGUST AND AS CONDECTION

OF DEPROVIDER OF AUGUST AND AS CONDECTION

OF DEPROVIDER OF AUGUST AND AS CONDECTION

OCALA O	AKS REHABILITATION CENTER		OCALA, FL 34470	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 6 the time of observation revealed the MD was aware of the door not closing fully.  Ref.: NFPA 101 (2012) 19.3.6.3. These findings were verified by Maintenance Director at the times of observation and the Administrator at the exit conference on 9/19/17 at 4:00 pm.  NFPA 101 Subdivision of Building Spaces - Smoke Barrier Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 363	DEFICIENCY)	10/19/17
	fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an artium 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 STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire and smoke barriers in the facility in accordance with LSC Sections 19.3.7.3, 8.3.5.1. which could allow for the transfer of fire and smoke from one compartment to another, endangering patients, staff, and other building occupants.  The findings include:  Observations on 9/19/17 during the tour from		The filing of this plan of correction does not constitute an admission of this alleged deficiency. The plan of correction is to comply with regulatory compliance  All identified breaches were sealed by the Maintenance Director with 3M Fire barrier packing material immediately.  Administrator educated Maintenance	

PRINTED: 11/08/2017

		ID HUMAN SERVICES					M APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	OVEN MESS	TIO( D	CONSTRUCTION	(X3) DATE	D. 0938-0391
NO PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				PLETED
		105724	B. WING			09	19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	930 E SILVER SPRINGS BLVD		
OCALA O	AKS REHABILITATION C	ENTER		c	DCALA, FL 34470		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE:	DAIL
K 372	Continued From page	7	К	372			
	12:30 pm to 3:45 pm	revealed that:			Director to seal all breaches after any		
					vendor has completed work on the		
	1. At 12:40 pm on 1s	t floor / east smoke doors,			building with 3M Fire barrier packing		
		conduit was not sealed for			material as per his NFPA training cours		
		he ceiling. An interview with			attended on 6-28-16 and the Maintena		
		ctor (MD) at the time of			Director will inspect building once a we	ek:	
		the MD was aware of the 3"			x 3 weeks and then once a month x 3		
	conduit was not seale	ed in the smoke wall.			months thereafter.		
	2. At 2:40 pm on 2nd	I floor / east smoke doors,			Audit of the entire building was done o	f	
		conduit was not sealed for			both the exterior/interior by the		
		he ceiling. An interview with			Maintenance Director to identify any of	ther	
		ctor (MD) at the time of			areas of deficiency.		
		the MD was aware of the 3"					
	conduit was not seale	ed in the smoke wall.			Maintenance Director will monitor area deficiency x 3 months via the monthly		
	3. At 3:20 pm on 2nd	I floor / west smoke doors,			meeting.		
		conduit was not sealed for					
		he celling. An interview with					
		ctor (MD) at the time of					
		the MD was aware of the 3"					
	conduit was not seale	ad in the smoke wall.					
	4. At 3:45 pm on 3rd	floor / west smoke doors,					
		conduit was not sealed for					
	smoke travel above the	ne ceiling. An interview with					
		ctor (MD) at the time of					
		the MD was aware of the 3"					
	conduit was not seale	ed in the smoke wall.					
	Ref.: NFPA 101 (201	2) 19.3.7.3., 8.3.5.1.					
	These findings were	verified by Maintenance					
	Director at the times	of observation and the					
		xit conference on 9/19/17 at					
	4:00 pm.						
K 911	NFPA 101 Electrical S	Systems - Other	i K	911			10/19/17

SS=D

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/08/2017

DEFAIL	WENT OF HEALTH AN	ID HOWAIN SERVICES				FORM	APPROVED
CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09				0.0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION 1, 04	(X3) DATE COMP	SURVEY LETED
		105724	B. WING			09/	19/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	930 E SILVER SPRINGS BLVD		
OCALA O	AKS REHABILITATION C	ENTER		С	CALA, FL 34470		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 911	Chapter 6 Electrical 2 are not addressed by are deficient. This infl applicable Life Safety citation, should be inc Chapter 6 (NFPA 99) This STANDARD is 1 Based on observatio facility failed to maint devices in the facility Sections 19,5-1, 9-1, Overloading of electroverheating of wires, fire. Endangering pat building occupants.  The findings include: Observations on 9/15 12:30 pm to 3:45 pm At 12:46 pm on 1st fit observed electrical ju protection cover abov with the Maintenance observation revealed electrical box missing Ref.: NFPA 101 (2012) These findings were Director at the times of the protection can be proceeded as the processor of the protection or evaled electrical to the processor of	Other section any NFPA 99 section any NFPA 99 systems requirements that the provided K-Tags, but by the provided K-Tags, but by the Code or NFPA standard sluded on Form CMS-2567. The content of the code of the	K	911	The filing of this plan of correction doe not constitute an admission of this alled deficiency. The plan of correction is to comply with regulatory compliance  Protective cover to junction box was pi place immediately and an audit was drof all the electrical junction boxes in the facility to ensure compliance.  All electrical boxes will be inspected for appropriate covers in place once a wear of a weeks and then monthly x 3 months thereafter.  Will monitor all noted deficiencies via the monthly QA meeting and report all corrections/findings x 3 months	ged ut in one e r ek x	

Facility ID: 34208

09/19/2017

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. BUILDING: 01, 04

NAME OF PROVIDER OR SUPPLIER

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

OCALA OAKS REHABILITATION CENTER

34208

3930 E SILVER SPRINGS BLVD

OCALA O	AKS REHABILITATION CENTER	OCALA, FL 34470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 8E PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS	K 000		
	An unannounced Fire & Life Safety re-licensus survey was conducted on September 19, 201 Ocala Oaks Rehabilitation Center, 3930 East Silver Springs, state license: #13230961, a nursing home in Ocala, Florida 34470 in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012 edition) 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 400 Part II, and F.S. 633.0215, adopting Natic Fire Protection Association (NFPA) 1 and 101 (2012 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFF 101, Chapter 2.	7 at and F.S.) onal		
	Initial Plan Review: 1989 New or Existing: Existing NFPA 220 Construction Type: II (111) Footage: 52,000 Number of beds: 120 Census: 104  The following is description of the deficiencies found at the time of the visit:	3,		
K 324 S\$=E	NFPA 101 Cooking Facilities	K 324		10/19/17
	Cooking Facilities Cooking equipment is protected in accordance with NFPA 95. Standard for Ventilation Contro 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	l		

AHCA Form 3020-0001

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

TITLE Electronically Signed

(X6) DATE 10/05/17

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. BUILDING: 01, 04 34208 B. WING\_ 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

OCALA O	AKS REHABILITATION CENTER 3930 E SIL OCALA, FI	VER SPRING: L 34470	S BLVD	
(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 324	Continued From page 1  * 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 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 epr 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, 19.2.3, TIA 12-2  This Statute or Rule is not met as evidenced by: Based on records review and staff interview, the facility failed to maintain kitchen hood system in the facility failed to maintain kitchen hood system in 19.3.2.5.1, 19.2.3, NFPA 96 (2011), NFPA 17A (2009), Failure to maintain cooking hood equipment endanger patients, staff, and other building occupants.  The findings include:  Observations on 9/19/17 during records review from 9:30 am to 12:00 pm revealed that:  At 11:01 am during records review, facility fail to produce documentation for hood system "quick check" inspection. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the hood system "quick check" was not completed.  Ref.: NFPA 101 (2012) 19.3.2.5.1, 9.2.3, NFPA 96 (2011) 10.2.6 (4). NFPA 17A (2009) 7.2.2. (1-8)  These findings were verified by Maintenance	K 324	The filing of this plan of correction does not constitute an admission of this alleged deficiency. The plan of correction is to comply with regulatory compliance  Maintenance Director inspected the system for all required observations immediately and created a monthly 'hood check' sheet to record the findings.  Maintenance Director will use the hood check sheet monthly to ensure system is maintained and complaint with the NFPA requirement.  Will monitor the use of the hood check sheet x 3 months and will follow in the monthly QA meeting as well as report the findings	
CA Form 3		1	1	Į.

PRINTED: 11/08/2017 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. BUILDING: 01. 04 B MING 34208 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3930 E SILVER SPRINGS BLVD OCALA OAKS REHABILITATION CENTER OCALA, FL 34470 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD RE COMPLETE PREFEX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 324 Continued From page 2 K 324 Director at the times of observation and the Administrator at the exit conference on 9/19/17 at 4:00 pm.

K 345

6820

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 NFPA 101 Fire Alarm System - Testing and

SS=E Maintenance

This Statute or Rule is not met as evidenced by: Based on records review and interview, the facility failed to maintain the duct detectors according with LSC 9.7.5., NFPA 72 (2010). Failure to maintain the duct detectors will allow for the travel of smoke gases from one compartment to another through the HVAC system endangering, patients, staff, or other building occupants.

The findings include:

Observations on 9/19/17 during records review from 9:30 am to 12:00 pm revealed that:

At 10.25 am the facility fail to produce documentation for alc unit duct detectors differential pressure test. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the duct detectors differential pressure test was not completed.

The filing of this plan of correction does not constitute an admission of this alleged deficiency. The plan of correction is to comply with regulatory compliance

10/19/17

Maintenance Director contacted the vendor/fire monitoring system company and had the necessary duct test done immediately.

Maintenance Director has added the required duct testing to the list of mandatory testing to be done and with the appropriate frequency

Maintenance Director will follow all identified fire safety inspections/testing via the monthly QA meeting x 3 months

Agency for Health Care Administration

STATEMENT OF DEPICIENCIES
AND PLAN OF CORRECTION

34208

| XI) PROVIDER/SUPPLIER/CLIA
| (X2) NULTIPLE CONSTRUCTION
| A BUILDING: 01, 04

| (X3) DATE SURVEY
| COMPLETED

| (X4) DATE SURVEY
| COMPLETED

| (X5) NULTIPLE CONSTRUCTION
| A BUILDING: 01, 04

| (X6) DATE SURVEY
| COMPLETED

| (X6) DATE SURVEY
| (X6) DATE S

				1 00	10,20,1
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
OCALAO	AKS REHABILITATION CENTER		ER SPRINGS	BLVD	
OUALA O.	ANS REPABLITATION CENTER	OCALA, FL	34470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU 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 3		K 345		
	Ref.: NFPA 101 (2012) 9.7.5., NFPA 72 (201	0)			
	These findings were verified by Maintenance Director at the times of observation and the Administrator at the exit conference on 9/19/ 4:00 pm.				THE RESERVE AND THE PERSONS ASSESSED.
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance a Testing	and	K 353		10/19/17
	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems a inspected, tested, and maintained in accord with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system desimalitenance, inspection and testing are maintenance, inspection and testing are maintained in a secure location and readily available.  a) Date sprinkler system last checked	are ance e			
	b) Who provided system test				
	c) Water system supply source				
	Provide in REMARKS information on coverage for any non-required or partial automatic springsystem.  9.7.5, 9.7.7, 9.7.8, and NFPA 25				***************************************
	This Statute or Rule is not met as evidencec Based on observation and staff interview, the facility failed to maintain their fire sprinkler sy in the facility in accordance with LSC Section 19.3.5, 9.7.5, NFPA 13 (2010), NFPA 25 (2 Failure to maintain fire sprinkler system incre the risk of injury to patients, staff, and other building occupants.	e ystem ns 011).		The filing of this plan of correction does not constitute an admission of this alleged deficiency. The plan of correction is to comply with regulatory compliance	

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STATE FORM 6906 EFNR21 If continuation sheet 4 of 10

10/19/17

PRINTED: 11/08/2017 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. BUILDING: 01. 04 B MING 34208 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3930 E SILVER SPRINGS BLVD OCALA OAKS REHABILITATION CENTER OCALA, FL 34470 (X43.ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD RE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 353 Continued From page 4 K 353 was ordered to replace the identified sign. The findings include: All exterior fire safety signage will be

> inspected once a week x 3 weeks and once a month thereafter to ensure

compliance with NFPA regulations

Maintenance Director will follow all

meeting x 3 months and reports all

findings.

identified deficiencies via the monthly QA

it. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the FDC location signage was faded. Ref.: NFPA 101 (2012) 19.3.5., 9.7.5., NFPA 13

Observations on 9/19/17 during the tour from

At 12:35 pm on exterior/ north side of building. observed FDC location signage faded/ can't read

12:30 pm to 3:45 pm revealed that:

These findings were verified by Maintenance Director at the times of observation and the Administrator at the exit conference on 9/19/17 at 4:00 pm.

K 363 NFPA 101 Corridor - Doors SS=D Corridor - Doors

(2010) NFPA 25 (2011)

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

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K 363

PRINTED: 11/08/2017 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. BUILDING: 01. 04 B MING 34208 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3930 E SILVER SPRINGS BLVD OCALA OAKS REHABILITATION CENTER OCALA, FL 34470 (X43.ID SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD RE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 363 Continued From page 5 K 363 and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9

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 class or

are permissible. Hold open devices that release

frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485

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.

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

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. BUILDING: 01, 04 34208 B. WING\_ 09/19/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

3930 F SILVER SPRINGS BLVD

	LICA DELIA DIL ITATIONI AENTED	3930 E SILV	ER SPRINGS	BLVD	
UCALA U	AKS REHABILITATION CENTER	OCALA, FL	34470		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 363	Continued From page 6		K 363		
	Show in REMARKS details of doors such a protection ratings, automatic closing device. This Statute or Rule is not met as evidence Based on observations and interview, the failed to maintain the proper operation of of door assemblies in accordance with LSC S 19.3.6.3 Corridor door assemblies to prope self-close and latch upon release to maintain the close assembly will allow for it travel of fire and smoke gases from one compartment to another endangering, pat staff, or other building occupants.  The findings include:  Observations on 9/19/17 during the tour fire 12:30 pm to 3:45 pm revealed that:  At 3:00 pm on 2nd floor/ Room 226, obser corridor door would not fully close and latcinterview with the Maintenance Director (W. the time of observation revealed the MD wawere of the door not closing fully.  Ref.: NFPA 101 (2012) 19.3.6.3.  These findings were verified by Maintenan Director at the times of observation and the	es, etc.  red by: facility fac		The filing of this plan of correction does not constitute an admission of this alleged deficiency. The plan of correction is to comply with regulatory compliance  Identified door was immediately repaired so that it could be appropriately latched and closed.  Maintenance Director will inspect all facility doors once a week x 3 weeks and then once a month thereafter for 3 months  Maintenance Director will follow all the identified deficiencies and report the findings at the monthly QA meeting x 3 months.	
K 372	Administrator at the exit conference on 9/4 4:00 pm.  NFPA 101 Subdivision of Building Spaces		K 372		10/19/17
SS=E	Smoke Barrie Subdivision of Building Spaces - Smoke B				-
	Construction	aner			

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PRINTED: 11/08/2017 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. BUILDING: 01. 04 B MING 34208 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3930 E SILVER SPRINGS BLVD OCALA OAKS REHABILITATION CENTER OCALA, FL 34470 (X43.ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD RE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 372 Continued From page 7 K 372 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 harrier 19.3,7.3, 8.6.7,1(1) Describe any mechanical smoke control system in REMARKS 2012 NEW Smoke barriers shall be constructed to provide at 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 Describe any mechanical smoke control system in REMARKS. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the The filing of this plan of correction does

AHCA Form 3020-0001

facility failed to maintain fire and smoke barriers

transfer of fire and smoke from one compartment to another, endangering patients, staff, and other

in the facility in accordance with LSC Sections

19.3.7.3., 8.3.5.1. which could allow for the

Observations on 9/19/17 during the tour from

12:30 pm to 3:45 pm revealed that:

building occupants.

The findings include:

STATE FORM 6820 EENR21 If continuation sheet 8 of 10

not constitute an admission of this alleged

All identified breaches were sealed by the

Maintenance Director with 3M Fire barrier packing material immediately.

Administrator educated Maintenance

Director to seal all breaches after any

vendor has completed work on the building with 3M Fire barrier packing

deficiency. The plan of correction is to

comply with regulatory compliance

09/19/2017

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. BUILDING: 01, 04

NAME OF PROVIDER OR SUPPLIER

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

34208

OCALA O	AKS REHABILITATION CENTER	3930 E SILVE	ILVER SPRINGS BLVD				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
К 372	Continued From page 8  1. At 12-40 pm on 1st floor / east smoke doors observed ends of 3" conduit was not sealed fo smoke travel above the ceiling. An interview we the Maintenance Director (MD) at the time of observation revealed the MD was aware of the conduit was not sealed in the smoke wall.  2. At 2:40 pm on 2nd floor / east smoke doors observed ends of 3" conduit was not sealed for smoke travel above the ceiling. An interview we the Maintenance Director (MD) at the time of observation revealed the MD was aware of the conduit was not sealed in the smoke wall.  3. At 3:20 pm on 2nd floor / west smoke doors observed ends of 3" conduit was not sealed for smoke travel above the ceiling. An interview we the Maintenance Director (MD) at the time of observation revealed the MD was aware of the conduit was not sealed in the smoke wall.  4. At 3:45 pm on 3rd floor / west smoke doors observed ends of 3" conduit was not sealed for smoke travel above the ceiling. An interview we the Maintenance Director (MD) at the time of observation revealed the MD was aware of the conduit was not sealed in the smoke wall.  4. At 3:45 pm on 3rd floor / west smoke doors observed ends of 3" conduit was not sealed for smoke travel above the ceiling. An interview we the Maintenance Director (MD) at the time of observation revealed the MD was aware of the conduit was not sealed in the smoke wall.  Ref.: NFPA 101 (2012) 19.3.7.3., 8.3.5.1.  These findings were verified by Maintenance Director at the times of observation and the Administrator at the ext conference on 91/91/1	or with so 3"  5. or with so 3"  5. or with so 3"  5. or with so 3"  6. or with so 3"  7. or with so 3"  7. or with so 3"  8. or with so 3"  8. or with so 3"	К 372	material as per his NFPA training course attended on 6-28-16 and the Maintenance Director will inspect building once a week x 3 weeks and then once a month x 3 months thereafter.  Audit of the entire building was done of both the exterior/interior to identify any other areas of deficiency.  Maintenance Director will monitor areas of deficiency x 3 months via the monthly QA meeting.			
K 911 SS=D	4:00 pm.  NFPA 99 Electrical Systems - Other  Electrical Systems - Other  List in the REMARKS section any NFPA 99		K 911		10/19/17		

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PRINTED: 11/08/2017  Agency for Health Care Administration  STATEMENT OF DERICIENCIES 0/1) PROVIDER/SUPPUER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY									
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING: 01, 04		COMPLETED				
	34208	B. WING		09/1	9/2017				
NAME OF PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	ATE, ZIP CODE						
OCALA OAKS REHABILITATION C	3930 E S	ILVER SPRINGS	BLVD						
OCALA DARS REHABILITATION C	OCALA,	FL 34470							
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE COMPLETE BE APPROPRIATE DATE					
are not addressed by are deficient. This inth applicable Life Safety citation, should be in in Chapter 6 (NFPA 99)  This Statute or Rule Based on observation facility failed to maint devices in the facility Sections 19.5.1, 9.1., Overloading of electric overheating of wires, fire. Endangering pati building occupants.  The findings include:  Observations on 9/19 12:30 pm to 3:45 pm  At 12:46 pm on 1st fit observed electrical ju protection cover abov with the Maintenance observation revealed electrical box missing electrical electrical box missing electrical box missing electrical electrical box missing electrical electrical box missing electrical electrical box missing electrical elec	systems requirements that the provided K-Tags, but ormation, along with the Code or NFPA standard luded on Form CMS-2567.  Is not met as evidenced by: and staff interview, the ain electrical system and in accordance with LSC NFPA 70 (2011). Calcinctit leads to short circuits, hot spots, and ents, staff, and other viewed that the control of the colling. An interview Director (MD) at the time of the MD was aware of the the Code of the colling. An interview Director (MD) at the time of the MD was aware of the the Code of the colling.	К911	The filing of this plan of correction do not constitute an admission of this alle deficiency. The plan of correction is to correly with regulatory compliance protection because of all the electrical junction boxes in the facility to ensure compliance.  All electrical boxes will be inspected frapropriate covers in place once a we 3 weeks and then monthly x 3 months thereafter.  Will monitor all noted deficiencies via monthly QA meeting and report all corrections/findings x 3 months	eged  but in  lone  ne  or  eek x					

4:00 pm.

These findings were verified by Maintenance Director at the times of observation and the Administrator at the exit conference on 9/19/17 at