STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 recertification survey was conducted September 19, 2017 at Ocala Oaks Rehabilitation Center, 3930 East Silver Springs Blvd., a nursing home in Ocala, Florida 34470. Ocala Oaks Rehabilitation Center 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: 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:	K 000		
K 324 SS=E	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	K 324		10/19/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD OCALA, FL 34470**

(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 324	Continued From page 1 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 records review and staff interview, the facility failed to maintain kitchen hood system in the facility in accordance with LSC Sections 19.3.2.5.1, 9.2.3, 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 Director at the times of observation and the	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 324	Continued From page 2 Administrator at the exit conference on 9/19/17 at 4:00 pm.	K 324		
K 345 SS=E	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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD 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 a/c 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	K 345	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 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	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 3 duct detectors differential pressure test was not completed. Ref.: NFPA 101 (2012) 9.7.5., NFPA 72 (2010) 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 345		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their fire sprinkler system in the facility in accordance with LSC Sections 19.3.5., 9.7.5., NFPA 13 (2010), NFPA 25 (2011). Failure to maintain fire sprinkler system increases the risk of injury to patients, staff, and other	K 353	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 353	Continued From page 4 building occupants. The findings include: Observations on 9/19/17 during the tour from 12:30 pm to 3:45 pm revealed that: At 12:35 pm on exterior/ north side of building, observed FDC location signage faded/ can't read 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 (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 353	FDC signage was painted and a new sign was ordered to replace the identified sign. 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 identified deficiencies via the monthly QA meeting x 3 months and reports all findings.	
K 363 SS=D	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	K 363		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 363	Continued From page 5 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, 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 observations and interview, the facility failed to maintain the proper operation of corridor door assemblies in accordance with LSC Section 19.3.6.3 Corridor door assemblies to properly self-close and latch upon release to maintain the fire resistance rated barrier penetration. Failure to maintain the door assembly will allow for the travel of fire and smoke gases from one compartment to another endangering, patients, staff, or other building occupants. The findings include: Observations on 9/19/17 during the tour from 12:30 pm to 3:45 pm revealed that: At 3:00 pm on 2nd floor/ Room 226, observed the corridor door would not fully close and latch. An interview with the Maintenance Director (MD) at	K 363	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD OCALA, FL 34470**

(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 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.	K 363		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This 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	K 372	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	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 372	Continued From page 7 12:30 pm to 3:45 pm revealed that: 1. At 12:40 pm on 1st floor / east smoke doors, observed ends of 3" conduit was not sealed for smoke travel above the ceiling. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 exit conference on 9/19/17 at 4:00 pm.	K 372	Director to seal all breaches after any vendor has completed work on the building with 3M Fire barrier packing 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 by the Maintenance Director 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	NFPA 101 Electrical Systems - Other	K 911		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105724	A. BUILDING **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 911	Continued From page 8 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical system and devices in the facility in accordance with LSC Sections 19.5.1, 9.1., NFPA 70 (2011). Overloading of electrical circuit leads to overheating of wires, short circuits, hot spots, and fire. Endangering patients, staff, and other building occupants. The findings include: Observations on 9/19/17 during the tour from 12:30 pm to 3:45 pm revealed that: At 12:46 pm on 1st floor/ east smoke doors, observed electrical junction box missing protection cover above the ceiling. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the electrical box missing protection cover. Ref.: NFPA 101 (2012) 19.3.7.1., 9.1., NFPA 70 (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 911	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 Protective cover to junction box was put in place immediately and an audit was done of all the electrical junction boxes in the facility to ensure compliance. All electrical boxes will be inspected for appropriate covers in place once a week x 3 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	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on September 19, 2017 at 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) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2012 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101 , Chapter 2. 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:	K 000		
K 324 SS=E	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	K 324		10/19/17

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/05/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 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 records review and staff interview, the facility failed to maintain kitchen hood system in the facility in accordance with LSC Sections 19.3.2.5.1, 9.2.3, 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	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 2 Director at the times of observation and the Administrator at the exit conference on 9/19/17 at 4:00 pm.	K 324		
K 345 SS=E	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 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 a/c 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.	K 345	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 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	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 3 Ref.: NFPA 101 (2012) 9.7.5., NFPA 72 (2010) 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 345		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their fire sprinkler system in the facility in accordance with LSC Sections 19.3.5., 9.7.5., NFPA 13 (2010), NFPA 25 (2011). Failure to maintain fire sprinkler system increases the risk of injury to patients, staff, and other building occupants.	K 353	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 FDC signage was painted and a new sign	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 353	Continued From page 4 The findings include: Observations on 9/19/17 during the tour from 12:30 pm to 3:45 pm revealed that: At 12:35 pm on exterior/ north side of building, observed FDC location signage faded/ can't read 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 (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 353	was ordered to replace the identified sign. 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 identified deficiencies via the monthly QA meeting x 3 months and reports all findings.	
K 363 SS=D	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	K 363		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 363	Continued From page 5 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, 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	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 363	Continued From page 6 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 observations and interview, the facility failed to maintain the proper operation of corridor door assemblies in accordance with LSC Section 19.3.6.3 Corridor door assemblies to properly self-close and latch upon release to maintain the fire resistance rated barrier penetration. Failure to maintain the door assembly will allow for the travel of fire and smoke gases from one compartment to another endangering, patients, staff, or other building occupants. The findings include: Observations on 9/19/17 during the tour from 12:30 pm to 3:45 pm revealed that: At 3:00 pm on 2nd floor/ Room 226, observed the corridor door would not fully close and latch. An interview with the Maintenance Director (MD) at 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.	K 363	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 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction	K 372		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: **01, 04** B. WING _____	**09/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	**3930 E SILVER SPRINGS BLVD** **OCALA, FL 34470**

(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 372	Continued From page 7 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 of 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. 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 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 12:30 pm to 3:45 pm revealed that:	K 372	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 Director to seal all breaches after any vendor has completed work on the building with 3M Fire barrier packing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 372	Continued From page 8 1. At 12:40 pm on 1st floor / east smoke doors, observed ends of 3" conduit was not sealed for smoke travel above the ceiling. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the 3" 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 exit conference on 9/19/17 at 4:00 pm.	K 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	NFPA 99 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34208	A. BUILDING: 01, 04 B. WING	09/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCALA OAKS REHABILITATION CENTER	3930 E SILVER SPRINGS BLVD OCALA, FL 34470

(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 911	Continued From page 9 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical system and devices in the facility in accordance with LSC Sections 19.5.1, 9.1., NFPA 70 (2011). Overloading of electrical circuit leads to overheating of wires, short circuits, hot spots, and fire. Endangering patients, staff, and other building occupants. The findings include: Observations on 9/19/17 during the tour from 12:30 pm to 3:45 pm revealed that: At 12:46 pm on 1st floor/ east smoke doors, observed electrical junction box missing protection cover above the ceiling. An interview with the Maintenance Director (MD) at the time of observation revealed the MD was aware of the electrical box missing protection cover. Ref.: NFPA 101 (2012) 19.3.7.1., 9.1., NFPA 70 (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 911	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 Protective cover to junction box was put in place immediately and an audit was done of all the electrical junction boxes in the facility to ensure compliance. All electrical boxes will be inspected for appropriate covers in place once a week x 3 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	