STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105250	A. BUILDING **01, 04** B. WING _____	**12/13/2017**

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HUNTINGTON PLACE	**1775 HUNTINGTON LANE** **ROCKLEDGE, FL 32955**

(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
E 000	Initial Comments During the unannounced recertification survey conducted on 12/14/2017 at Metro West Nursing and Rehabilitation Center, a nursing home in Rockledge, Florida the Emergency Preparedness was reviewed. Huntington Place is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities. The following is a description of the noncompliance.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan	E 004		1/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/24/2018

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.

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E 004	Continued From page 1 that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain a comprehensive emergency preparedness plan. Per 483.73(a) "The facility must establish and maintain a comprehensive emergency preparedness program..." Findings: During the review of records on December 13, 2017, at approximately 10:00 a.m. a copy of the facility"s Emergency Preparedness plan was requested of the Administrator. A copy of the Comprehensive Emergency Manage Plan for the State of Florida was produced. The plan was examined for conformity to the Federal regulations and was found to be not in conformance. Interview with the Administrator, at that time, revealed that an Emergency Management plan had not been developed and established. These findings were reconfirmed with the Administrator during the exit conference at 2:30 p.m.	E 004	E004- Emergency Plan 1- Center emergency plan was revised to meet federal requirements; 2- no other areas identified to be adverse; 3- Administrator will monitor CEMP for updates to ensure compliance with Federal requirements; 4- Administrator will report findings/updates to the QAPI committee monthly for three (3) months	
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification	K 000		

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K 000	Continued From page 2 survey was conducted on 12/13/2017 at Huntington Place a nursing home in Rockledge, Florida. Huntington Place is not compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 Edition) and NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1969 NFPA 220 Construction Type: II (111) Number of Beds: 100 Census: 85 The following is description of the noncompliance.	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were inspected on a monthly basis. NFPA 101 Ch 19.3.5.12 establishes that "Portable fire extinguishers shall be installed in all healthcare occupancies in accordance with 9.7.4.1." Per 9.7.4.1 "...inspected and maintained in accordance with NFPA 10, Standard for portable fire extinguishers." Also per NFPA 1 Ch. 13.6.4.2.1.2.1, "Fire extinguishers and Class D extinguishing agents shall be inspected at least	K 355	Huntington Place provides this plan without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. K355-Fire Extinguishers- 1. All extinguishers were inspected in January 2018. 2. Monthly inspections were scheduled	1/27/18

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K 355	Continued From page 3 once per calendar month. (10:7.2.1.3)." Findings: During the tour of the building on December 13, 2017 between 11:00 a.m. and noon, the fire extinguishers mounted in cabinets in the corridors were observed. Each extinguisher featured an annual inspection tag supplied by a certified technician. The reverse side of the annual inspection tag has a space to indicate the date of monthly inspections. Each of the tags observed did not show initials or dates of inspections done by facility personnel. Interview with the maintenance director revealed that he was unaware of the requirement. These findings were reconfirmed with the Administrator during the exit conference a 2:30 p.m. NFPA 101 19.3.5.12, Ch 9.7.4.1, NFPA 1 Ch.13.6.4.2.1.2.1, NFPA 10 7.2.1.3	K 355	for facility personnel; 3. Maintenance Director will monitor extinguishers monthly; education provided for Maintenance Director to inspect and document on reverse side of inspection tag 4. Results of the inspections will be reported to the monthly QAPI committee for three months and quarterly thereafter.	
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are	K 362		1/27/18

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K 362	Continued From page 4 in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to maintain smoke walls that are installed to resist the spread of smoke and the toxic products of combustion. Per NFPA 101 Ch. 19.3.6.2.3 "Corridor walls shall form a barrier to limit the transfer of smoke." During the tour of the building on 12/13/17 at approximately 1:30 p.m. ceiling tiles were displaced to observe the smoke wall installed above the double doors in the corridor near the nurse's station in the 100 wing. The wall featured several penetrating items and openings in the wall could be observed. Caulk was installed to seal the various sleeves and penetrating items and were observed to be loose and not forming an air tight barrier. These findings were reconfirmed with the Administrator during the exit conference a 2:30 p.m. NFPA 101 Ch. 19.3.6.2.3	K 362	K362-Walls/Corridors 1. Wall identified during survey was repaired to form a barrier to limit transfer of smoke. 2. Firewalls inspected for appropriate barrier to limit transfer of smoke 3. Education provided for Maintenance Director to inspect and ensure walls are inspected for appropriate barriers 4. Maintenance Director will submit monthly report to the QAPI committee to track progress towards improvement and compliance.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		1/27/18

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K 363	Continued From page 5 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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 REQUIREMENT is not met as evidenced by: Based on observations and testing, the facility	K 363	K363-Corridor- Doors	

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K 363	Continued From page 6 did not maintain doors to prevent impediments to opening doors installed in exits. NFPA 101 Ch 7.2.1.5.10.1 establishes that "The releasing mechanism for any latch shall be located as follows: (1) Not less than 34 in. above the finished floor, (2) Not more than 48 in. above the finished floor." Findings: During the tour of the building with the Maintenance Director on December 13, 2017 at approximately 10:00 a.m. the corridor door from the kitchen was observed. The door featured a locking mechanism with a dead bolt that was lockable from the corridor side. The lock was exposed on the kitchen side and the door knob was removed. The door could be locked and not opened from the inside. The door was marked as an exit. A passage door latch was observed at the uppermost corner of the door leaf and could be used to open the door, if it was closed but unlocked. Interview with the Maintenance Director, at that time, revealed that the door knob was subject to damage and was moved to reduce maintenance. These findings were reconfirmed with the Administrator during the closing conference at 2:30 p.m. Code: NFPA 101 (2012 Edition) Ch 7.2.1.5.10.1	K 363	1. Kitchen door identified during survey was repaired for a releasing mechanical lock; 2. No other doors were found to be affected. 3. Education of Maintenance director provided to inspect doors are equipped with releasing mechanical locks; 4. The results of the audits will be reported to the monthly QAPI committee to track progress towards improvement and compliance for three monthly and quarterly thereafter.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall	K 741		1/27/18

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K 741	Continued From page 7 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to remain in compliance with standards to ensure the safety of the residents, staff and the public from accidental fires caused by smoking. Per NFPA 101 CH.19.7.4 "The most rigid discipline with regard to prohibition of smoking might not be nearly as effective in reducing incipient fires from surreptitious smoking as the open recognition of smoking, with provision of suitable facilities for smoking..." Also per Ch 19.7.4(5) "Ashtrays of non-combustible material and safe designs shall be provided in all areas	K 741	K741- Smoking Regulations- 1. Cigarette butts and metal container were removed from gazebo area immediately; 2. Signs posted in designated smoking areas and non-smoking areas; 3. Education of staff regarding only designated smoking areas to be used; Environmental rounds to be completed by Maintenance Director/designee 4. The results of environmental rounds will be reported to the monthly QAPI	

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K 741	Continued From page 8 where smoking is permitted." Findings: During the tour of the building on December 13, 2017, at approximately 10:45 a.m. the exterior of the exit near the gazebo was observed. The area had a large accumulation of cigarette butts on the ground near a bench. A metal container was provided but no ashtray. Interview with the Maintenance Director revealed that an ashtray was not provided because the metal can could be used. These findings were reconfirmed with the Administrator during the exit conference at 2:30 p.m. NFPA Ch 19.7.4(5)	K 741	committee to track progress towards improvement and compliance for three months and quarterly thereafter.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL	K 920		1/27/18

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K 920	Continued From page 9 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview during the survey, the facility failed to maintain the electrical supply and distribution system in compliance with the requirements of the National Electric Code. Extension cords and power strips used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Findings: During the tour of the building on December 13, 2017 at approximately 10:00 a.m. in the kitchen, the breaker panel was observed. A 50 amp circuit was observed in the on position and the circuit schedule was marked as blank. At approximately 10:05 a.m. the junction box mounted on the wall in the kitchen was observed to be un attached to the wall. At 10:15 a.m. the Christmas tree in the lobby was observed to be connected to the wall outlet with an extension cord. At 10:30 a.m. resident room #134 was entered	K 920	K920- Electrical equipment- power cords and Extensions- 1. Breaker panel in kitchen marked accordingly; junction box attached accordingly; Christmas tree extension cord removed; room #134 checked and upon discovery appropriate equipment provided; Room 130 multi-plug adaptor removed; damaged, loose, and broken outlets replaced upon discovery; 2. Room rounds completed; items requiring repair/replacement were handled upon discovery- 3. Education of staff for items noticed during room rounds to complete work orders for attention; CED/designee will conduct room rounds for compliance regarding electrical equipment safety; 4. The results of the audits will be reported to the monthly QAPI committee to track progress towards improvement and compliance for three months and quarterly thereafter.	

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K 920	Continued From page 10 and the electrical connections were observed. A plastic power strip was zip tied to the bottom of a shelf and was being used to connect multiple appliances. At 12:15 p.m. resident room # 130 was entered and a multi-plug adaptor was observed to connect several appliances. During the tour of the building, several damaged, loose and broken electrical outlets were observed. Interview with the Maintenance Director at 12:30 p.m. revealed that the facility had not established an inspection program for the electrical distribution system. These findings were reconfirmed with the Administrator during the exit conference at 2:30 p.m. Chapter 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		
K 929 SS=D	Gas Equipment - Precautions for Handling Oxyg CFR(s): NFPA 101 Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced	K 929		1/27/18

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K 929	Continued From page 11 by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored and handled appropriately. Per NFPA 99 (2012) Chapter 11.5.3.3.1 "Flow control valves on administering equipment shall be closed prior to connection and when not in use." Findings: During the tour of the building on December 13, 2017 at approximately 1:30 p.m. the oxygen storage room near the nurse's station was entered and the oxygen cylinders were observed. Of the several cylinders stored, two were empty and the regulator was open as well as the cylinder valve. Interview with the Maintenance Director, at that time revealed that the CNAs are responsible for returning the empty cylinders to storage. 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) These findings were reconfirmed with the Administrator during the closing conference at 2:30 p.m.	K 929	K- 929 Oxygen Cylinders 1- Oxygen cylinders identified were checked, closed, and stored properly upon discovery; 2- remaining stored cylinders were checked for proper storage and handling; 3- Staff re-educated on proper Oxygen cylinder handling techniques; ensuring that equipment shall be closed prior to connection and when not in use; 4- Maintenance Director/designee will audit/monitor oxygen cylinders for proper handling and storage. Director/designee will report findings to the QAPI committee monthly for 3 months to ensure compliance.	

Agency for Health Care Administration

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K 000	INITIAL COMMENTS An unannounced relicensure survey was conducted on December 13, 2107 at Huntington Place, a nursing home in Rockledge, Florida 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. State license #1003096 Huntington Place had deficiencies at the time of the visit.	K 000		
K 355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were inspected on a monthly basis. NFPA 101 Ch 19.3.5.12 establishes that "Portable fire extinguishers shall be installed in all healthcare occupancies in accordance with 9.7.4.1." Per 9.7.4.1 "..inspected and maintained in accordance with NFPA 10, Standard for portable fire extinguishers." Also per NFPA 1 Ch.	K 355	K355-Fire Extinguishers- 1. All extinguishers were inspected in January 2018. 2. Monthly inspections were scheduled for facility personnel; 3. Maintenance Director will monitor extinguishers monthly; education provided for facility staff to inspect and document	1/27/18

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K 355	Continued From page 1 13.6.4.2.1.2.1, "Fire extinguishers and Class D extinguishing agents shall be inspected at least once per calendar month. (10:7.2.1.3)." Findings: During the tour of the building on December 13, 2017 between 11:00 a.m. and noon, the fire extinguishers mounted in cabinets in the corridors were observed. Each extinguisher featured an annual inspection tag supplied by a certified technician. The reverse side of the annual inspection tag has a space to indicate the date of monthly inspections. Each of the tags observed did not show initials or dates of inspections done by facility personnel. Interview with the maintenance director revealed that he was unaware of the requirement. These findings were reconfirmed with the Administrator during the exit conference a 2:30 p.m. NFPA 101 19.3.5.12, Ch 9.7.4.1, NFPA 1 Ch.13.6.4.2.1.2.1, NFPA 10 7.2.1.3	K 355	on reverse side of inspection tag 4. Results of the inspections will be reported to the monthly QAPI committee for three months and quarterly thereafter.	
K 362 SS=D	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically	K 362		1/27/18

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K 362	Continued From page 2 permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke, No fire resistance rating is required for the corridor walls. 18.3.6.2 This Statute or Rule is not met as evidenced by: Based on observation and testing, the facility failed to maintain smoke walls that are installed to resist the spread of smoke and the toxic products of combustion. Per NFPA 101 Ch. 19.3.6.2.3 "Corridor walls shall form a barrier to limit the transfer of smoke." During the tour of the building on 12/13/17 at approximately 1:30 p.m. ceiling tiles were displaced to observe the smoke wall installed above the double doors in the corridor near the nurse's station in the 100 wing. The wall featured several penetrating items and openings in the wall could be observed. Caulk was installed to seal the various sleeves and penetrating items and were observed to be loose and not forming an air tight barrier.	K 362	K362-Walls/Corridors 1. Wall identified during survey was repaired to form a barrier to limit transfer of smoke. 2. Firewalls inspected for appropriate barrier to limit transfer of smoke 3. Education provided for Maintenance Director to inspect and ensure walls are inspected for appropriate barriers 4. Maintenance Director will submit monthly report to the QAPI committee to track progress towards improvement and compliance.	

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K 362	Continued From page 3 These findings were reconfirmed with the Administrator during the exit conference a 2:30 p.m. NFPA 101 Ch. 19.3.6.2.3	K 362		
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 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		1/27/18

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K 363	Continued From page 4 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 observations and testing, the facility did not maintain doors to prevent impediments to opening doors installed in exits. NFPA 101 Ch 7.2.1.5.10.1 establishes that "The releasing mechanism for any latch shall be located as follows: (1) Not less than 34 in. above the finished floor, (2) Not more than 48 in. above the finished floor." Findings:	K 363	K363-Corridor- Doors 1. Kitchen door identified during survey was repaired for a releasing mechanical lock; 2. No other doors were found to be affected. 3. Education of Maintenance director provided to inspect doors are equipped with releasing mechanical locks; 4. The results of the audits will be	

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K 363	Continued From page 5 During the tour of the building with the Maintenance Director on December 13, 2017 at approximately 10:00 a.m. the corridor door from the kitchen was observed. The door featured a locking mechanism with a dead bolt that was lockable from the corridor side. The lock was exposed on the kitchen side and the door knob was removed. The door could be locked and not opened from the inside. The door was marked as an exit. A passage door latch was observed at the uppermost corner of the door leaf and could be used to open the door, if it was closed but unlocked. Interview with the Maintenance Director, at that time, revealed that the door knob was subject to damage and was moved to reduce maintenance. These findings were reconfirmed with the Administrator during the closing conference at 2:30 p.m. Code: NFPA 101 (2012 Edition) Ch 7.2.1.5.10.1	K 363	reported to the monthly QAPI committee to track progress towards improvement and compliance for three monthly and quarterly thereafter.	
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741		1/27/18

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K 741	Continued From page 6 that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 (Note smoking tower disposal receptacles are not ashtrays) This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to remain in compliance with standards to ensure the safety of the residents, staff and the public from accidental fires caused by smoking. Per NFPA 101 CH.19.7.4 "The most rigid discipline with regard to prohibition of smoking might not be nearly as effective in reducing incipient fires from surreptitious smoking as the open recognition of smoking, with provision of suitable facilities for smoking..." Also per Ch 19.7.4(5) "Ashtrays of non-combustible material and safe designs shall be provided in all areas where smoking is permitted." Findings: During the tour of the building on December 13, 2017, at approximately 10:45 a.m. the exterior of the exit near the gazebo was observed. The area had a large accumulation of cigarette butts on the ground near a bench. A metal container was provided but no ashtray. Interview with the Maintenance Director revealed that an ashtray	K 741	K741- Smoking Regulations- 1. Cigarette butts and metal container were removed from gazebo area immediately; 2. Signs posted in designated smoking areas and non-smoking areas; 3. Education of staff regarding only designated smoking areas to be used; Environmental rounds to be completed by Maintenance Director/designee 4. The results of environmental rounds will be reported to the monthly QAPI committee to track progress towards improvement and compliance for three months and quarterly thereafter.	

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K 741	Continued From page 7 was not provided because the metal can could be used. These findings were reconfirmed with the Administrator during the exit conference at 2:30 p.m. NFPA Ch 19.7.4(5)	K 741		
K 920 SS=D	NFPA 99 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This Statute or Rule is not met as evidenced by:	K 920		1/27/18

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K 920	Continued From page 8 Based on observation and interview during the survey, the facility failed to maintain the electrical supply and distribution system in compliance with the requirements of the National Electric Code. Extension cords and power strips used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Findings: During the tour of the building on December 13, 2017 at approximately 10:00 a.m. in the kitchen, the breaker panel was observed. A 50 amp circuit was observed in the on position and the circuit schedule was marked as blank. At approximately 10:05 a.m. the junction box mounted on the wall in the kitchen was observed to be un attached to the wall. At 10:15 a.m. the Christmas tree in the lobby was observed to be connected to the wall outlet with an extension cord. At 10:30 a.m. resident room #134 was entered and the electrical connections were observed. A plastic power strip was zip tied to the bottom of a shelf and was being used to connect multiple appliances. At 12:15 p.m. resident room # 130 was entered and a multi-plug adaptor was observed to connect several appliances. During the tour of the building, several damaged, loose and broken electrical outlets were observed. Interview with the Maintenance	K 920	K920- Electrical equipment- power cords and Extensions- 1. Breaker panel in kitchen marked accordingly; junction box attached accordingly; Christmas tree extension cord removed; room #134 checked and upon discovery appropriate equipment provided; Room 130 multi-plug adaptor removed; damaged, loose, and broken outlets replaced upon discovery; 2. Room rounds completed; items requiring repair/replacement were handled upon discovery- 3. Education of staff for items noticed during room rounds to complete work orders for attention; CED/designee will conduct room rounds for compliance regarding electrical equipment safety; 4. The results of the audits will be reported to the monthly QAPI committee to track progress towards improvement and compliance for three months and quarterly thereafter.	

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K 920	Continued From page 9 Director at 12:30 p.m. revealed that the facility had not established an inspection program for the electrical distribution system. These findings were reconfirmed with the Administrator during the exit conference a 2:30 p.m.	K 920		
K 929 SS=D	NFPA 99 Gas Equipment - Precautions for Handling Oxyg Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored and handled appropriately. Per NFPA 99 (2012) Chapter 11.5.3.3.1 "Flow control valves on administering equipment shall be closed prior to connection and when not in use." Findings: During the tour of the building on December 13, 2017 at approximately 1:30 p.m. the oxygen storage room near the nurse's station was entered and the oxygen cylinders were observed. Of the several cylinders stored, two were empty	K 929	K- 929 Oxygen Cylinders 1- Oxygen cylinders identified were checked, closed, and stored properly upon discovery; 2- remaining stored cylinders were checked for proper storage and handling; 3- Staff re-educated on proper Oxygen cylinder handling techniques; ensuring that equipment shall be closed prior to connection and when not in use; 4- Maintenance Director/designee will audit/monitor oxygen cylinders for proper handling and storage. Director/designee	1/27/18

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K 929	Continued From page 10 and the regulator was open as well as the cylinder valve. Interview with the Maintenance Director, at that time revealed that the CNAs are responsible for returning the empty cylinders to storage. 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) These findings were reconfirmed with the Administrator during the closing conference at 2:30 p.m.	K 929	will report findings to the QAPI committee monthly for 3 months to ensure compliance.	