STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105421	A. BUILDING **01 - MAIN FED** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE NURSING AND REHABILITATION CENTER	**3601 LAKEWOOD BLVD** **NAPLES, FL 34112**

(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 3/6/18 at Manorcare Nursing and Rehabilitation Center, a skilled nursing facility in Naples, Florida. Manorcare Nursing and Rehabilitation Center is not in compliance with Code of Federal Regulations (CFR) 42, Section 483.70, Physical Environment Requirements for Long-Term Care Facilities and the National Fire Protection Association (NFPA) 101 (2012 edition) Life Safety Code. Initial Plan Review: 1981 Existing NFPA 220 Construction Type: II (000) Number of beds: 120 Census: 104	K 000		
K 761 SS=F	The following is description of the noncompliance. Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		4/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105421	A. BUILDING **01 - MAIN FED** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE NURSING AND REHABILITATION CENTER	**3601 LAKEWOOD BLVD NAPLES, FL 34112**

(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 761	Continued From page 1 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of the facility records and interview with the maintenance director, the facility failed to test and inspect fire doors in accordance with NFPA 101 2012 edition 19.7.6, 8.3.3.1., and NFPA 80 2010 edition. Undetected problems with fire doors would allow fire, smoke, and toxic gases to migrate from one fire compartment to another. The findings included: On 3/6/18 there was no documentation to show the fire doors were inspected in the last year. On 3/6/18 at 1:30 p.m., the maintenance director said that he did not inspect them, and had no training on what to look for during these inspections and tests as required.	K 761	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken, or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or date(s) indicated. It is the practice of the center to inspect and test fire doors and assemblies annually in accordance with NFPA 80, Standard for fire doors and other opening protectives, and to maintain written records of inspection and testing that are available to review. No specific residents were identified. Fire doors will be inspected and tested in accordance with NFPA 80, Standard for fire doors and assemblies. Maintenance Director will be in-serviced on the requirement of having fire doors tested and inspected annually in accordance with NFPA 80, Standard for fire doors and assemblies, and on maintaining written records of inspection and testing that are available to review. Audit for validation that fire doors are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105421	A. BUILDING **01 - MAIN FED** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE NURSING AND REHABILITATION CENTER	**3601 LAKEWOOD BLVD** **NAPLES, FL 34112**

(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 761	Continued From page 2	K 761	inspected and tested in accordance with NFPA 80, Standard for fire doors and assemblies will be conducted by the Administrator/or designee. The result of the audit will be reported to the QA&A Committee by the Administrator and/or designee for recommendations and follow up as indicated.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105421	A. BUILDING _____ B. WING _____	03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE NURSING AND REHABILITATION CENTER	**3601 LAKEWOOD BLVD NAPLES, FL 34112**

(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 Fire & Life Safety recertification survey conducted 3/6/18 at Manorcare Nursing and Rehabilitation Center, a skilled nursing facility in Naples, Florida, Emergency Preparedness was reviewed. Manorcare Nursing and Rehabilitation Center is in compliance with Code of Federal Regulations (CFR) 42, Part 483.73, Emergency Preparedness Requirement for Long-Term Care Facilities.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/30/2018

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.

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
	81101	A. BUILDING: **03 - CLOSED -MAIN LIC** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE NURSING AND REHABILITATION CENT	**3601 LAKEWOOD BLVD NAPLES, FL 34112**

(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 relicensure survey was conducted on 3/6/18 at Manorcare Nursing and Rehabilitation Center, a skilled nursing facility in Naples, Florida. This survey was conducted in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015 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 (2015 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is description of the deficiency found at the time of the visit.	K 000		
K 700 SS=F	NFPA 101 Operating Features - Other Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features 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. This Statute or Rule is not met as evidenced by: Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility	K 700	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken, or will take the actions set forth in the following	4/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/18

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
	81101	A. BUILDING: **03 - CLOSED -MAIN LIC** B. WING _____	**03/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE NURSING AND REHABILITATION CENT	**3601 LAKEWOOD BLVD NAPLES, FL 34112**

(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 700	Continued From page 1 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) Based on a review of the facility records and interview with the maintenance director, the facility failed to test and inspect fire doors in accordance with NFPA 101 2012 edition 19.7.6, 8.3.3.1., and NFPA 80 2010 edition. Undetected problems with fire doors would allow fire, smoke, and toxic gases to migrate from one fire compartment to another. The findings included: On 3/6/18 there was no documentation to show the fire doors were inspected in the last year. On 3/6/18 at 1:30 p.m., the maintenance director said that he did not inspect them, and had no training on what to look for during these inspections and tests as required. Class III	K 700	plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been, or will be corrected by the date or date(s) indicated. It is the practice of the center to inspect and test fire doors and assemblies annually in accordance with NFPA 80, Standard for fire doors and other opening protectives, and to maintain written records of inspection and testing that are available to review. No specific residents were identified. Fire doors will be inspected and tested in accordance with NFPA 80, Standard for fire doors and assemblies. Maintenance Director will be in-serviced on the requirement of having fire doors tested and inspected annually in accordance with NFPA 80, Standard for fire doors and assemblies, and on maintaining written records of inspection and testing that are available to review. Audit for validation that fire doors are inspected and tested in accordance with NFPA 80, Standard for fire doors and assemblies will be conducted by the Administrator/or designee. The result of the audit will be reported to the QA&A Committee by the Administrator and/or designee for recommendations and follow up as indicated.	