## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/27/2018 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED		(X3) DATE SURVEY COMPLETED	
		105421	B. WING	_		03/	06/2018
	ROVIDER OR SUPPLIER  ARE NURSING AND REH	ABILITATION CENTER	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 LAKEWOOD BLVD NAPLES, FL 34112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
К 000	An unannounced Fire survey was conducted to Nursing and Rehabilith nursing facility in Nap Manorcare Nursing at not in compliance with Regulations (CFR) 42 Environment Require Facilities and the Nati	a & Life Safety recertification at 3/6/18 at Manorcare atton Center, a skilled les, Florida.  And Rehabilitation Center is no Code of Federal 2, Section 483.70, Physical ments for Long-Term Care onal Fire Protection 01 (2012 edition) Life Safety	к	000			
K 761 SS=F	The following is descr Maintenance, Inspect CFR(s): NFPA 101 Maintenance, Inspect Fire doors assemblies annually in accordan for Fire Doors and Ot Non-reted doors, incl patient rooms and sir routinely inspected as maintenance program individuals performing testing possess know that demonstrates ab	ion & Testing - Doors s are inspected and tested eventh NFPA 80, Standard her Opening Protectives. uding corridor doors to looke barrier doors, are spart of the facility g the door inspections and ledge, training or experience litry. pection and testing are	к	761			4/6/18

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

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Electronically Signed

program participation.

Event tD: 0LY721

Facility ID: 81101

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/27/2018

DEFAIL	MENT OF HEALTH AN	ID HOWAIN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		105421	B. WING _			03/	06/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
			1	36	01 LAKEWOOD BLVD		
MANORC	ARE NURSING AND REF	IABILITATION CENTER		N.	APLES, FL 34112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 761	by: Based on a review o interview with the ma facility failed to test a accordance with NFF 8.3.3.1, and NFPA 8 roblems with fire do and toxic gases to mi compartment to anott The findings included On 3/6/18 there was the fire doors were in On 3/6/18 at 1:30 p.m	A 80) is not met as evidenced it the facility records and intenance director, the nd inspect fire doors in A 101 2012 edition 19.7.6, 2010 edition. Undetected ors would allow fire, smoke, grate from one fire ner. :  no documentation to show spected in the last year. n., the maintenance director spect them, and had no sk for during these	к7	6	The statements made in this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies herein. To remain compliance with all Federal and State regulations, the center has taken, or we take the actions set forth in 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) indicased the state of the center to inspect and test fire doors and assemblies annually in accordance with NFPA 80, Standard for fire doors and testing that a available to review.  No specific residents were identified.  Fire doors will be inspected and tested accordance with NFPA 80, Standard for fire doors and assemblies.  Maintenance Director will be in-service 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 tested and assemblies.	in iiil iiil iiil iiil iiil iiil iiil i	

Audit for validation that fire doors are

## PRINTED: 04/27/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN FED 105421 R MING 03/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3601 LAKEWOOD BLVD MANORCARE NURSING AND REHABILITATION CENTER NAPLES, FL 34112 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 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 PRINTED: 04/27/2018 CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 ASTANDAYON DEPICHONES OMB NO. 0938-0391

ENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
TEMENT OF DEFICIENCIES O PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105421	B. WING	03/06/2018

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

E 000 Initial Comments E 000

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.

ΔNI

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.

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

TITLE

DEFICIENCY)

(X6) DATE

Electronically Signed 03/30/2018

Any deficiency statement ending with an asterick (1) 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 whather 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 fo	or Health Care Adminis	tration				): 04/27/2018 1 APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	(X3) DATE SURVEY COMPLETED		
		81101	B. WING		03/0	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MANORC	ARE NURSING AND REH	ABILITATION CENT	WOOD BLVD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ORRECTIVE ACTION SHOULD BE COM- FERENCED TO THE APPROPRIATE D	
K 000	INITIAL COMMENTS		K 000			
	survey was conducted Nursing and Rehabilit nursing facility in Nap This survey was cond National Fire Protectic 101 (2015 edition) an Florida State Fire Ma Regulations, Florida State Fire Ma Regulations, Florida Fire Mac	les, Florida.  ucted in accordance with on Association (NFPA) 1 and d applicable requirements of shal's Rules and displicable reducements of shal's Rules and displicable reducements of shal's Rules and string and the string of				
K 700 SS=F	18.7 and 19.7 Operat that are not addresse but are deficient. This	Other section any LSC Section ing Features requirements d by the provided K-lags, information, along with the Code or NFPA standard	K 700			4/6/18

routinely inspected as part of the facility

patient rooms and smoke barrier doors, are LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

TITLE (X6) DATE Electronically Signed 03/30/18

The statements made in this plan of

not constitute an agreement with the

compliance with all Federal and State

correction are not an admission to and do

alleged deficiencies herein. To remain in

regulations, the center has taken, or will

take the actions set forth in the following

STATE FORM 0LY721 if continuation sheet 1 of 2

Agency fo	or Health Care Adminis	stration					: 04/27/2018 I APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/	CHA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING: 03 - CLOSED -MAIN LIC		COMPLETED		
		81101		B. WING		03/0	6/2018
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	ITE, ZIP CODE		
			3601 LAKE	WOOD BLVD			
MANORG	ARE NURSING AND REF	IABILITATION CENT	NAPLES, FI	L 34112			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		1D	PROVIDER'S PLAN OF CORRECTION	ų.	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETE DATE
K 700	Continued From page	1		K 700			
	maintenance progran	<ol> <li>Individuals performir</li> </ol>	g the		plan of correction. The following plan	of	
	door inspections and	testing possess knowle	idge,		correction constitutes the center's		
		that demonstrates abi	lity.		allegation of compliance. All alleged		
		pection and testing are			deficiencies cited have been, or will be		
	maintained and are a				corrected by the date or date(s) indica	ited.	
	19.7.6, 8.3.3.1 (LSC)						
	5.2, 5.2.3 (2010 NFP	A 80)			It is the practice of the center to inspe	ct	
					and test fire doors and assemblies		
		the facility records and			annually in accordance with NFPA 80		
		intenance director, the			Standard for fire doors and other oper	ning	
		nd inspect fire doors in			protectives, and to maintain written		
		A 101 2012 edition 19.			records of inspection and testing that	are	
		2010 edition. Undete			available to review.		
	and toxic gases to mi	ors would allow fire, sm	оке,		No specific residents were identified.		
	compartment to anoth				No specific residents were identified.		
	compartment to anon	ici.			Fire doors will be inspected and tester	d in	
	The findings included				accordance with NFPA 80. Standard f		
	The intense	•			fire doors and assemblies.	0,	
	On 3/6/18 there was	no documentation to sh	ow				
		spected in the last year			Maintenance Director will be in-service	ed	
					on the requirement of having fire door	s	
	On 3/6/18 at 1:30 p.m	n., the maintenance dire	ector		tested and inspected annually in		
		spect them, and had no			accordance with NFPA 80, Standard f	or	
	training on what to lo	ok for during these			fire doors and assemblies, and on		
	inspections and tests	as required.			maintaining written records of inspecti	on	
					and testing that are available to revieu	v.	
	Class III						
					Audit for validation that fire doors are		
					inspected and tested in accordance w	ith	
					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	

6590

the QA&A Committee by the Administrator and/or designee for recommendations and follow up as indicated.