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
	35961031	A. BUILDING: **04 - MAIN LIC** B. WING _____	**04/11/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HEALTH AND REHAB OF SARASOTA	**5381 DESOTO ROAD SARASOTA, FL 34235**

(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 relicensure survey was conducted on 4/10/18 through 4/11/18 at Hawthorne Health and Rehab of Sarasota, a skilled nursing facility (license #130471051) in Sarasota, 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 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.	K 000		
K 321 SS=F	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		5/12/18

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K 321	Continued From page 1 19.3.2.1 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This Statute or Rule is not met as evidenced by: Based on observations, interview and document review, the facility failed to utilize hazardous area enclosures where situations would require, and the areas were properly equipped to protect from the specific hazards utilized. Doors to rooms were not equipped with listed and labeled fire rated hardware. This in the event of a fire could result in the accelerated spread of a fire from the	K 321	*Locks were purchased to replace the locks that were in place for the last three years. *All locks were inspected to determine which locks were on Fire walls to determine which locks had to be replaced.	

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K 321	Continued From page 2 enclosure, endangering the occupants of the building. The findings included: On 4/11/18 while on tour of the facility with the Maintenance Director at the soiled linen rooms, door hardware was observed. The door hardware (lever sets and backsets) did not bear the label of a testing agency. On 4/11/18 at 11:10 a.m., the Maintenance Director said that he was not aware of the different types of hardware and acknowledged the finding. According to NFPA 101 (2015 edition) 8.3.3.1; "Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code." On 4/11/18 at 12:06 p.m., a review of the facility construction drawings showed the areas were part of rated enclosures thus requiring listed and labeled door hardware. NFPA 101 (2015 edition) 19.3.2.1, 19.3.5.9, 8.3 CLASS III	K 321	*All new locks are fire rated. If locks have to be replaced the will be replaced with commercial fire hardware where appropriate. *Maintenance will present a list of all new hardware for doors and will complete the annual inspection for doors and present it to the QA committee.	

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E 000	Initial Comments During the Fire & Life Safety recertification survey conducted on 4/10/18 through 4/11/18 at Hawthorne Health and Rehab of Sarasota, a skilled nursing facility, Emergency Preparedness regulations were reviewed. Hawthorne Health and Rehabilitation of Sarasota is not in compliance with Code of Federal Regulations (CFR) 42, Part 483.73, Emergency Preparedness Requirement for Long-Term Care Facilities.	E 000		
E 004 SS=F	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 that must be [reviewed], and updated at least annually.	E 004		5/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2018

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 * [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 provide the annual review and update of their Emergency Preparedness Program (EP). Annual review and updating of the program is required to address the changing environments of the community, the facility and the facility populations. The findings included: On 4/11/18 while reviewing the facility's EP, no evidence of annual updates and review by the facility administration was found. On 4/11/18 at 1:02 p.m., the Administrator provided QAPI notes, but the notes did not include a comprehensive review and updates to the EP.	E 004	*A list of review and updates to the EP will be kept with the EP. Updates will be added to the sheet as they occur. *This was the first year for this plan, but a list of review and updates to the EP will be kept with the EP. Updates will be added to the sheet as they occur. *Administrator and Maintenance director received training from the Life Safety Inspector. This plan will be reviewed annually by the facility administration/designee and QA committee. *This plan will be reviewed annually by the facility administration and QA committee.	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E 013		5/12/18

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E 013	Continued From page 2 *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide the annual review and update of their Emergency Preparedness Program (EP). Annual review and updating of the program is	E 013	*Policy and Procedures for communications plan and the policy and procedures were in the other Emergency management Binder. A copy of both are	

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E 013	Continued From page 3 required to address the changing environments of the community, the facility and the facility populations. The findings included: On 4/11/18 while reviewing the facility's EP, no evidence of annual updates and review of the communication plan and policy and procedures was found. On 4/11/18 at 1:12 p.m., the Administrator said that they needed to complete the communications plan and they were working on their annual facility administrative review.	E 013	now in the EP for easy access. * annual updates and review of the communication plan and policy and procedures are in the EP for review. * Annual review and updating of the program will address the changing environments of the community, the facility and the facility populations. Administrator and Maintenance director received training from the Life Safety Inspector. *Communications plan and policy will be presented to the QAPI on May 9 and annually there after. Administrator and Maintenance director will monitor for compliance.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies	E 015		5/12/18

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E 015	Continued From page 4 (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide the annual review and update of their Emergency Preparedness Program (EP). Annual review and updating of the program is required to address the changing environments of the community, the facility and the facility	E 015	*Annual updates and review of the hazard vulnerability assessment, communication plan, and policy and procedures were moved to the EP binder. *All required policies are moved to the EP	

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E 015	Continued From page 5 populations. The findings included: On 4/11/18 while reviewing the facility's EP, no evidence of annual updates and review of the hazard vulnerability assessment, communication plan, and policy and procedures was found. On 4/11/18 at 1:22 p.m., the Administrator said they needed to complete the communications plan and they were working on their annual facility administrative review.	E 015	binder for easy access. *Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an	E 024		5/12/18

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E 024	Continued From page 6 emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to incorporate Emergency Preparedness Program (EP) procedures for the use of volunteers in the event of an emergency. Increased staffing needs during an emergency would require policies and procedures to address a surge in the resident population, caregivers, and volunteers providing services to the facility. The findings included: On 4/11/18 while reviewing the facility's EP, there was no policy and procedures that specifically addressed the roles duties of volunteers and non-employee caregivers. On 4/11/18 at 1:32 p.m., the Administrator said there were no policy and procedures in place.	E 024	*policy and procedures that specifically addressed the roles duties of volunteers and non-employee caregivers were moved to the EP binder. *All required policies are moved to the EP binder for easy access. *Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate	E 026		5/12/18

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E 026	Continued From page 7 care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to incorporate Emergency Preparedness Program (EP) policies and procedures for the provision of care under an 1135 waiver. This in the event of an emergency including an emergencies requiring an evacuation as well as intake of residents from other jurisdictions would leave caregivers without the ability to provide for the specialized medical needs of residents. The findings included: On 4/11/18 while reviewing the facility's EP, there was no policy and procedure that specifically addressed the duties of caregivers following the issuance of an 1135 waiver by the Secretary of Health and Human Services. On 4/11/18 at 1:42 p.m., the Administrator described the process the facility would use but said the 1135 waiver was not specifically addressed in the EP.	E 026	*Policy and procedure that specifically addressed the duties of caregivers following the issuance of an 1135 waiver by the Secretary of Health and Human Services were moved to the EP binder. *All required policies are moved to the EP binder for easy access. *Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 033		5/12/18

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E 033	Continued From page 8 and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide as part of their Emergency Preparedness Program (EP), an annual review of	E 033	*procedures for the transfer of resident medical information in the event of a resident transfer was moved to the EP	

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E 033	Continued From page 9 the methods of sharing resident information and medical documentation with receiving facilities and other providers. This in the event of a transfer of residents would leave the receiving facility and caregivers without information needed for the care and treatment of the residents. The findings included: On 4/11/18 while reviewing the facility's EP, the plan did not include annual review of the procedures for the transfer of resident medical information in the event of a resident transfer. On 4/11/18 at 1:52 p.m., the Administrator said that the review for all components would be conducted annually and changes made to the EP documented and approved.	E 033	binder. *All required policies/procedures are moved to the EP binder for easy access. *Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command	E 034		5/12/18

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	106098	A. BUILDING _____ B. WING _____	04/11/2018

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E 034	Continued From page 10 Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide as part of their Emergency Preparedness Program (EP), a method of sharing occupancy information and occupancy needs to the authority having jurisdiction. This in the event of a transfer or intake of residents would leave the receiving facility and caregivers without information needed for occupancy of the transferred residents. The findings included: On 4/11/18 during review of the facility EP, there was no description of how the facility shares occupancy needs with other facilities. On 4/11/18 at 2:02 p.m., the Administrator said that they would us the online resource "Florida Health Stat."	E 034	*Description of how the facility shares occupancy needs with other facilities (Florida Health Stat.) was added to the EP binder. *All required policies/procedures are moved to the EP binder for easy access. *Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and	E 036		5/12/18

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E 036	Continued From page 11 procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide emergency preparedness training and testing for the calendar year. This in the event of an emergency would leave staff unprepared putting the residents, staff and occupants of the facility at risk to the hazards of	E 036	*records of training, testing, and annual review of the program was added to the EP binder. *All required policies/procedures are moved to the EP binder for easy access.	

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E 036	Continued From page 12 the emergency. The findings included: On 4/11/18 while reviewing the facility Emergency Preparedness Program (EP), no records of training, testing, and annual review of the program were provided. On 4/11/18 at 2:12 p.m., the Administrator said the plan would be reviewed and updated annually and training provided to all staff.	E 036	*Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may	E 039		5/12/18

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E 039	Continued From page 13 include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of post disaster analysis including potential areas of improvement and revision of the Emergency Preparedness Program to meet needed areas of improvement. This in the event of an emergency would leave	E 039	*the post drill and post events are now include an AAR that included areas of improvement was added to the EP binder. *All required policies/procedures are moved to the EP binder for easy access.	

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E 039	Continued From page 14 the facility unprepared for unexpected situations that would have been addressed and documented in an After Action Report (AAR). The findings included: On 4/11/18 while reviewing disaster drills dated 3/5/18 and an actual event on 9/10/17 through November 2017, the post drill and post events did not include an AAR that included areas of improvement. On 4/11/18 at 2:22 p.m., the Administrator said that all drills in the future would include an AAR including areas for improvement.	E 039	*Committee will be educated on the new requirements of the EP. Administrator and Maintenance director received training from the Life Safety Inspector. *administrator/designee will Audit for 3 months and annually thereafter and present to QA for review.	

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	106098	A. BUILDING **01 - MAIN FED** B. WING _____	**04/11/2018**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on 4/10/18 through 4/11/18 at Hawthorne Health and Rehab of Sarasota, a skilled nursing facility in Sarasota, Florida. Hawthorne Health and Rehab of Sarasota 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: 2012 Existing NFPA 220 Construction Type: I (332) Number of beds: 120 Census: 100 The following is description of the noncompliance.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		5/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2018

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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K 321	Continued From page 1 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to utilize hazardous area enclosures where situations would require, and the areas were properly equipped to protect from the specific hazards utilized. Doors to rooms were not equipped with listed and labeled fire rated hardware. This in the event of a fire could result in the accelerated spread of a fire from the enclosure, endangering the occupants of the building. The findings included: On 4/11/18 while on tour of the facility with the Maintenance Director at the soiled linen rooms, door hardware was observed. The door hardware (lever sets and backsets) did not bear the label of a testing agency. On 4/11/18 at 11:10 a.m., the Maintenance Director said that he was not aware of the different types of hardware and acknowledged the finding. According to NFPA 101 (2012 edition) 8.3.3.1; "Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door	K 321	*Locks were purchased to replace the locks that were in place for the last three years. *All locks were inspected to determine which locks were on Fire walls to determine which locks had to be replaced. *All new locks are fire rated. If locks have to be replaced the will be replaced with commercial fire hardware where appropriate. *Maintenance will present a list of all new hardware for doors and will complete the annual inspection for doors and present it to the QA committee.	

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K 321	Continued From page 2 assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code." On 4/11/18 at 12:06 p.m., a review of the facility construction drawings showed the areas were part of rated enclosures thus requiring listed and labeled door hardware. NFPA 101 (2012 edition) 19.3.2.1, 19.3.5.9, 8.3	K 321		