STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	**3600 OLD BOYNTON ROAD** **BOYNTON BEACH, FL 33436**

(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 07/17/18- 07/18/18 at Heartland Health Care Center-Boynton Beach, a nursing home in Boynton Beach, Florida. Heartland Health Care Center-Boynton Beach is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012) requirements for nursing homes. Plan Review: 1989 Existing NFPA 220 Construction Type: II (000) Number of beds: 120 Census: 120 The following is description of the noncompliance.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on written document review, and staff interview the facility failed to maintain the building exit egress. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include:	K 211	It is the practice of this facility that the facility maintain the building exit egress. Fire and smoke door annual testing was completed on 8/1/2018 by a licensed, certified inspection company in accordance with the 2010 NFPA 80	8/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/2018

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
	105755	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2018**

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HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	**3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436**

(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 211	Continued From page 1 On 07/18/2018 at 8:15 A.M. when doing the facility written documentation review of required Fire and Smoke door annual testing, required documentation was not provided. Based on the requirement, the facility could not show that all fire door assemblies were annually inspected and tested in accordance with the 2010 NFPA 80 requirements. Additionally, the facility could not show any documentation showing the maintenance director or a qualified person had followed the code requirements to maintain, inspect or test all the required doors. No additional written documentation was provided at the time of exit. The findings were acknowledged by the Administrator and verified by the maintenance director at the time of observations and at the exit conference on 07/18/2018. Actual NFPA Standards: NFPA LSC 101 (2015) 4.5.3.2, 7.2.1.15, 7.3.2.2., 19.1.1.3.2 and NFPA 80 (2010)	K 211	requirements. The facility will ensure that they met this requirement on an annual basis. Results of the inspection were brought to QA&A for trends and patterns	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan	K 711		8/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	**3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436**

(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 711	Continued From page 2 components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on written document review and staff interview the facility failed to maintain a current approved written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is reviewed and updated annually. and is not in substantial compliance with Emergency Preparedness per LTC Code of Federal Regulations (CFR), 42 Part 483.73, Requirements for Long-Term Care Facilities. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 07/18/2018 at 1:15 P.M. after the facility document review the facility failed to produce a current complete and approved written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is required to be reviewed and updated annually. The plan was not maintained as required and is not in substantial compliance with Emergency Preparedness per LTC Code of Federal Regulations (CFR), 42 Part 483.73, Requirements for Long-Term Care Facilities. An interview was conducted at this time with the administrator who acknowledged that the current copy of the emergency management plan was not complete and approved. The findings were acknowledged and verified at	K 711	It is the practice of this facility to maintain a current approved written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is reviewed and updated annually. The facility has a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which has been reviewed and updated annually. The Emergency Plan will be brought through QA&A annually for approval.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	**3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436**

(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 711	Continued From page 3 the times of document review and at the exit conference with the administrator on 07/18/2018. Actual NFPA Standards: NFPA LSC 101 (2012) 19.7.1..., Emergency Preparedness per Long Term Care code of Federal Regulations (CFR), 42 Part 483.73, requirements for Long Term Care.	K 711		
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the electrical equipment used for care, treatment or diagnostic for residents. This deficient practice has the ability to affect all residents requiring use of this	K 915	It is the practice of this facility to maintain the electrical equipment used for care, treatment or diagnostic for residents. This deficient practice has the ability to affect all residents requiring use of this	8/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. BUILDING **01 - MAIN FED** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	**3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436**

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K 915	Continued From page 4 equipment. Findings include: On 07/18/2018 between 7:30 A.M. and 12 P.M. accompanied by the maintenance director during the observation tour in rooms 208 A, 303 B, 404 B and 602 as examples, residents were found using electrical oxygen machines and other medical equipment. The rooms cited do not have a electrical outlet plug which is connected to the generator. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. In these rooms the resident is dependent on the oxygen for life support. An electrical system failure is likely to cause major injury or death of residents, including all rooms where electric life support equipment is required. An interview was conducted at these times with the maintenance director who acknowledged that the equipment in the room used for the residents was not in a room that had hospital grade electrical outlets that are powered by the generator. No additional documentation was supplied at the exit conference. The findings were acknowledged by the Administrator and verified by the maintenance director at the time of observations and at the exit conference on 07/18/2018. Actual NFPA Standards: NFPA LSC 101 (2012) 4.5.3.2, 19.1.1.3.2, NFPA 99 (2012) Chapter 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 , 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	K 915	equipment. The building's generator is existing to original construction. The facility has approved plans for an upgraded generator to be installed by December 31, 2018. The emergency generator will allow for electrical outlet plugs in resident rooms for those residents who are dependent on oxygen. The facility will continue to monitor the process for installation of the new generator.	

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E 000	Initial Comments During the unannounced Fire and Life Safety re-certification survey conducted on 07/17/18 - 07/18/18 at Heartland Health Care Center Boynton Beach, a nursing home in Boynton Beach, Florida, the Emergency Preparedness plans and policies were reviewed. Heartland Health Care Center Boynton Beach, is not in substantial compliance with Emergency Preparedness per Code of Federal Regulations (CFR), 42 Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.	E 006		8/12/18

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Electronically Signed		08/03/2018

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
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HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436

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E 006	Continued From page 1 * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on written document review and staff interview the facility failed to develop emergency preparedness policies and procedures that must be reviewed, and updated at least annually. This deficient practice affects all staff, visitors and residents. Findings include: On 07/18/2018 between 10:45 A.M. and 1:15 P.M. based on review of the written facility emergency plan and policy with the administrator, the facility was not able to produce the requested written documentation. Based on the provided emergency plan, it could not be verified that the facility had included documentation that the emergency preparedness plan was reviewed, and updated at least annually. The written documentation for the required facility federal emergency plan and policy to meet code requirements was not available in the plan at the time reviewed and when requested to produce requested written documentation to substantiate compliance. The facility Risk assessment was for a facility called Big Bend Healthcare not Heartland Boynton Beach. An interview was conducted at this time with the administrator who acknowledged that the documentation requested was not available in the facility emergency plan.	E 006	It is the practice of this facility that it develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* Heartland of Boynton Beach has an Emergency Preparedness Plan based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* The plan has been reviewed, updated and documented and placed in the front of the Emergency Preparedness Plan. The Emergency Plan will be reviewed annually and brought through QA&A.	

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	105755	A. BUILDING _____ B. WING _____	07/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEACH	3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436

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E 006	Continued From page 2 The findings were acknowledged by and verified by the administrator at the time of documentation review and at the exit conference on 07/18/2018. Actual code requirements: 483.73 (a)	E 006		
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 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	E 036		8/12/18

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E 036	Continued From page 3 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 written document review and staff interview the facility failed to develop emergency preparedness policies and procedures that must be reviewed, and updated at least annually, regarding Training and Testing. This deficient practice affects all staff, visitors and residents. Findings include: On 07/18/2018 between 10:45 A.M. and 1:15 P.M. based on document review of the required facility federal emergency plan and policies with the administrator, there is no written documentation to meet code requirements, the facility was not able to produce requested written documentation regarding 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 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. An interview was conducted at this time with the administrator who acknowledged that the documentation requested	E 036	It is the practice of this facility to 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 facility completed testing and training for a Loss of generator event on 12/15/17 and an active shooter event on July 6, 2018. Copies of the training are available in the etag book for compliance. The facility will ensure that emergency preparedness policies and procedure be reviewed and updated at least annually regarding testing and training.	

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E 036	Continued From page 4 was not available in a written facility federal emergency plan. No additional documentation was provided at the time of exit. The findings were acknowledged by and verified by the administrator at the time of documentation review and at the exit conference on 07/18/2018. Actual code requirements: 483.73	E 036		

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
	95019	A. BUILDING: **05 - MAIN LIC** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEA	**3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 07/17-18/2018 at Heartland Healthcare Center-Boynton Beach, State license:[#1210096] a nursing home in Boynton Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015) 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 deficiencies, found at the time of the visit.	K 000		
K 915 SS=F	NFPA 99 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an	K 915		8/12/18

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/18

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K 915	Continued From page 1 alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the electrical equipment used for care, treatment or diagnostic for residents. This deficient practice has the ability to affect all residents requiring use of this equipment. Findings include: On 07/18/2018 between 7:30 A.M. and 12 P.M. accompanied by the maintenance director during the observation tour in rooms 208 A, 303 B, 404 B and 602 as examples, residents were found using electrical oxygen machines and other medical equipment. The rooms cited do not have a electrical outlet plug which is connected to the generator. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. In these rooms the resident is dependent on the oxygen for life support. An electrical system failure is likely to cause major injury or death of residents, including all rooms where electric life support equipment is required. An interview was conducted at these times with the maintenance director who acknowledged that the equipment in the room used for the residents was not in a room that had hospital grade electrical outlets that are powered by the generator. No additional documentation was supplied at the exit conference. The findings were acknowledged by the Administrator and verified by the maintenance	K 915	It is the practice of this facility to maintain the electrical equipment used for care, treatment or diagnostic for residents. This deficient practice has the ability to affect all residents requiring use of this equipment. The building's generator is existing to original construction. The facility has approved plans for an upgraded generator to be installed by December 31, 2018. The emergency generator will allow for electrical outlet plugs in resident rooms for those residents who are dependent on oxygen. The facility will continue to monitor the process for installation of the new generator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95019	A. BUILDING: **05 - MAIN LIC** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER BOYNTON BEA	**3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436**

(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 915	Continued From page 2 director at the times of observation and at the exit conference on 07/18/2018. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 4.5.3.2, 19.1.1.3.2, NFPA 99 (2012) Chapter 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 , 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	K 915		
K1011 SS=F	NFPA 101 Fire Doors Communicating openings in dividing fire barriers required by 18.1.1.4.1 & 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) 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. NFPA 101 (2012 edition) 18.1.1.4.1.1 & 19.1.1.4.1.2, 8.3.3.1. This Statute or Rule is not met as evidenced by: Based on written document review, and staff interview the facility failed to maintain the building exit egress. This deficient practice affects all smoke compartments, staff, visitors and all residents.	K1011	It is the practice of this facility that the facility maintain the building exit egress. Fire and smoke door annual testing was completed by a licensed, certified inspection company on 8/1/2018 in	8/12/18

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K1011	Continued From page 3 Findings include: On 07/18/2018 at 8:15 A.M. when doing the facility written documentation review of required Fire and Smoke door annual testing, required documentation was not provided. Based on the requirement, the facility could not show that all fire door assemblies were annually inspected and tested in accordance with the 2010 NFPA 80 requirements. Additionally, the facility could not show any documentation showing the maintenance director or a qualified person had followed the code requirements to maintain, inspect or test all the required doors. No additional written documentation was provided at the time of exit. The findings were acknowledged by the Administrator and verified by the maintenance director at the times of observation and at the exit conference on 07/18/2018. Class III Actual NFPA Standards: NFPA LSC 101 (2015) 4.5.3.2, 7.2.1.15, 7.3.2.2., 19.1.1.3.2 and NFPA 80 (2010)	K1011	accordance with the 2010 NFPA 80 requirements. The facility will ensure that they met this requirement on an annual basis. Results of the inspection were brought to QA&A for trends and patterns	
K1051 SS=F	FAC 59A-4. 133 FBC (2014) 5th Ed. 450 Plans Submittal PRIOR to Work No health care facility construction work, including demolition, shall be started until prior written approval has been given by the Office of Plans and Construction. This includes all construction of new facilities and any and all additions, modifications, or renovations to existing facilities. When construction is required,	K1051		8/12/18

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K1051	Continued From page 4 either for new buildings or additions, alterations or renovations to existing buildings, the plans and specifications shall be prepared and submitted to the Office of Plans and Construction for approval by a Florida-registered architect and a Florida-registered professional engineer. Florida Administrative Code 59A-4.133 & Florida Building Code (2014) 5th edition Section 450.1. This Statute or Rule is not met as evidenced by: Based on observation tour, telephone conversation and staff interview the facility failed to notify the Agency for Health Care Administration of changes to the building made from the original approved plans. Work was not approved or reviewed by the Agency. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 07/18/2018 at 8:30 A.M., when reviewing documentation for a temporary generator approval as a replacement generator, by the Agency for Health Care Administration (AHCA) Office of plans and construction (OPC), no written documentation was available. According to documents reviewed from 05/24/2018 the facility requested an extension to install the mandated required emergency generator until 01/01/2019 (EMERGENCY POWER RULE COMPLIANCE (EPR) under Florida law, F.S. 120.542) On 06/01/2018 a 300 KW temporary generator on a trailer was delivered from Sunbelt rental services along with 2 skids of diesel fuel pods to comply with the EPR On 07/18/2018 a phone call was made to Sunbelt rental equipment company to verify that the generator is under contract to be	K1051	It is the practice of this facility and HCR-Manorcare to notify the Agency for Health Care Administration Office of Plans and Construction of proposed changes to be made from the original approved plans. The facility has not yet undertaken any construction related to generators. The facility will keep copies of all relevant plans, permits, and approvals related to construction on site. Any projects initiated will be reviewed for AHCA OPC submission compliance.	

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K1051	Continued From page 5 hooked up and activated in the event of a power failure. The company representative from Sunbelt stated that they only rent and deliver the generators and they do not have electricians to hook the generator up or connect the diesel fuel pods to the generator. When contacted AHCA OPC had no record of this temporary generator installation. Based on interviews of the maintenance director, Sunbelt rental office, the Office of Plans and Construction, and the administrator, during the survey, no one was able to produce any written documentation to substantiate the installation had been reviewed or that plans were approved for the installation of these changes. No additional paperwork was provided at the time of exit from the facility. The findings were acknowledged by the Administrator and verified by the maintenance director at the time of document review and at the exit conference on 07/18/2018. Class III Actual NFPA Standards: NFPA LSC 101 (2012) Chapter 19 - 4.2.1, 4.5.7 - 4.2.1	K1051		