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
	55245	A. BUILDING: 01, 05 B. WING	05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HERITAGE HEALTH & REHABILITATION CEN	718 LAKEVIEW AVE S SAINT PETERSBURG, FL 33705

(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 A re-licensure survey was conducted on 05/18/2021 at South Heritage Health and Rehabilitation Center, a nursing home in St. Petersburg, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2018 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 (2018 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Date Opened: 1968 Bldg. Type: II (000) Square Footage: 15,977 Smoke Compartments: 4 Floor Levels: 1 Generator: 100 kW Licensed Bed: 69 Census: 59 Fully Sprinklered: Yes Fire Alarm: Yes, monitored The following is description of the deficiencies found at the time of the visit.	K 000		
K 200 SS=D	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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	K 200		6/20/21

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/11/21

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K 200	Continued From page 1 citation, should be included. 18.2, 19.2 This Statute or Rule is not met as evidenced by: Based on observations and interview with the maintenance director, the facility failed to maintain exit doors in accordance with NFPA 101. The findings include: On 05/18/2021 between the hours of 11:40 a.m. and 1:00 p.m. during the facility tour with the maintenance director, it was found that: 1) the main entrance door failed to be equipped with a latch to close; 2) the central wing exit door failed to positively latch on the right leaf. The facility did not survey all exit doors to ensure positive latching. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. per NFPA 101 (2018 Edition) 19.2.2.2, 19.2.2.2.1, 7.2.1, 7.2.1.5.10, 7.2.1.15, 7.2.1.15.1, 7.2.1.15.6 (3), 7.2.1.15.7 Class III	K 200	Corrective Action(s): Facility emergency exit doors at the time of survey were equipped with locking latches which allow for emergency exit when engaged to ensure the door remains closed if power is lost. ;2) the central wing right leaf exit door latch was repaired, engaged and securely latches when closed. Identification of Deficient Practices & Correction Action(s): All the building exit doors may have potentially been affected. An audit was completed by the facility's maintenance direct to ensure all exit doors have locking latches engaged on 6/4/2021. Contractor has been scheduled for repair on the latching system for 2 doors. Systemic Change(s): Facility has updated TELLS system to include auditing of all exit doors for proper latching. Maintenance Director/designee will perform audits on a routine bases for proper latching. Findings of any door not properly latching will be report to the NHA. Monitoring: Maintenance Director/designee will complete weekly audit x 4 weeks and monthly x 3 months to ensure substantial compliance. Results will be reviewed during QA monthly x 3 months followed by quarterly x 4 to ensure continued compliance.	

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K 325	Continued From page 2	K 325		
K 325 SS=D	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to store alcohol-based hand rub (ABHR) in accordance with NFPA 101. The findings include: On 05/18/2021 between the hours of 11:40 a.m. and 1:00 p.m. during the facility tour with the maintenance director, it was found that the administrator's office contained approximately 6.5 gallons (832 ounces) of ABHR.	K 325	Corrective Action(s): The extra 1-gallon alcohol-based hand rub (ABHR) bottles located in the Administrator's office were removed immediately during the survey visit. Identification of Deficient Practices & Correction Action(s): All storage areas of the building may have potentially been affected. An audit was completed by the	6/20/21

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K 325	Continued From page 3 An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. per NFPA 101 (2018 Edition) 19.4.3 (7) Class III (Photographic evidence obtained)	K 325	facility's maintenance direct to ensure all storage areas with ABHR are within guidelines for the amount in storage not to exceed 5 1-gallon bottles if not located behind a fire rated door. Systemic Change(s): Maintenance Director has Identified storage areas in the facility appropriate for the storage of multiple 1-gallon ABHR bottles. Maintenance Director/designee will receive all ABHR deliveries to insure they are placed in the correct storage areas. Monitoring: Maintenance Director/designee will complete weekly audit x 4 weeks and monthly x 3 months to ensure substantial compliance. Results will be reviewed during QA monthly x 3 months followed by quarterly x 4 to ensure continued compliance.	
K 761 SS=D	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 (NFPA 101) 5.2, 5.2.3 (NFPA 80)	K 761		6/20/21

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K 761	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on document review, observations, and interview, the facility failed to maintain fire doors in accordance with NFPA 101. The findings include: On 05/18/2021 between the hours of 9:45 a.m. and 1:00 p.m. during the document review and facility tour with the maintenance director, a fire rated access panel was observed by resident room #115. No fire rated access panels were included in the annual fire door inspection report. The facility shall identify all fire rated access doors, inspect them, and add them to the annual fire door inspection report. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. per NFPA 101 (2018 Edition) 19.2.2.2, 19.2.2.2.1, 7.2.1, 7.2.15.1, 8.3.3.3, 8.3.3.3.1 per NFPA 80 (2016 Edition) 5.2, 5.2.1, 5.2.2, 5.2.2.4, 16.2.2, 16.2.2.1 Class III (Photographic evidence obtained)	K 761	Corrective Action(s): Maintenance Director identified all fire rated access panels and inspection rounds were initiated and completed on 6/9/2021 Identification of Deficient Practices & Correction Action(s): All fire rated access panels may have potentially been affected. Regional Maintenance Consultant in-serviced the NHA and facility Maintenance director on NFPA 80 requirements to ensure proper inspection procedures and documentation. Systemic Change(s): Facility has updated the annual fire door inspection report system to include annual auditing for all fire rated access panels. Maintenance Director/designee will perform audits on a routine basis. Findings of any missed fire rated access panel inspection will be report to the NHA. NHA will review quarterly to ensure inspections are completed. Monitoring: Maintenance Director/designee will complete quarterly audit x 4 to ensure annual inspection is scheduled and completed. Administrator will verify audits and annual inspection to ensure substantial compliance. Results will be reviewed during QA quarterly x 4 to ensure continued compliance.	

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	105117	A. BUILDING **01, 05** B. WING _____	**05/18/2021**

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E 000	Initial Comments During the Recertification survey conducted on 05/18/2021 at South Heritage Health and Rehabilitation Center, a nursing home, Emergency Preparedness was reviewed. South Heritage Health and Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73 Requirement for Long-Term Care Facilities.	E 000		
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 05/18/2021 at South Heritage Health and Rehabilitation Center, a nursing home in St. Petersburg, Florida. The Facility is not in compliance with 42 CFR 483.90 (a), and National Fire Protection Association (NFPA) 101 (2012 edition), NFPA 99 (2012 edition) requirements for nursing homes. Initial Plan Review: 1968 New or Existing: Existing NFPA 220 Construction Type: II (000) Number of beds: 69 Census: 59 The following is a description of the noncompliance.	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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	K 200		6/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 200	Continued From page 1 citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview with the maintenance director, the facility failed to maintain exit doors in accordance with NFPA 101. The findings include: On 05/18/2021 between the hours of 11:40 a.m. and 1:00 p.m. during the facility tour with the maintenance director, it was found that: 1) the main entrance door failed to be equipped with a latch to close; 2) the central wing exit door failed to positively latch on the right leaf. The facility did not survey all exit doors to ensure positive latching. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. per NFPA 101 (2012 Edition) 19.2.2.2.1, 7.2.1.5.10, 7.2.1.15, 7.2.1.15.1, 7.2.1.15.6, 7.2.1.15.7(3), 7.2.1.15.8	K 200	Corrective Action(s): Facility emergency exit doors at the time of survey were equipped with locking latches which allow for emergency exit when engaged to ensure the door remains closed if power is lost. ;2) the central wing right leaf exit door latch was repaired, engaged and securely latches when closed. Identification of Deficient Practices & Correction Action(s): All the building exit doors may have potentially been affected. An audit was completed by the facility's maintenance direct to ensure all exit doors have locking latches engaged on 6/4/2021. Contractor has been scheduled for repair on the latching system for 2 doors. Systemic Change(s): Facility has updated TELLS system to include auditing of all exit doors for proper latching. Maintenance Director/designee will perform audits on a routine bases for proper latching. Findings of any door not properly latching will be report to the NHA. Monitoring: Maintenance Director/designee will complete weekly audit x 4 weeks and monthly x 3 months to ensure substantial compliance. Results	

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K 200	Continued From page 2	K 200	will be reviewed during QA monthly x 3 months followed by quarterly x 4 to ensure continued compliance.	
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to store alcohol-based hand rub (ABHR) in accordance with NFPA 101. The findings include:	K 325	Corrective Action(s): The extra 1-gallon alcohol-based hand rub (ABHR) bottles located in the Administrator's office were removed immediately during the survey visit.	6/20/21

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K 325	Continued From page 3 On 05/18/2021 between the hours of 11:40 a.m. and 1:00 p.m. during the facility tour with the maintenance director, it was found that the administrator's office contained approximately 6.5 gallons (832 ounces) of ABHR. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. per NFPA 101 (2012 Edition) 19.3.2.6 (7) (Photographic evidence obtained)	K 325	Identification of Deficient Practices & Correction Action(s): All storage areas of the building may have potentially been affected. An audit was completed by the facility's maintenance direct to ensure all storage areas with ABHR are within guidelines for the amount in storage not to exceed 5 1-gallon bottles if not located behind a fire rated door. Systemic Change(s): Maintenance Director has Identified storage areas in the facility appropriate for the storage of multiple 1-gallon ABHR bottles. Maintenance Director/designee will receive all ABHR deliveries to insure they are placed in the correct storage areas. Monitoring: Maintenance Director/designee will complete weekly audit x 4 weeks and monthly x 3 months to ensure substantial compliance. Results will be reviewed during QA monthly x 3 months followed by quarterly x 4 to ensure continued compliance.	
K 761 SS=D	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	K 761		6/20/21

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K 761	Continued From page 4 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) This REQUIREMENT is not met as evidenced by: Based on document review, observations, and interview, the facility failed to maintain fire doors in accordance with NFPA 101. The findings include: On 05/18/2021 between the hours of 9:45 a.m. and 1:00 p.m. during the document review and facility tour with the maintenance director, a fire rated access panel was observed by resident room #115. No fire rated access panels were included in the annual fire door inspection report. The facility shall identify all fire rated access doors, inspect them, and add them to the annual fire door inspection report. An interview was conducted with the maintenance director concurrent with the observations and confirmed the findings. per NFPA 101 (2012 Edition) 19.2.2.2, 19.2.2.2.1, 7.2.1, 7.2.15.2 per NFPA 80 (2010 Edition) 5.2, 5.2.1, 16.2.2, 16.2.2.1 (Photographic evidence obtained)	K 761	Corrective Action(s): Maintenance Director identified all fire rated access panels and inspection rounds were initiated and completed on 6/9/2021 Identification of Deficient Practices & Correction Action(s): All fire rated access panels may have potentially been affected. Regional Maintenance Consultant in-serviced the NHA and facility Maintenance director on NFPA 80 requirements to ensure proper inspection procedures and documentation. Systemic Change(s): Facility has updated the annual fire door inspection report system to include annual auditing for all fire rated access panels. Maintenance Director/designee will perform audits on a routine basis. Findings of any missed fire rated access panel inspection will be report to the NHA. NHA will review quarterly to ensure inspections are completed. Monitoring: Maintenance Director/designee will complete quarterly audit x 4 to ensure annual inspection is scheduled and completed. Administrator will verify audits and annual inspection to ensure substantial compliance. Results	

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K 761	Continued From page 5	K 761	will be reviewed during QA quarterly x 4 to ensure continued compliance.	