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
	55213	A. BUILDING: **01, 05** B. WING ________	**12/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	**1270 TURNER ST** **CLEARWATER, FL 33756**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety relicensure survey was conducted on 12/02/2021 at Clearwater Center, a nursing home in Clearwater, 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: 1969 Bldg. Type: II (000) Square Footage: 24,152 Smoke Compartments: 5 Floor Levels: 1 Generator: 30 kW, 60 kW Licensed Bed: 120 Census: 103 Fully Sprinklered: Yes Fire Alarm: Yes, monitored The following is description of the deficiencies, found at the time of the visit.	K 000		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		1/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55213	A. BUILDING: **01, 05** B. WING ______	**12/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	**1270 TURNER ST** **CLEARWATER, FL 33756**

(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 353	Continued From page 1 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview with the Administrator, Maintenance Director and the Maintenance Supervisor, the facility failed to maintain the automatic fire sprinkler system in accordance with NFPA 101 and NFPA 25. Findings included: 1) During the facility record review with the Maintenance Director and the Maintenance Supervisor on 12/02/2021 between 9:30 a.m. and 11:45 a.m., the facility failed to provide evidence of the five-year internal inspection of the fire service backflow. An interview was conducted with the Maintenance Director and the Maintenance Supervisor concurrent with the observations and confirmed the findings. Per NFPA 101 (2018 Edition) 19.7.6, 4.6.12.1, 9.11.1 Per NFPA 25 (2017 Edition) 13.7.1.3 2) During the facility tour with the Administrator, the Maintenance Director, and the Maintenance	K 353	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1) The 5 year internal inspection of the fire service backflow was completed. Facility has scheduled the replacement of the 8 sprinkler heads on the front patio area. 2) An audit of other required inspections was completed with no issues. An audit of facility sprinkler heads was completed any sprinkler heads needing replace were replaced. 3) Maintenance Director was educated on ensuring the 5 year backflow inspection was completed timely and on replacing corroded sprinkler heads. 4) Audits will be presented to the QA&A	

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
	55213	A. BUILDING: **01, 05** B. WING ______	**12/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	**1270 TURNER ST CLEARWATER, FL 33756**

(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 353	Continued From page 2 Supervisor on 12/02/2021 between 12:30 p.m. and 2:00 p.m., it was observed that 8 of 8 sprinklers located within the outdoor patio area in front of the main entrance were corroded. An interview was conducted with the Maintenance Director and the Maintenance Supervisor concurrent with the observations and confirmed the findings. Per NFPA 101 (2018 Edition) 19.7.6, 4.6.12.1, 9.11.1 Per NFPA 25 (2017 Edition) 5.2.1.1.1 Class III	K 353	committee for 3 months, then quarterly for 1 year until substantial compliance is met. Maintenance Director will also report quarterly to QA&A committee on all required inspections their completions.	
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Statute or Rule is not met as evidenced by: Based on observation and interview with the Administrator, Maintenance Director and the Maintenance Supervisor, the facility failed to monitor the overload of relocatable power taps (power strips) in accordance with NFPA 101 and NFPA 70. Findings included: During the facility tour with the Administrator, the Maintenance Director, and the Maintenance Supervisor on 12/02/2021 between 12:30 p.m.	K 511	1) Power strip was removed upon discovering. 2) Facility offices were inspected to verify no other power strips were being used incorrectly. 3) Facility Managers were educated on not using power strips in offices. 4) Maintenance director to audit offices weekly x 1 month and monthly x 2 months to ensure compliance. Audits will be presented to the QA&A committee for 3 months, then quarterly for 1 year until	1/3/22

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
	55213	A. BUILDING: **01, 05** B. WING ______	**12/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	**1270 TURNER ST** **CLEARWATER, FL 33756**

(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 511	Continued From page 3 and 2:00 p.m., a portable air conditioner was observed plugged into a power strip in the Dietary Manager's office located within the kitchen. An interview was conducted with the Maintenance Director and the Maintenance Supervisor concurrent with the observations and confirmed the findings. Per NFPA 101 (2018 Edition) 19.5.1, 9.1.2 Per NFPA 70 (2017 Edition) 110.3(b) Class III	K 511	substantial compliance is met.	
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) This Statute or Rule is not met as evidenced by: Based on record review and interview with the Maintenance Director and the Maintenance Supervisor, the facility failed to maintain the fire doors in accordance with NFPA 101 and NFPA 80.	K 761	1) Maintenance Director was educated on using the correct fire door inspection form which meets NFPA 80 (2017 Edition) requirements. The fire door inspection was completed to meet the NFPA 80	1/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55213	A. BUILDING: 01, 05 B. WING ______	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	1270 TURNER ST CLEARWATER, FL 33756

(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 761	Continued From page 4 Findings included: During the facility record review with the Maintenance Director and the Maintenance Supervisor on 12/02/2021 between 9:30 a.m. and 11:45 a.m., the annual fire door inspection report dated 01/08/2021 failed to meet NFPA 80 (2017 Edition) requirements for recording fire door inspections as the report failed to provide: 1) The address of the facility. 2) Signature of the inspector of record. 3) Type and description of each inspected and tested fire door assembly. 4) Verification of visual inspection and functional operation. 5) An individual record for each inspected fire door, as the fire doors were grouped together by the corresponding hall they were located in. An interview was conducted with the Maintenance Director and the Maintenance Supervisor concurrent with the observations and confirmed the findings. per NFPA 101 (2018 Edition) 19.7.6, 4.6.12, 8.3.3.1 per NFPA 80 (2016 Edition) 5.2, 5.2.2.4 Class III	K 761	(2017 Edition) requirements to include 1) Facility Address 2) Signature of inspector 3) Type and description of each inspected and tested fire door assembly 4) Verification of visual inspection and functional operation 5) an individual inspection record keep for each individually inspected fire doors, including where they are located. 2) All other inspections were completed per requirements 3) Maintenance Director was educated on using the correct fire door inspection form which meets NFPA 80 (2017 Edition) requirements. 4) NHA and/ or designee will audit the annual fire inspection door to ensure inspection was completed per NFPA 80 Requirements and the results of audit will be report to the QA&A for review annually.	
K1053 SS=F	FAC 59A-4.126 Emergency Management Plan A written, comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is reviewed and updated annually, shall be maintained. The health care facility shall test the implementation of the emergency management plan semiannually, either in response to a	K1053		1/3/22

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
	55213	A. BUILDING: **01, 05** B. WING ______	**12/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	**1270 TURNER ST CLEARWATER, FL 33756**

(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
K1053	Continued From page 5 disaster or an emergency or in a planned drill, and shall evaluate and document the health care facility performance to the health care facility safety committee. Florida Administrative Code 59A-4.126. This Statute or Rule is not met as evidenced by: Based on record review, and interview with the Administrator, the Maintenance Director, and the Maintenance Supervisor, the facility failed to renew their comprehensive emergency management plan (CEMP) prior to its expiration. Findings included: During the facility record review with the Maintenance Director and the Maintenance Supervisor on 12/02/2021 between 9:30 a.m. and 11:45 a.m., it was revealed that the facility's CEMP had expired on 09/01/2020. In an interview with the Administrator, he said the CEMP had been submitted for renewal and was awaiting the county to perform their review. Per FAC 59A-4.126 Class III	K1053	1) Facility CEMP was sent to the county and is awaiting approval. 2) No other items were affected. 3) Maintenance Director was educated on submitting CEMP 2 months prior to expiration. 4) NHA and/ or designee will contact the Pinellas County Emergency Management Office weekly regarding the status of the CEMP until CEMP is approved. Maintenance will report on the approval status of the CEMP to the QA&A monthly and then annually after approval.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105274	A. BUILDING 01, 05 B. WING ______	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	1270 TURNER ST CLEARWATER, FL 33756

(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 on 12/02/2021 at Clearwater Center, a nursing home in Clearwater, 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: 1969 Existing NFPA 220 Construction Type: II (000) Number of beds: 120 Census: 103 The following is description of the noncompliance.	K 000		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Administrator, Maintenance Director and the Maintenance Supervisor, the facility failed to monitor the overload of relocatable power taps (power strips) in accordance with NFPA 101 and	K 511	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of	1/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2021

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105274	A. BUILDING 01, 05 B. WING	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER CENTER	1270 TURNER ST CLEARWATER, FL 33756

(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 511	Continued From page 1 NFPA 70. Findings included: During the facility tour with the Administrator, the Maintenance Director, and the Maintenance Supervisor on 12/02/2021 between 12:30 p.m. and 2:00 p.m., a portable air conditioner was observed plugged into a power strip in the Dietary Manager's office located within the kitchen. An interview was conducted with the Maintenance Director and the Maintenance Supervisor concurrent with the observations and confirmed the findings. Per NFPA 101 (2012 Edition) 19.5.1, 9.1.2 Per NFPA 70 (2011 Edition) 110.3(b)	K 511	deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. 1) Power strip was removed upon discovering. 2) Facility offices were inspected to verify no other power strips were being used incorrectly. 3) Facility Managers were educated on not using power strips in offices. 4) Maintenance director to audit offices weekly x 1 month and monthly x 2 months to ensure compliance. Audits will be presented to the QA&A committee for 3 months, then quarterly for 1 year until substantial compliance is met.	