PRINTED: 09/14/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01, 05 B MING 74828 08/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1620 MAYELOWER COURT MAYFLOWER HEALTHCARE CENTER WINTER PARK, FL 32792 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 An unannounced Fire & Life Safety re-licensure survey was conducted on August 2, 2022 at Mayflower Healthcare Center, a nursing home in Winter Park, 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 (NEPA) 1 and 101 (2018) edition known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted

K 223

The following is a description of the deficiencies found at the time of the visit.

per NFPA 101, Chapter 2,

K 223 NFPA 101 Doors with Self-Closing Devices SSEF

Electronically Signed

Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required

 Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7. 18.2.2.2.8. 19.2.2.2.7. 19.2.2.2.8

smoke detection system: and

This Statute or Rule is not met as evidenced by: Based on observation and testing, the facility LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

This Plan of Correction is prepared and

(X6) DATE 08/26/22

9/2/22

STATE FORM if continuation sheet 1 of 5 RJ9221

9/2/22

PRINTED: 09/14/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01, 05 B MING 74828 08/02/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1620 MAYELOWER COURT MAYFLOWER HEALTHCARE CENTER WINTER PARK, FL 32792 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 223 Continued From page 1 K 223 failed to remain in compliance with standards executed solely because it is required by established to ensure the operation of fire doors the provisions of the federal and state law. installed in the building to prevent the spread of Preparation and execution of this plan of fire, smoke and the toxic products of combustion. correction does not constitute admission NFPA 101 Chapter 19.2.2.2.1 specifies that or agreement by this provider of the truth "Doors complying with 7.2.1 shall be permitted." of the facts alleged or conclusions set Per 7.2.1.8.1 "A door leaf normally required to be forth in the Statement of Deficiencies kept closed shall not be secured in the open position at any time and shall be self-closing or 1. Double doors near room 222, and room automatic closing..." 230 were fixed and tested on 8-18-2022 Findings: 2. Fire doors are being checked and all will be completed by 9-2-2022 to ensure During a tour of the building on August 2, 2022 at they are operating correctly. All residents approximately 10:30 a.m. the double doors in the had the potential to be affected by this corridor near resident room #222 were tested. deficient practice. The doors failed to close and engage the lock. 3. On 8/19/2022, all maintenance staff At approximately 10:45 a.m. the double doors assigned to the health center were

educated on CODE NEPA 80

months

4. All fire doors will be checked for

compliance weekly for 1 month, bi- weekly

for 1 month, and monthly. All results will be reported through QAPI for 90 days, QA committee to review the need for

continued audit process at the end of 3

SS=F Testing

near room #230 were tested. The doors failed to

These findings were reconfirmed with Senior

Staff during the exit conference at 12 noon.

Code: NFPA 101 Ch 7.2.1.8.1 & Ch 19.2.2.2.1

K 353 NFPA 101 Sprinkler System - Maintenance and

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. maintenance, inspection and testing are

close and latch.

K 353

						: 09/14/2022 APPROVE
	or Health Care Adminis				,	
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SI COMPLE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	01, 05	COMPLE	: IED
		74828	B. WING		08/0	2/2022
			-		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
MAYFLOY	VER HEALTHCARE CEN'	TER	FLOWER COU			
		WINTER P	ARK, FL 3279	2		
(X4) ID		ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE
TAG	REGULATORT UKT	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIE	ONLE
			 	<u> </u>		
K 353	Continued From page	2	K 353		-	
	maintained in a secur	a location and roadily				
	available.	e location and readily				
	a) Date sprinkler sys	store last shocked				
	a) Date sprinkler sys	sterri last checked			-	
	b) Who provided sys	tem test				
	b) Title provided sys	nom test			-	
	c) Water system sup	ply source				
	Drovido in DEMARKS	information on coverage		5 5 5 8		
		or partial automatic sprinkler				
	system.	or partial automatic sprinkler				
	9.7.5, 9.7.7, 9.7.8, an	d NEDA 25				
	5.1.5, 5.1.1, 5.1.6, an	U NFFA 25				
	This Statute or Rule	is not met as evidenced by:				
	Based on record revie	ew and interview, the facility		This Plan of Correction is prepared ar	nd	
	failed to remain in cor	inpliance with the standards		executed solely because it is required	by	
	established to ensure	the complete operation of		the provisions of the federal and state	law.	
	the sprinkler system i	nstalled throughout the		Preparation and execution of this plan	of	
	building. The facility fa	ailed to maintain the		correction does not constitute admiss	ion	
	automatic fire sprinkle	er system through regularly		or agreement by this provider of the tr	uth	
	scheduled program o			of the facts alleged or conclusions set		
	maintenance. Per NF	PA 101 Chapter 19.1.6.1		forth in the Statement of Deficiencies		
	"healthcare facilities s	shall be protected throughout				
	by an approved, supe	rvised automatic fire		1. Hydrostatic testing that is complian	t to	
		er Ch. 9.7.5, "All automatic		NFPA 25 (2017) edition was complete		
	sprinkler and standpir	oe systems required by this		8/24/2022.		
		ed,tested and maintained in			-	
		A 25," Per NFPA 25 (2017)		2. This test is only required every 5 ye	ears.	
		g from the fire department		All residents had the potential to be		

sprinkler system was followed. The report of the AHCA Form 3020-0001

Findings:

connection to the fire department check valve

shall be hydrostatically tested at 150 psi (10 bar) for 2 hours at least once every 5 years."

During the review of records on August 2, 2022 at

approximately 10:00 a.m. documents were

reviewed that would indicate an established program of inspection and maintenance of the

STATE FORM caso RJ9221 If continuation sheet 3 of 5

affected by deficient practice.

8/26/2022.

3. Director of Building Services, and Building Services Supervisor assigned to

the Health Center were educated on this requirement NFPA 101 Ch 19.1.6.1, Ch

.9.7.5 & NFPA 25 (2017) CH 13.7.4 on

5 years. Reoccurring PM work order to

4. This inspection is to be completed every

Agency for Health Care Adminis	stration		FORM APPROVEL
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01, 05	(X3) DATE SURVEY COMPLETED
	74828	B. WING	00/02/2022

	<u>'</u>	•	•	·		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, S	TATE, ZIP CODE			
MAYELON	VER HEALTHCARE CENTER	1620 MAYFLOWER CO	AYFLOWER COURT			
MATTEOT	TER HERE(HOARE GENTER	WINTER PARK, FL 327	92			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FL REGULATORY OR LSC IDENTIFYING INFORMATI		PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
К 353	Continued From page 3 most recent 5 year sprinkler inspection was located and the report indicated a date of 5/. The report indicated the inspection had beer conducted under the standards of NFPA 25, edition which does not require hydrostatic te of the fire department connection.	2002 sting	conduct hydrostatic testing put in Maintenance care system.			
	These findings were reconfirmed with the Se Staff during the exit conference at 12:00 noc NFPA 101 Ch 19.1.6.1, 9.7.5, NFPA 25 Ch 1	on.		and		
K1053 SS=F	FAC 59A-4.126 Emergency Management PI: A written, comprehensive emergency management plan for emergency care durin internal or external disaster or emergency, w is reviewed and updated annually, shall be maintained. The health care facility shall test implementation of the emergency managem plan semiannually, either in response to a disaster or an emergency or in a planned dri and shall evaluate and document the health facility performance to the health care facility safety committee. Florida Administrative Code 59A-4.126.	g an vhich t the ent ill, care		9/2/22		
	This Statute or Rule is not met as evidence Based on record review and interview, the fa failed to exercise and evaluate their Comprehensive Emergency Management PI (CEMP). Per FAC 59A-4.126 "A written, comprehensive emergency management ple emergency care during an internal or externa disaster or emergency, which is reviewed an	acility Ian an for al	This Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set			

AHCA Form 3020-0001

STATE FORM 699 RJ9221 H continuation sheet 4 of 5

Agency fo	or Health Care Adminis	tration				: 09/14/2022 APPROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: I	CONSTRUCTION 01, 05	(X3) DATE S COMPLE	
		74828	B. WING		08/0	2/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
MAYFLOV	VER HEALTHCARE CENT	TER .	LOWER COU			
			ARK, FL 3279			
(X4) ID PREFEX TAG	(EACH DEFICIENC)	XTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K1053	Continued From page	4	K1053			
	updated annually, sha care facility shall test emergency manager either in response to it or in a planned drill, a document the health of the health care facility Findings: During the review of r Manager on August 2 11:15 a.m. documents indicate the facility he the CEMP at least twi	all be maintained. The health the implementation of the ent plan seminanually, a disaster or an emergency and shall evaluate and care facility performance to safely committee."		forth in the Statement of Deficiencies 1. An active shooter drill scheduled to conducted on 8-30-2022, a table top exercise for hurricane evacuation to b conducted on 8-31-2022. 2. Current Life safety drill calendar we reviewed for completeness. Semi-ann Disaster drills are added/scheduled in the annual Life Safety drill calendar. A residents had the potential to be affec by this deficient practice. 3. Annual Life Safety Drill Calendar is	e us ual ito Ul	
	be located. These findings were r	econfirmed with the Senior onference at 12:00 noon.		place. This calendar will be reviewed OA Committee annually and as need 4. QA Meeting Agenda was amende include Quarterly Review of Life Safet drills conducted in the past quarter to ensure if scheduled drills were condu- as per Life safety drill calendar.	by ed. to ty	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-0391

AND DUAN OF CODDECTION INCIDENTIFICATION NUMBER.			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05			(X3) DATE SURVEY COMPLETED	
		105720	B. WING	_		08/	02/2022
	ROVIDER OR SUPPLIER	TER		1	STREET ADDRESS. CITY, STATE, ZIP CODE 620 MAYFLOWER COURT WINTER PARK, FL 32792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	on August 2, 2022, at Center, a nursing hor	fe Safety survey conducted t Mayflower Healthcare ne in Winter Park, Florida, aredness was reviewed.					
	(CFR) 42, Part 483.7 Long-Term Care Fac	e of Federal Regulations 3, Requirement for lities.					
E 004 SS=F	Develop EP Plan, Re CFR(s): 483.73(a)	view and Update Annually	E	004			9/2/22
	\$403.748(a), \$416.54 \$441.184(a), \$460.84 \$483.475(a), \$484.10 \$485.625(a), \$485.72 \$486.360(a), \$491.12	4(a), §482.15(a), §483.73(a),)2(a), §485.68(a), 27(a), §485.920(a),					
	Federal, State and lo preparedness require develop establish and emergency prepared requirements of this	ements. The [facility] must d maintain a comprehensive ness program that meets the section. The emergency m must include, but not be					
	and maintain an eme	The [facility] must develop rgency preparedness plan rd], and updated at least lan must do all of the					
		ency Plan. The [hospital or ith all applicable Federal,					

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

(X6) DATE

Electronically Signed 08/26/2022

Any deficiency statement ending with an asteriak (1) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safequards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings as stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For unsing homes, the above findings and plans of correction are disclossable 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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CENTERS FOR MEDICARE & MEDICAID SERVICES						
CENTERS FOR MEDICARE & I	MEDICAID SERVICES		OMB NO. 0938-039			
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05	(X3) DATE SURVEY COMPLETED			
		D 14010				

		105720	B. WING		08/02/2022
	ROVIDER OR SUPPLIER	rer		STREET ADDRESS. CITY, STATE, ZIP CODE 1620 MAYFLOWER COURT WINTER PARK, FL 32792	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 004	requirements of this s all-hazards approach. *[For LTC Facilities a Plan. The LTC facility an emergency prepar reviewed, and update *[For ESRD Facilities Plan. The EsRD facilities facilities and the EsRD facilities facilities and the EsRD facilities	ospital or CAH] must a comprehensive a comprehensive sess program that meets the ection, utilizing an I §483.73(a):] Emergency must develop and maintain edness plan that must be dealess plan that must be did at least annually. at §494.62(a):] Emergency ty must develop and maintain edness plan that must be did teast annually. at §494.62(a):] Emergency ty must develop and y preparendress plan that and updated at least every 2 is not met as evidenced and record review, the facility pErR 483.73 (a), eliop and maintain a pency preparedness to requirements of this (a) "updated at least ecords with the Risk attely 11:00 a.m. on August cy Preparedness Plan for review. The Risk cournents that were ergency Preparedness complete and had not been	E 00	This Plan of Correction is prepared and executed solely because it is required the provisions of the federal and state is Preparation and execution of this plan correction does not constitute admission or agreement by this provider of the tru of the facts alleged or conclusions set forth in the Statement of Deficiencies 1. The Emergency Preparedness Plan (EPP) was reviewed and the organizational chart was updated with a current staff on 8/24/2022. 2. The EPP was reviewed in it is entirety completeness and accuracy. All resider had the potential to be affected by this deficient	y saw. of n h h

PRINTED: 09/14/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							APPROVED
			T				0. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05			SURVEY LETED
		105720	B. WING			08/	02/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAYELOW	ER HEALTHCARE CEN	TER			620 MAYFLOWER COURT		
				٧	VINTER PARK, FL 32792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
E 004	Continued From page	2	F	004			
	, ,	ncluded previous facility	-	-	3. EPP will be reviewed/updated annual	ally	
		hip positions. Interview, at			for accuracy and as needed with any s		
		e plan was not dated and			change over. A new process was		
	included the name of	the previous Director of			established to ensure EPP will be upda	ited	
		the employ of the facility			immediately with any change in key		
	over one year ago.				leadership position involved in disaster		
	These findings were t	reconfirmed with Senior			management. (HR Director or designer will immediately email Building Service		
		onference at 12:00 noon			Coordinator and Health Services Direct		
	out auring the out o	onioronio de taros nosini			of any new hire, turn-over or any chang		
	CFR 483.73(a)				in staff positions with role in disaster		
					management. Building Services Adm		
					Coordinator will update EPP based on	the	
					above email notification from HR Director.)		
					4. Health Services Director or designer	Ð	
					will verify if EPP has been accordingly updated at the end of each month).		
					Monitor through QAPI until substantial		
					compliance has been reached for 90		
					days. Any staff change will be reviewed	d at	
					QAPI. QA committee to review the nee		
					for continued audit process at the end	of 3	
					months.		
K 000	INITIAL COMMENTS		K	000			
	An unannounced Fire	e & Life Safety					
	Recertification survey	was conducted on August					
	2, 2022 at Mayflower						
	nursing home in Wint	er Park, Florida.					
		e Center is not in compliance					
		part B, 42 CFR 488.307,					
		tection Association (NFPA) guirements for nursing					
	TO THE OWNER THE	gan ornorlio for hundring					

PRINTED: 09/14/2022

		ID HUMAN SERVICES MEDICAID SERVICES				MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION 1, 05	(X3) DATE	
		105720	B. WING		08/	02/2022
NAME OF P	ROVIDER OR SUPPLIER	•	8	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAYFLOV	VER HEALTHCARE CEN	TER	1	620 MAYFLOWER COURT VINTER PARK, FL 32792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
K 000	Continued From page The following is a des noncompliance. Initial Plan Review: 1: Existing NFPA type II (222) Number of Beds 60 Census 47	scription of the	₭ 000			
K 223 SS=F	Doors with Self-Closi CFR(s): NFPA 101 Doors with Self-Closi Doors in an exit pass or horizontal exit, sm area enclosure are set closed position, unles device complying wit closes all such doors compartment or entire * Required manual fire * Local smoke detection syst * Automatic sprinkler * Loss of power. * Automatic sprinkler * Loss of power. * 18.2.2.2.7. * 18.2.2.8 This REGUIREMENT by: Based on observatio failed to remain in co-established to ensure setablished to ensure	ng Devices ageway, stainway enclosure, oke barrier, or hazardous elf-closing and kept in the is held open by a release 17.2.1.8.2 that automatically throughout the smoke is facility upon activation of: e alarm system; and or or designed to detect of the opening or a required	K 223	This Plan of Correction is prepared a executed solely because it is required the provisions of the federal and state Preparation of this pla	d by e law.	9/2/22
	NFPA 101 Chapter 19 "Doors complying wit	products of combustion. 3.2.2.2.1 specifies that h 7.2.1 shall be permitted," leaf normally required to be		correction does not constitute admiss or agreement by this provider of the t of the facts alleged or conclusions se forth in the Statement of Deficiencies	ruth	

kept closed shall not be secured in the open position at any time and shall be self-closing or

1. Double doors near room 222, and room

Facility ID: 74828

PRINTED: 09/14/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05	(X3) DATE SURVEY COMPLETED
	105720	B. WING	08/02/2022

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

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYELOW	VER HEALTHCARE CENTER	1	1620 MAYFLOWER COURT		
MATILOT	VER HEACHTOAKE CENTER	l v	VINTER PARK, FL 32792		
(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 223	Continued From page 4 automatic closing" Findings: Findings: During a tour of the building on August 2, 2022 at approximately 10:30 a.m. the double doors in the corridor near resident room #222 were tested. The doors failed to close and engage the lock. At approximately 10:45 a.m. the double doors near room #230 were tested. The doors failed to close and latch. These findings were reconfirmed with Senior Staff during the exit conference at 12 noon. Code: NFPA 101 Ch 7.2.1.8.1 & Ch 19.2.2.2.1	K 223	230 were fixed and tested on 8-18-2022. 2. Fire doors are being checked and all will be completed by 9-2-2022 to ensure they are operating correctly. All residents had the potential to be affected by this deficient practice. 3. On 8/19/2022, all maintenance staff assigned to the health center were educated on CODE NFPA 80. 4. All fire doors will be checked for compliance weekly for 1 month, bi- weekly for 1 month, bi- weekly for 1 month, and monthly. All results will be reported through QAPI for 90 days. QA committee to review the need for continued audit process at the end of 3 months.		