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
	74828	A. BUILDING: **01, 05** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFLOWER HEALTHCARE CENTER	**1620 MAYFLOWER COURT** **WINTER 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) COMPLETE DATE
K 000	INITIAL COMMENTS 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 (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. The following is a description of the deficiencies found at the time of the visit.	K 000		
K 223 SS=F	NFPA 101 Doors with Self-Closing Devices 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 smoke detection system; and * 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 This Statute or Rule is not met as evidenced by: Based on observation and testing, the facility	K 223	This Plan of Correction is prepared and	9/2/22

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/22

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K 223	Continued From page 1 failed to remain in compliance with standards established to ensure the operation of fire doors installed in the building to prevent the spread of fire, smoke and the toxic products of combustion. NFPA 101 Chapter 19.2.2.2.1 specifies that "Doors complying with 7.2.1 shall be permitted." Per 7.2.1.8.1 "A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic closing..." 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	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 forth in the Statement of Deficiencies 1. Double doors near room 222, and room 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, 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.	
K 353 SS=F	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, maintenance, inspection and testing are	K 353		9/2/22

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K 353	Continued From page 2 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 record review and interview, the facility failed to remain in compliance with the standards established to ensure the complete operation of the sprinkler system installed throughout the building. The facility failed to maintain the automatic fire sprinkler system through regularly scheduled program of inspection and maintenance. Per NFPA 101 Chapter 19.1.6.1 "healthcare facilities shall be protected throughout by an approved, supervised automatic fire sprinkler system." Per Ch. 9.7.5, "All automatic sprinkler and standpipe systems required by this code shall be inspected,tested and maintained in accordance with NFPA 25,..." Per NFPA 25 (2017) Ch. 13.7.4 "The piping from the fire department 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." Findings: 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 sprinkler system was followed. The report of the	K 353	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 forth in the Statement of Deficiencies 1. Hydrostatic testing that is compliant to NFPA 25 (2017) edition was completed on 8/24/2022. 2. This test is only required every 5 years. All residents had the potential to be affected by deficient practice. 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 8/26/2022. 4. This inspection is to be completed every 5 years. Reoccurring PM work order to	

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K 353	Continued From page 3 most recent 5 year sprinkler inspection was located and the report indicated a date of 5/21/19. The report indicated the inspection had been conducted under the standards of NFPA 25, 2002 edition which does not require hydrostatic testing of the fire department connection. These findings were reconfirmed with the Senior Staff during the exit conference at 12:00 noon. NFPA 101 Ch 19.1.6.1, 9.7.5, NFPA 25 Ch 13.7.4	K 353	conduct hydrostatic testing put in Maintenance care system.	
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 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, the facility failed to exercise and evaluate their Comprehensive Emergency Management Plan (CEMP). Per FAC 59A-4.126 "A written, comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is reviewed and	K1053	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	9/2/22

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K1053	Continued From page 4 updated annually, shall be maintained. The health care facility shall test the implementation of the emergency management plan semiannually, either in response to a 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." Findings: During the review of records with the Risk Manager on August 2, 2022 at approximately 11:15 a.m. documents were requested that would indicate the facility had exercised and evaluated the CEMP at least twice per year. Disaster drills were recorded in 2018 and no recent drills could be located. These findings were reconfirmed with the Senior Staff during the exit conference at 12:00 noon. FAC 59A-4.126	K1053	forth in the Statement of Deficiencies 1. An active shooter drill scheduled to be conducted on 8-30-2022, a table top exercise for hurricane evacuation to be conducted on 8-31-2022. 2. Current Life safety drill calendar was reviewed for completeness. Semi-annual Disaster drills are added/scheduled into the annual Life Safety drill calendar. All residents had the potential to be affected by this deficient practice. 3. Annual Life Safety Drill Calendar is in place. This calendar will be reviewed by QA Committee annually and as needed. 4. QA Meeting Agenda was amended to include Quarterly Review of Life Safety drills conducted in the past quarter to ensure if scheduled drills were conducted as per Life safety drill calendar.	

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E 000	Initial Comments During the Annual Life Safety survey conducted on August 2, 2022, at Mayflower Healthcare Center, a nursing home in Winter Park, Florida, the Emergency Preparedness was reviewed. Mayflower Healthcare Center was not in compliance with Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004		9/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with CFR 483.73 Requirements for Long-Term Care Facilities. Per 483.73(a), "The facility must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section.. " And, under (a) "...updated at least annually" Findings: During the review of records with the Risk Manager at approximately 11:00 a.m. on August 2, 2022, the Emergency Preparedness Plan (EPP) was requested for review. The Risk Manager presented documents that were assembled as the Emergency Preparedness Plan. The plan was incomplete and had not been reviewed and updated annually. The	E 004	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 forth in the Statement of Deficiencies 1. The Emergency Preparedness Plan (EPP) was reviewed and the organizational chart was updated with all current staff on 8/24/2022. 2. The EPP was reviewed in its entirety for completeness and accuracy. All residents had the potential to be affected by this deficient	

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E 004	Continued From page 2 organizational chart included previous facility employees in leadership positions. Interview, at that time, revealed the plan was not dated and included the name of the previous Director of Nursing that had left the employ of the facility over one year ago. These findings were reconfirmed with Senior Staff during the exit conference at 12:00 noon.. CFR 483.73(a)	E 004	3. EPP will be reviewed/updated annually for accuracy and as needed with any staff change over. A new process was established to ensure EPP will be updated immediately with any change in key leadership position involved in disaster management. (HR Director or designee will immediately email Building Services Coordinator and Health Services Director of any new hire, turn-over or any change in staff positions with role in disaster management. Building Services Admin Coordinator will update EPP based on the above email notification from HR Director.) 4. Health Services Director or designee 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 at QAPI. QA committee to review the need for continued audit process at the end of 3 months.	
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on August 2, 2022 at Mayflower Healthcare Center, a nursing home in Winter Park, Florida. Mayflower Healthcare Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes.	K 000		

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K 000	Continued From page 3 The following is a description of the noncompliance. Initial Plan Review: 1989 Existing NFPA type II (222) Number of Beds 60 Census 47	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 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 smoke detection system; and * 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 This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to remain in compliance with standards established to ensure the operation of fire doors installed in the building to prevent the spread of fire, smoke and toxic products of combustion. NFPA 101 Chapter 19.2.2.2.1 specifies that "Doors complying with 7.2.1 shall be permitted." Per 7.2.1.8.1 "A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or	K 223	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 forth in the Statement of Deficiencies 1. Double doors near room 222, and room	9/2/22

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K 223	Continued From page 4 automatic closing..." 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, 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.	