

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10950962	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MAIN LIC B. WING	(X3) DATE SURVEY COMPLETED 07/16/2025
NAME OF PROVIDER OR SUPPLIER LEXINGTON HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6300 46TH AVE N , SAINT PETERSBURG, Florida, 33709	
(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
K0000	<p>INITIAL COMMENTS</p> <p>A re-licensure survey was conducted on 07/16/2025 at Lexington Healthcare and Rehabilitation Center, a nursing home in St. Petersburg, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 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 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2.</p> <p>Date Opened: 1982</p> <p>Bldg. Type: III (200)</p> <p>Square Footage: 65,188</p> <p>Smoke Compartments:</p> <p>Floor Levels: 1</p> <p>Generator: 60kW (NG), 125 kW, 80 kW, 40 kW (diesel)</p> <p>Licensed Bed: 159</p> <p>Fully Sprinklered: yes</p> <p>Fire Alarm: yes</p> <p>The following is a description of the deficiencies found at the time of the visit.</p>	K0000		08/17/2025
K0345	<p>Fire Alarm System - Testing and Maintenance</p> <p>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance</p> <p>Detection systems, where required, shall be in accordance with Section 9.6. Fire alarm systems required by this Code shall be installed, tested, and maintained in accordance with the applicable</p>	K0345	<p>The facility Administrator/Designee contacted vendor to service the backflow tamper switches. The Fire service backflow tamper switches were inspected and tested by a vendor company.</p> <p>No residents were found to be affected by this alleged deficient practice.</p> <p>The Nursing Home Administrator educated the Maintenance staff on maintaining the fire service backflow tamper</p>	08/17/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K0345	<p>Continued from page 1 requirements of NFPA70 and NFPA72 unless otherwise permitted by 9.6.1.4.</p> <p>18.3.4.1, 19.3.4.1, 9.6, and NFPA 70, and NFPA 72</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, observations and interviews, the facility failed to maintain the automatic fire alarm system (AFAS) in accordance with NFPA 101 (2021 Edition).</p> <p>On 07/16/2025 at 9:40 AM during record review with the Facility Manager (FM), it was revealed that the facility failed to provide documentation of the quarterly visual inspections and semi-annual testing of the fire service backflow tamper switches. The devices could not be located on any inspection or testing reports inventory list.</p> <p>On 07/16/2025 at 2:15 PM during the facility tour with the Facility Manager (FM), the tamper switches were observed to be installed on the fire service backflow device.</p> <p>In an interview, the FM acknowledged concurrent with the findings and said that they did not realize the devices were not being inspected or tested.</p> <p>Per NFPA 101 (2021 Edition) 19.3.4.4, 9.6.5, 9.6.5.1 per NFPA 72 (2019 Edition) Chapter 14.3.1, (table) 14.3.1 (11), 14.4.4, Table 14.4.3.2 (17)(10)(a)</p> <p>Class III</p>	K0345	<p>Continued from page 1 switches in accordance with NFPA 101, which includes servicing and maintaining documentation of the fire service backflow tamper switches inspections.</p> <p>The Nursing Home Administrator/Designee will audit appropriate documentation of inspections conducted and quarterly documentation as it relates in accordance with NFPA101. These audits will be conducted monthly for 3 months. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring</p>	
K0353	<p>Sprinkler System - Maintenance and Testing</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system.</p> <p>19.7.6, 4.6.12, 4.6.12.1, 9.11 through 9.11.3.2, and NFPA 25</p>	K0353	<p>The facility Administrator/Designee contacted a vendor to service the 14 pendant sprinkler heads located at the front porch and cover drive, the 2 pendant sprinkler heads located in the laundry washroom, the 1 upright sprinkler head located behind the dryers, and the 1 sprinkler head covered with dust behind the dryers, as it relates to meeting compliance with NFPA 101.</p> <p>No residents were found to be affected by this alleged deficient practice</p> <p>The Nursing Home Administrator educated the Maintenance staff on maintaining sprinkler heads in accordance NFPA 101, which includes maintaining free of dust or corrosion.</p> <p>The Nursing Home Administrator/Designee will conduct</p>	08/17/2025

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K0353	<p>Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to maintain the automatic fire sprinkler system (AFSS) in accordance with NFPA 101 (2021 Edition) and NFPA 25 (2020 Edition). This in the event of fire could reduce the reliability of the system and jeopardize the safety of the occupants in the facility</p> <p>On 07/16/2025 between 1:30 PM and 4:00 PM, during the facility tour with the Facility Manager (FM), observations of the AFSS showed loaded and corroded ceiling pendant sprinklers detrimental to sprinkler performance in the following areas:</p> <ol style="list-style-type: none"> 1) 14 of 14 corroded pendant sprinkler heads in the front porch and exterior covered drive 2) 2 of 3 corroded pendant sprinkler heads in the laundry washroom 3) 1 of 2 corroded upright sprinkler heads behind the dryers 4) 1 of 2 loaded with dust upright sprinkler heads behind the dryers. <p>An interview was conducted with the FM concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2021 Edition) 19.3.5.1, 9.11.1</p> <p>per NFPA 25 (2020 Edition) 5.2.1, 5.2.1.1.2 (2) (5)</p> <p>Class III</p>	K0353	<p>Continued from page 2 weekly audits for 3 months on 5 sprinkler heads to ensure they are maintained in accordance with NFPA 101, including being free of dust and corrosion. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring.</p>	
K0741	<p>Smoking Regulations</p> <p>CFR(s): NFPA 101</p> <p>Smoking Regulations</p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <ol style="list-style-type: none"> (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all 	K0741	<p>The Staff member was identified and was immediately educated on the facility's non-smoking policy. The nursing home administrator conducted walking rounds of the outdoor areas surrounding the facility as it relates to any concerns with facility adherence to non-smoking policy. No concerns were identified.</p> <p>No residents were found to be affected by this alleged deficient practice.</p> <p>The Nursing Home Administrator/Designee re-educated facility staff on the non-smoking policy.</p> <p>The Nursing Home Administrator/Designee will conduct a random audit weekly 3 times a week on the facility staff's adherence to the facility's non-smoking policy by visual inspection. These audits will be conducted weekly for 3 months. The findings of these audits will</p>	08/17/2025

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K0741	<p>Continued from page 3</p> <p>major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18/19.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>(Note smoking tower disposal receptacles are not ashtrays)</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to provide the required smoking equipment in accordance with NFPA 1 (2021 Edition).</p> <p>On 07/16/2025 between 1:30 PM and 4:00 PM, during the facility tour with the Facility Manager (FM), an employee was observed smoking on the property outside of a designated smoking area that failed to provide ashtrays of noncombustible material and safe design, and metal containers with self-closing cover devices in which ashtrays can be emptied into. An interview was conducted with the FM concurrent with the observations and confirmed the findings.</p> <p>On 07/16/2025, during the exit conference, the administrator stated that the facility has a smoking regulations policy that states there is no smoking permitted on the facility's property at any time.</p> <p>per NFPA 1 (2021 Edition) 20.4.2.4(5)(6)</p> <p>Class III</p>	K0741	<p>Continued from page 3</p> <p>be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring</p>	
K0761 Bldg. 05	<p>Maintenance Inspection & Testing - Doors</p> <p>CFR(s): NFPA 101</p> <p>Fire door assemblies shall be installed, inspected, tested, and maintained in accordance with NFPA 80.</p>	K0761	<p>The corridor door equipped with a self-closing mechanism leading to the clean utility room by the nurse's station was called for servicing and repairs.</p> <p>No residents were found to be affected by this alleged deficient practice.</p>	08/17/2025

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K0761 Bldg. 05	<p>Continued from page 4 All fire door assemblies shall be labeled.</p> <p>Labels on fire door assemblies shall be maintained in a legible condition. In existing installations, steel door frames without a label shall be permitted where approved by the authority having jurisdiction. Unless otherwise specified, fire doors shall be self-closing or automatic-closing.</p> <p>Doors, other than those listed in 8.2.2.4 and 8.3.3.3.1, that are required to be self-closing or automatic closing shall comply with all of the following:</p> <p>(1) Door assemblies shall be inspected annually.</p> <p>(2) Doors shall be operated to confirm full closure.</p> <p>(3) Parts found to be damaged or inoperative shall be replaced.</p> <p>(4) Door openings and the surrounding areas shall be kept clear of anything that could obstruct or interfere with the free operation of the door.</p> <p>(5) Blocking or wedging of doors in the open position shall be prohibited.</p> <p>(6) Self-closing and automatic-closing devices shall be kept in working condition at all times.</p> <p>Written records of inspection and testing are maintained and are available for review.</p> <p>19.7.6, 4.6.12.1, 8.3.3.3 through 8.3.3.3.5, 8.5.4.3, 8.5.4, 8.7.1.3, 8.8 (NFPA 101)</p> <p>5.2, 5.2.3 (NFPA 80)</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to maintain the fire doors in accordance with NFPA 101 (2021 Edition). In the event of a fire, this condition could put occupants attempting shelter or evacuating in an unsafe environment.</p> <p>On 07/16/2025 between 1:30 PM and 4:00 PM, during the facility tour with the Facility Manager, it was observed that the corridor door equipped with a self-closing mechanism leading to the clean utility room by the nurse's station failed to close or self-latch when tested. An interview was conducted with</p>	K0761	<p>Continued from page 4 The Nursing Home Administrator educated the Maintenance staff on maintaining fire doors in working condition, including latching and closing appropriately.</p> <p>The Nursing Home Administrator/Designee will conduct weekly audits on 3 fire doors to ensure they are latching and closing appropriately for 3 months. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring.</p>	

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K0761 Bldg. 05	Continued from page 5 the FM concurrent with the observations and confirmed the findings. per NFPA 101 (2021 Edition) 19.7.6, 4.6.12.1, 8.3.3.3.1 per NFPA 80 (2019 Edition) 6.4.1.4 Class III	K0761		

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K0000	<p>INITIAL COMMENTS</p> <p>An unannounced recertification survey was conducted on 07/16/2025 at Lexington Healthcare and Rehabilitation Center, a nursing home in St. Petersburg, Florida.</p> <p>Lexington Healthcare and Rehabilitation 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.</p> <p>Initial Plan Review: 1982</p> <p>New or Existing: Existing</p> <p>NFPA 220 Construction Type: III (200)</p> <p>Number of beds: 159</p> <p>The following is description of the noncompliance</p>	K0000		08/17/2025
K0345	<p>Fire Alarm System - Testing and Maintenance</p> <p>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review, observations and interviews, the facility failed to maintain the automatic fire alarm system (AFAS) in accordance with NFPA 101 (2012 Edition).</p> <p>On 07/16/2025 at 9:40 AM during record review with the Facility Manager (FM), it was revealed that the facility failed to provide documentation of the</p>	K0345	<p>The facility Administrator/Designee contacted vendor to service the backflow tamper switches. The Fire service backflow tamper switches were inspected and tested by a vendor company.</p> <p>No residents were found to be affected by this alleged deficient practice.</p> <p>The Nursing Home Administrator educated the Maintenance staff on maintaining the fire service backflow tamper switches in accordance with NFPA 101, which includes servicing and maintaining documentation of the fire service backflow tamper switches inspections.</p> <p>The Nursing Home Administrator/Designee will audit appropriate documentation of inspections conducted and quarterly documentation as it relates in accordance with NFPA101. These audits will be conducted monthly for 3 months. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring</p>	08/17/2025
<p>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 reverse for further 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.</p>				
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K0345	<p>Continued from page 1</p> <p>quarterly visual inspections and semi-annual testing of the fire service backflow tamper switches. The devices could not be located on any inspection or testing reports inventory list.</p> <p>On 07/16/2025 at 2:15 PM during the facility tour with the Facility Manager (FM), the tamper switches were observed to be installed on the fire service backflow device. In an interview, the FM acknowledged concurrent with the findings and said that they did not realize the devices were not being inspected or tested.</p> <p>Per NFPA 101 (2012 Edition) 19.3.4.4, 9.6.5, 9.6.5.1</p> <p>Per NFPA 72 (2010 Edition) 14.3.1, table 14.3.1 (9f), 14.4.5, table 14.4.5 (15)(L)(1)</p>	K0345		
K0353	<p>Sprinkler System - Maintenance and Testing</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>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 maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to maintain the automatic fire sprinkler system (AFSS) in accordance with NFPA 101 (2012 Edition) and NFPA 25 (2011 Edition). This in the event of fire could reduce the reliability of the system and jeopardize the safety of the occupants in the facility.</p>	K0353	<p>The facility Administrator/Designee contacted a vendor to service the 14 pendant sprinkler heads located at the front porch and cover drive, the 2 pendant sprinkler heads located in the laundry washroom, the 1 upright sprinkler head located behind the dryers, and the 1 sprinkler head covered with dust behind the dryers, as it relates to meeting compliance with NFPA 101.</p> <p>No residents were found to be affected by this alleged deficient practice</p> <p>The Nursing Home Administrator educated the Maintenance staff on maintaining sprinkler heads in accordance NFPA 101, which includes maintaining free of dust or corrosion.</p> <p>The Nursing Home Administrator/Designee will conduct weekly audits for 3 months on 5 sprinkler heads to ensure they are maintained in accordance with NFPA 101, including being free of dust and corrosion. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring.</p>	08/17/2025

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K0353	<p>Continued from page 2 On 07/16/2025 between 1:30 PM and 4:00 PM, during the facility tour with the Facility Manager (FM), observations of the AFSS showed loaded and corroded ceiling pendant sprinklers detrimental to sprinkler performance in the following areas:</p> <ol style="list-style-type: none"> 1) 14 of 14 corroded pendant sprinkler heads in the front porch and cover drive 2) 2 of 3 corroded pendant sprinkler heads in the laundry washroom 3) 1 of 2 corroded upright sprinkler heads behind the dryers 4) 1 of 2 loaded with dust upright sprinkler heads behind the dryers. <p>An interview was conducted with the FM concurrent with the observations and confirmed the findings.</p> <p>per NFPA 101 (2012 Edition) 19.3.5.1, 9.11.1</p> <p>per NFPA 25 (2011 Edition) 5.2.1, 5.2.1.1.2 (2) (5)</p>	K0353		
K0741	<p>Smoking Regulations</p> <p>CFR(s): NFPA 101</p> <p>Smoking Regulations</p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <ol style="list-style-type: none"> (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is 	K0741	<p>The Staff member was identified and was immediately educated on the facility's non-smoking policy. The nursing home administrator conducted walking rounds of the outdoor areas surrounding the facility as it relates to any concerns with facility adherence to non-smoking policy. No concerns were identified.</p> <p>No residents were found to be affected by this alleged deficient practice.</p> <p>The Nursing Home Administrator/Designee re-educated facility staff on the non-smoking policy.</p> <p>The Nursing Home Administrator/Designee will conduct a random audit weekly 3 times a week on the facility staff's adherence to the facility's non-smoking policy by visual inspection. These audits will be conducted weekly for 3 months. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring</p>	08/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED B. WING	(X3) DATE SURVEY COMPLETED 07/16/2025
NAME OF PROVIDER OR SUPPLIER LEXINGTON HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6300 46TH AVE N, SAINT PETERSBURG, Florida, 33709	
(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
K0741	<p>Continued from page 3 permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to provide the required smoking equipment in accordance with NFPA 101 (2012 Edition).</p> <p>On 07/16/2025 between 1:30 PM and 4:00 PM, during the facility tour with the Facility Manager (FM), an employee was observed smoking on the property outside of a designated smoking area that failed to provide ashtrays of noncombustible material and safe design, and metal containers with self-closing cover devices in which ashtrays can be emptied into. An interview was conducted with the FM concurrent with the observations and confirmed the findings.</p> <p>On 07/16/2025, during the exit conference, the administrator stated that the facility has a smoking regulations policy stated that the facility has a smoking regulations policy that states there is no smoking permitted on the facility's property at any time.</p> <p>per NFPA 101 (2012 Edition) 19.7.4(5)(6)</p>	K0741		
K0761 Bldg. 01	<p>Maintenance, Inspection & Testing - Doors</p> <p>CFR(s): NFPA 101</p> <p>Maintenance, Inspection & Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.</p> <p>Written records of inspection and testing are maintained and are available for review.</p>	K0761	<p>The corridor door equipped with a self-closing mechanism leading to the clean utility room by the nurse's station was called for servicing and repairs.</p> <p>No residents were found to be affected by this alleged deficient practice.</p> <p>The Nursing Home Administrator educated the Maintenance staff on maintaining fire doors in working condition, including latching and closing appropriately.</p> <p>The Nursing Home Administrator/Designee will conduct weekly audits on 3 fire doors to ensure they are latching and closing appropriately for 3 months. The findings of these audits will be reported in the next risk management/Quality assurance committee meeting until the committee determines substantial compliance has been met and recommends quarterly monitoring.</p>	08/17/2025

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K0761 Bldg. 01	Continued from page 4 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to maintain the fire doors in accordance with NFPA 101 (2012 Edition). In the event of a fire, this condition could put occupants attempting shelter or evacuating in an unsafe environment On 07/16/2025 between 1:30 PM and 4:00 PM, during the facility tour with the Facility Manager, it was observed that the corridor door equipped with a self-closing mechanism leading to the clean utility room by the nurse's station failed to close or self-latch when tested. An interview was conducted with the FM concurrent with the observations and confirmed the findings. per NFPA 101 (2012 Edition) 19.7.6, 4.6.12.1, 8.3.3.1 per NFPA 80 (2010 Edition) 6.4.1.4	K0761		

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E0000	<p>Initial Comments</p> <p>During the recertification survey conducted on 07/16/2025 at Lexington Healthcare and Rehabilitation Center, a Nursing Home, Emergency Preparedness was reviewed.</p> <p>Lexington Healthcare 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</p>	E0000		08/17/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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