

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

PRINTED: 05/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105712	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05 B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER ALHAMBRA HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7501 38TH AVE N SAINT PETERSBURG, FL 33710	
(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
E 000	Initial Comments During the Fire & Life Safety recertification survey completed on 03/31/2025 at Alhambra Healthcare and Rehabilitation Center, a nursing home, Emergency Preparedness was reviewed. The facility is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities. The following is a description of the noncompliance.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015		4/30/25

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

TITLE

(X6) DATE

Electronically Signed

04/17/2025

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 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 015	<p>Continued From page 1</p> <p>safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to incorporate into their Emergency Preparedness Program (EPP) the procedures for sewage and waste disposal for 56 of 56 residents, in accordance with the Code of Federal Regulations.</p> <p>Findings included:</p>	E 015	<p>Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the accuracy of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted to comply with the requirements set forth under state and federal laws and agencies.</p>	

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E 015	Continued From page 2 During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide a procedure for sewage and waste disposal, in the event of the loss of the system. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant during the record review, who acknowledged that the procedure was not provided. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. per 42 CFR § 483.73(b)(1)(D)	E 015	1. The QA & A committee will review to approve the procedure for sewage and waste disposal on 4/24/2025. 2. No other areas or residents were affected by deficient practice. 3. Education provided to the Maintenance Director by NHA or designee on procedures for sewage and waste disposal by 4/24/2025. 4. All policies and procedures will be reviewed and monitored annually by the QA& A committee.	
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on 03/31/2025 at Alhambra Healthcare 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: 1968 Existing NFPA 220 Construction Type: V (000) Number of beds: 60 Census: 56 The following is a description of the noncompliance.	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101	K 200		4/30/25

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K 200	<p>Continued From page 3</p> <p>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 citation, should be included on Form CMS-2567. 18.2, 19.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain one of two exits in the corridor(s) of the 100-wing.</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that the exit door located by resident room 102 had a sign posted on it that said "DO NOT EXIT" "ALARM WILL SOUND!" The exit door also failed to close and latch when tested.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p>	K 200	<p>Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the accuracy of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted to comply with the requirements set forth under state and federal laws and agencies.</p> <ol style="list-style-type: none"> The sign was removed from the exit door on 3/31/2025 located by resident room 102 by maintenance staff. The door that failed to latch was repaired by Regional Maintenance Consultant on 3/31/2025 and the door now closes and latches appropriately. Exit doors in facility were audited for removal of any do not exit signs and to ensure doors close and latch by Maintenance Director on 04/01/2025. Education was provided to the 	

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K 200	Continued From page 4 Photographic Evidence Obtained per NFPA 101 (2012 Edition) 19.2.1, 19.2.2.2, 7.1.10.1, 7.1.10.2.1, 7.2.1.4.5, 7.2.1.5.1	K 200	Maintenance Director on Means of Egress Requirements. The Maintenance Director or designee will conduct quality assurance checks weekly for 12 weeks ensuring no exit signs on exit doors and doors closing and latching appropriately. 4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		4/30/25

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K 324	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain one of one commercial cooking hood in accordance with NFPA 101.</p> <p>Findings included:</p> <p>1.) During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of: a.) one of two semi-annual inspections of the fire suppression system for 2024, as the provided inspection was dated 01/09/2024, and b.) the 8-point monthly kitchen quick check inspection, as the only one provided was dated March 2025.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>per NFPA 101 (2012 Edition) 19.3.2.5.1, 9.2.3 per NFPA 96 (2011 Edition) 10.2.6(4), 11.2.1, per NFPA 17A (2009 Edition) 7.2, 7.2.1, 7.2.2</p> <p>2.) During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that one of one</p>	K 324	<p>1. Education was provided to the Maintenance Director on ensuring the two semi -annual inspection of the fires suppression system are completed, completing the monthly 8-point monthly kitchen quick check by NHA on 4/1/2025. The commercial cooking hoods seams were resealed to be made grease tight on 04/01/2025 by the Maintenance Director.</p> <p>2. No other areas or residents were affected by deficient practice.</p> <p>3. Education was provided to the Maintenance Director by the NHA on 4/1/2025 on ensuring the two semi -annual inspections of the fires suppression system are completed, completing the 8-point monthly kitchen quick check and ensuring the commercial cooking hood seams are sealed and grease tight.</p> <p>The Maintenance Director will conduct quality assurance checks on the commercial cooking hood to ensure seams are sealed and grease tight weekly for 12 weeks.</p> <p>4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured.</p>	

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K 324	Continued From page 6 commercial cooking hood failed to be made grease tight, as the hood's seams failed to be sealed. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. Photographic Evidence Obtained Per NFPA 101 (2012 Edition) 19.3.2.5.1, 9.2.3 Per NFPA 96 (2011 Edition) 5.1.4	K 324		
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	K 325		4/30/25

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K 325	<p>Continued From page 7</p> <p>sprinklered smoke compartments</p> <ul style="list-style-type: none"> * 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 <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to install alcohol-based hand rub (ABHR) dispensers in accordance with NFPA 101, in one of three smoke compartments.</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that:</p> <ol style="list-style-type: none"> 1.) the ABHR dispenser located in the employee lounge, within the third smoke compartment, was installed within 1" of an ignition source (light switch/receptacle), and 2.) the ABHR dispenser located in the corridor across from the water heater room within the third smoke compartment, was installed within 1" of an ignition source (receptacle). <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p>	K 325	<ol style="list-style-type: none"> 1. The ABHR dispenser located in the employee lounge was moved by Maintenance Director on 4/1/2025 and is no longer installed within 1 of an ignition source. The ABHR dispense located in the corridor across from the water heater room was moved by Maintenance Director on 4/1/2025 and is no longer installed within 1 of an ignition source. 2. An audit was completed by Maintenance Director on 4/17/2025 to ensure all ABHR dispensers are not within 1 of an ignition source. No additional findings noted. 3. Education was provided to the Maintenance Director by NHA on ensuring ABHR dispensers are installed in accordance with NFPA 101 on 4/1/2025. Quality assurance checks will be completed quarterly ongoing at an integrated facility preventive maintenance program. 4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly to ensure continued compliance. 	

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K 325	Continued From page 8 Photographic Evidence Obtained	K 325		
K 345 SS=D	per NFPA 101 (2012 Edition) 19.3.2.6(8) Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain two of two duct smoke detectors in accordance with NFPA 101. Findings included: During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of: 1.) the annual duct detector differential pressure testing for two of two duct detectors, as the most recent annual testing provided was from 03/21/2023, and 2.) the biennial sensitivity testing for two of two duct smoke detectors. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review,	K 345	1. The annual duct detector differential pressure testing for both duct detectors was completed on 2/3/2025 and 3/31/2025. The biennial sensitivity testing for both duct smoke detectors was completed on 03/24/2025. 2. No other areas or residents were affected by deficient practice. 3. Education was provided to the Maintenance Director regarding maintaining the duct detector differential pressure testing and biennial sensitivity testing for both duct smoke detectors per NFPA 101 by NHA on 4/17/2025. 4. Results from the annual duct detector differential pressure testing for both duct detectors and the biennial sensitivity testing for both detectors will be reported to the QA&A committee.	4/30/25

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K 345	Continued From page 9 and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. per NFPA 101 (2012 Edition) 19.3.4.4, 9.6.5.1 per NFPA 72 (2010 Edition) 14.4.2.2, 14.4.2.2(14)(g)(6), 14.4.5.3.2	K 345		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain one of one automatic fire sprinkler systems in accordance with NFPA 101.	K 353		4/30/25
			1. The Maintenance Director removed the zip tie from the cable related to the facilities satellite system on 4/9/2025. The sprinkler in the medical records storage	

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K 353	<p>Continued From page 10</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that:</p> <p>1.) a cable related to the facility's satellite system was zip tied to the fire sprinkler piping located on the exterior of the building, and</p> <p>2.) one of one sprinklers in the medical records storage room contained foreign material.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>Photographic Evidence Obtained</p> <p>per NFPA 101 (2012 Edition) 19.3.5, 9.7 per NFPA 25 (2011 Edition) 5.2.1.1.1, 5.2.2.2</p>	K 353	<p>room was serviced and cleaned by Maintenance staff on 04/2/2025.</p> <p>2. The Maintenance Director conducted a quality assurance check on sprinkler heads on 4/18/2025.</p> <p>3. Education was provided to the Maintenance Director by NHA on 4/17/2025 regarding maintaining the automatic fire sprinkler system in accordance with NFPA 101. Ongoing monthly quality assurance checks will be completed by the Maintenance Director or designee on facility sprinkler heads as a part of facility preventive maintenance program.</p> <p>4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly to ensure continued compliance.</p>	
K 712 SS=D	<p>Fire Drills CFR(s): NFPA 101</p> <p>Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded</p>	K 712		4/30/25

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

PRINTED: 05/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105712	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05 B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER ALHAMBRA HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7501 38TH AVE N SAINT PETERSBURG, FL 33710	
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K 712	<p>Continued From page 11</p> <p>announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to conduct fire drills in accordance with NFPA 101, as no evidence was provided for one of four quarterly fire drills for each of the three shifts in 2024.</p> <p>Findings included:</p> <p>During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of:</p> <p>1.) one of three fire drills during the third quarter of 2024, for the second shift, and</p> <p>2) two of three fire drills during the fourth quarter of 2024, for the first and third shifts.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>per NFPA 101 (2012 Edition) 19.7.1.4, 19.7.1.6, 19.7.1.8, 4.5.5</p>	K 712	<ol style="list-style-type: none"> The Maintenance Director in charge of oversight of fire drills in 2024 is no longer with the facility. A fire drill was conducted on each shift of the three shifts during the first quarter of 2025 by the new Maintenance Director. No other areas or residents were affected by deficient practice. Education was provided to the new Maintenance Director by NHA on 4/17/2025 on the requirement to conduct fire drills in accordance with NFPA 101. Monthly audits will be conducted by the Maintenance Director or designee to ensure fire drills are conducted on each of the three shifts monthly. Results from the fire drills will be reported to and reviewed by the QA&A committee. 	
K 918 SS-F	<p>Electrical Systems - Essential Electric Syste CFR(s): NFPA 101</p>	K 918		4/30/25

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K 918	<p>Continued From page 12</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain one of one generator in</p>	K 918	<p>1. The Maintenance Director in charge of oversight of generator weekly and monthly</p>	

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K 918	Continued From page 13 accordance with NFPA 99. Findings included: During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of: 1.) the weekly visual inspections of the generator prior to February 2025, and 2.) the monthly load testing of the generator prior to February 2025. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.	K 918	testing in 2024 is no longer with the facility. The new Maintenance Director is in compliance with weekly and monthly testing of generator. 2. No other areas or residents were affected by deficient practice. 3. Education was provided to the Maintenance Director by NHA on 4/17/2025 on maintaining the generator in accordance with NFPA 99. 4. Results of the weekly and monthly generator testing will be reported to the QA&A committee and reviewed monthly.	
K 929 SS=D	per NFPA 99 (2012 Edition) 15.5.1.3 per NFPA 110 (2010 Edition) 8.1.1, 8.3, 8.4, 8.4.2 Gas Equipment - Precautions for Handling Oxy CFR(s): NFPA 101 Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA	K 929		4/30/25

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K 929	<p>Continued From page 14 99)</p> <p>11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to manage one of one oxygen cylinder in accordance with NFPA 99.</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that one of one e-size oxygen cylinder in transport carts was unsecured, as the cylinder failed to be secured to the cart.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>Photographic Evidence Obtained</p> <p>per NFPA 99 (2012 Edition) 11.6.2.3(1)(11)</p>	K 929	<ol style="list-style-type: none"> The e-size oxygen cylinder in transport cart was secured on 03/31/2025 by the Maintenance Director. The Maintenance Director conducted quality assurance check on e-size oxygen cylinders in transport carts to ensure they were secured on 4/1/2025 and no additional findings notes. Education was provided to facility staff on securing e-size oxygen cylinder in transport securely by the NHA or designee by 4/25/2025. The Maintenance Director, or designee, will conduct weekly for 12 weeks audit on 5 random e-size oxygen cylinders in transport carts to ensure they are secured. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured. 	

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER ALHAMBRA HEALTHCARE & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 7501 38TH AVE N SAINT PETERSBURG, FL 33710
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K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Fire & Life Safety relicensure survey was conducted on 03/31/2025 at Alhambra 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 of Plan Review: 1968 Building Construction Type: V (000) Square Footage: 30,632 Smoke Compartments: 3 Floor Levels: 1 Generator: 150 kW diesel Licensed Bed: 60 Census: 56 Fully Sprinklered: Yes Fire Alarm: Yes</p> <p>The following is a description of the deficiencies found at the time of the visit.</p>	K 000		
K 200 SS=D	<p>NFPA 101 Means of Egress Requirements - Other</p> <p>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</p>	K 200		4/30/25

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/17/25
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K 200	<p>Continued From page 1</p> <p>applicable Life Safety Code or NFPA standard citation, should be included. 18.2, 19.2</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain one of two exits in the corridor(s) of the 100-wing.</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that the exit door located by resident room 102 had a sign posted on it that said ""DO NOT EXIT"" "ALARM WILL SOUND!" The exit door also failed to close and latch when tested.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>Photographic Evidence Obtained</p> <p>per NFPA 101 (2021 Edition) 19.2.1, 19.2.2.2, 7.1.10.1, 7.1.10.2.1, 7.2.1.8.1</p> <p>Class III</p>	K 200	<p>Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the accuracy of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted to comply with the requirements set forth under state and federal laws and agencies.</p> <ol style="list-style-type: none"> 1. The sign was removed from the exit door on 3/31/2025 located by resident room 102 by maintenance staff. The door that failed to latch was repaired by Regional Maintenance Consultant on 3/31/2025 and the door now closes and latches appropriately. 2. Exit doors in facility were audited for removal of any do not exit signs and to ensure doors close and latch by Maintenance Director on 04/01/2025. 3. Education was provided to the Maintenance Director on Means of Egress Requirements. The Maintenance Director or designee will conduct quality assurance checks weekly for 12 weeks ensuring no exit signs on exit doors and doors closing and latching appropriately. 4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured. 	

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K 324	<p>Continued From page 3</p> <p>b.) the 8-point monthly kitchen quick check inspection, as the only one provided was dated March 2025.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>per NFPA 101 (2021 Edition) 19.3.2.5.1, 9.2.3 per NFPA 96 (2021 Edition) 10.2.6(4), 11.2.1, per NFPA 17A (2021 Edition) 8.2, 8.2.1, 8.2.2, 8.3.3 Class III</p> <p>2.) During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that one of one commercial cooking hood failed to be made grease tight, as the hoods seams failed to be sealed.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>Photographic Evidence Obtained</p> <p>per NFPA 101 (2021 Edition) 19.3.2.5.1, 9.2.3</p>	K 324	<p>inspections of the fires suppression system are completed, completing the 8-point monthly kitchen quick check and ensuring the commercial cooking hood seams are sealed and grease tight.</p> <p>The Maintenance Director will conduct quality assurance checks on the commercial cooking hood to ensure seams are sealed and grease tight weekly for 12 weeks.</p> <p>4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured.</p>	

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K 324	Continued From page 4 per NFPA 96 (2021 Edition) 5.1.4 Class III	K 324		
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 observation and interview, the facility failed to install alcohol-based hand rub (ABHR) dispensers in accordance with NFPA 101, in one of three smoke compartments.	K 325	1. The ABHR dispenser located in the employee lounge was moved by Maintenance Director on 4/1/2025 and is no longer installed within 1 of an ignition source. The ABHR dispense located in	4/30/25

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K 325	Continued From page 5 Findings included: During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that: 1.) the ABHR dispenser located in the employee lounge, within the third smoke compartment, was installed within 1" of an ignition source (light switch/receptacle), and 2.) the ABHR dispenser located in the corridor across from the water heater room within the third smoke compartment, was installed within 1" of an ignition source (receptacle). An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. Photographic Evidence Obtained per NFPA 101 (2021 Edition) 19.4.4(B) Class III	K 325	the corridor across from the water heater room was moved by Maintenance Director on 4/1/2025 and is no longer installed within 1 of an ignition source. 2. An audit was completed by Maintenance Director on 4/17/2025 to ensure all ABHR dispensers are not within 1 of an ignition source. No additional findings noted. 3. Education was provided to the Maintenance Director by NHA on ensuring ABHR dispensers are installed in accordance with NFPA 101 on 4/1/2025. Quality assurance checks will be completed quarterly ongoing at an integrated facility preventive maintenance program. 4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly to ensure continued compliance.	
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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	K 345		4/30/25

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NAME OF PROVIDER OR SUPPLIER ALHAMBRA HEALTHCARE & REHABILITATION CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 38TH AVE N SAINT PETERSBURG, FL 33710		
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K 345	<p>Continued From page 6</p> <p>and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain two of two duct smoke detectors in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of:</p> <p>1.) the annual duct detector differential pressure testing for two of two duct detectors, as the most recent annual testing provided was from 03/21/2023, and</p> <p>2.) the biennial sensitivity testing for two of two duct smoke detectors.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>per NFPA 101 (2021 Edition) 19.3.4.1, 9.6.1.3 per NFPA 72 (2019 Edition) 14.3, 14.4.3, 14.4.3.2(17)(7)(e), 14.4.4.3.2</p> <p>Class III</p>	K 345	<ol style="list-style-type: none"> 1. The annual duct detector differential pressure testing for both duct detectors was completed on 2/3/2025 and 3/31/2025. The biennial sensitivity testing for both duct smoke detectors was completed on 03/24/2025. 2. No other areas or residents were affected by deficient practice. 3. Education was provided to the Maintenance Director regarding maintaining the duct detector differential pressure testing and biennial sensitivity testing for both duct smoke detectors per NFPA 101 by NHA on 4/17/2025. 4. Results from the annual duct detector differential pressure testing for both duct detectors and the biennial sensitivity testing for both detectors will be reported to the QA&A committee. 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01, 05 B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2025
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NAME OF PROVIDER OR SUPPLIER ALHAMBRA HEALTHCARE & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 7501 38TH AVE N SAINT PETERSBURG, FL 33710
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K 353 SS=D	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>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 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain one of one automatic fire sprinkler systems in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that:</p> <p>1.) a cable related to the facility's satellite system was zip tied to the fire sprinkler piping located on the exterior of the building and connected to the fire riser piping, and</p> <p>2.) one of one sprinkler in the medical records</p>	K 353	<p>1. The Maintenance Director removed the zip tie from the cable related to the facility's satellite system on 4/9/2025. The sprinkler in the medical records storage room was serviced and cleaned by Maintenance staff on 04/2/2025.</p> <p>2. The Maintenance Director conducted a quality assurance check on sprinkler heads on 4/18/2025.</p> <p>3. Education was provided to the Maintenance Director by NHA on 4/17/2025 regarding maintaining the automatic fire sprinkler system in accordance with NFPA 101. Ongoing monthly quality assurance checks will be completed by the Maintenance Director or</p>	4/30/25
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K 353	Continued From page 8 storage room contained foreign material. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. Photographic Evidence Obtained per NFPA 101 (2012 Edition) 19.3.5.1, 9.7.1.1(1) per NFPA 13 (2019 Edition) 31.1 per NFPA 25 (2020 Edition) 5.2.1.1.1(6), 5.2.2.2 Class III	K 353	designee on facility sprinkler heads as a part of facility preventive maintenance program. 4. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly to ensure continued compliance.	
K 712 SS=E	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1, 19.7.1, 4.7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills in accordance with	K 712	1. The Maintenance Director in charge of oversight of fire drills in 2024 is no longer	4/30/25

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K 712	Continued From page 9 NFPA 101, as no evidence was provided for one of four quarterly fire drills for each of the three shifts in 2024. Findings included: During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of: 1.) one of three fire drills during the third quarter of 2024, for the second shift, and 2.) two of three fire drills during the fourth quarter of 2024, for the first and third shifts. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the record review, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. per NFPA 101 (2021 Edition) 19.7.1.4, 19.7.1.6, 19.7.1.8, 4.5.5 Class III	K 712	with the facility. A fire drill was conducted on each shift of the three shifts during the first quarter of 2025 by the new Maintenance Director. 2. No other areas or residents were affected by deficient practice. 3. Education was provided to the new Maintenance Director by NHA on 4/17/2025 on the requirement to conduct fire drills in accordance with NFPA 101. Monthly audits will be conducted by the Maintenance Director or designee to ensure fire drills are conducted on each of the three shifts monthly. 4. Results from the fire drills will be reported to and reviewed by the QA&A committee.	
K 918 SS=F	NFPA 99 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		4/30/25

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K 918	<p>Continued From page 10</p> <p>service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain one of one generator in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the facility record review with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between</p>	K 918	<ol style="list-style-type: none"> The Maintenance Director in charge of oversight of generator weekly and monthly testing in 2024 is no longer with the facility. The new Maintenance Director is in compliance with weekly and monthly testing of generator. No other areas or residents were affected by deficient practice. Education was provided to the 		

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K 918	Continued From page 11 9:30 a.m. and 1:30 p.m., the facility failed to provide evidence of: 1.) the weekly visual inspections of the generator prior to February 2025, and 2.) the monthly load testing of the generator prior to February 2025. An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m. per NFPA 101 (2021 Edition) 19.1.1.1.3, 4.6.12.1 per NFPA 99 (2021 Edition) 6.7.4.1, 6.7.4.1.1.3 per NFPA 110 (2019 Edition) 8.1.1, 8.3.1, 8.4.1, 8.4.2 Class III	K 918	Maintenance Director by NHA on 4/17/2025 on maintaining the generator in accordance with NFPA 99. 4. Results of the weekly and monthly generator testing will be reported to the QA&A committee and reviewed monthly.	
K 929 SS=D	NFPA 99 Gas Equipment - Precautions for Handling Oxyg Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99)	K 929		4/30/25

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K 929	<p>Continued From page 12</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to manage one of one oxygen cylinder in accordance with NFPA 101.</p> <p>Findings included:</p> <p>During the facility tour with the Maintenance Director and the Regional Maintenance Consultant on 03/31/2025 between 2:00 p.m. and 4:10 p.m., it was found that one of one e-size oxygen cylinder in transport carts were unsecured, as the cylinder failed to be secured to the cart.</p> <p>An interview was conducted with the Maintenance Director and the Regional Maintenance Consultant, concurrent with the observations, and acknowledged the findings. These findings were reviewed with the Administrator, the Maintenance Director, and the Regional Maintenance Consultant during the exit conference on 03/31/2025 between 4:15 p.m. and 4:30 p.m.</p> <p>Photographic Evidence Obtained</p> <p>per NFPA 101 (2021 Edition) 19.1.1.1.3, 4.6.12.1 per NFPA 99 (2021 Edition) 11.6.2.3(1)(11)</p> <p>Class III</p>	K 929	<ol style="list-style-type: none"> The e-size oxygen cylinder in transport cart was secured on 03/31/2025 by the Maintenance Director. The Maintenance Director conducted quality assurance check on e-size oxygen cylinders in transport carts to ensure they were secured on 4/1/2025 and no additional findings notes. Education was provided to facility staff on securing e-size oxygen cylinder in transport securely by the NHA or designee by 4/25/2025. The Maintenance Director, or designee, will conduct weekly for 12 weeks audit on 5 random e-size oxygen cylinders in transport carts to ensure they are secured. All results of the quality assurance checks will be monitored and reviewed by the QA&A committee monthly until substantial compliance is assured. 	