STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (A1) PROVIDER'SUPPLIER'CL IDENTIFICATION NUMBER:		IA (X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 01 - MAIN LIC 08/04/2025 B. WING					E SURVEY COMPLETED	
F PROVIDER OR SUPPLIER		T	STREET AC	DRESS, CITY, STATE, ZIP COI	DE			
ERON HEALTH AND REHABIL	LITATION		5085 EAGLI	ESTON BLVD , WESLEY CHAP	EL, Floric	la, 33544		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE			(X5) COMPLETION DATE		
Blue Heron Health and Reha Wesley Chape, Florida in a or Protection Association (NFP) and applicable requirements Marshalf's Rules and Regulat Code (FA.C) 698-3, FA.C. 6. Florida Statutes (FS.) 400 Pradopting Marshalf's Rules and 101 (2021 Edition) know Prevention Code and all NFF requirements adopted per NI Date Opened: 2021 Bidg, Type: II (222) Square Footage: 102,826 Smoke Compartments: 15 Floor Levels: 2 Generator: 800 kW diesel 80 License Bed: 141 Fully Sprinklered: yes Fire Alarm: yes	to Center, a nursing home in cordance with National Fire N1 and 101 (2021 Edition) of Florida State of Florida State of Florida State for Florida State State of Stat	к00	000				08/31/2025	
Doors with Self-Closing Devi CFR(s): NFPA 101 Doors with Self-Closing Devi Any door in an exit passagev horizontal exit, smoke barrier enclosure (except boiler (except boilers)	ces vay, stairway enclosure, , or hazardous area ss, heater rooms, and	к02	2) No r 3) Adm found t	esidents were identified. inistrator immediately discarded o be propping fire door open on	08/04/202		08/31/2025	
	PLAN OF CORRECTIONS F PROVIDER OR SUPPLIER FON HEALTH AND REHABIL SUMMARY STATEME (RACH DEFICIENCY MUS) REGULATORY OR LSC IDI INITIAL COMMENTS A re-licansure survey was co Blue Heron Health and Reha Wesley Chapel, Florida in a Protection Association (NFP) and applicable requirements Marshal's Rules and Regulat Code (FA.C) 698-3, FA.C. 6 Florida Statutes (FS.) 400 Px adopting National Fire Protect and 101 (2021 Edition) know Preventino Code and all NFP requirements adopted per NI Date Opened: 2021 Bidg. Type: II (222) Square Footage: 102,826 Smoke Compartments: 15 Floor Levels: 2 Generator: 800 kW diesel 80 License Bed: 141 Fully Sprinklered: yes Fire Alarm: yes The following is a description found at the time of the visit. Doors with Self-Closing Devi CFR(s): NFPA 101 Doors with Self-Closing Devi Any door in an exit passagev horizontal exit, smoke barrier enclosure (except boller roor)	F PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A re-licensure survey was conducted on 08/04/2025 at Blue Heron Health and Rehab Center, a nursing home in Wesley Chapel, Fiorida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshaff Rutes and Regulations, Florida Administrative Code (FA.C.) 69A-3, FA.C. 69A-53, FA.C. 59A-4, and Florida Statutes (FS.) 400 Part, Il, and FS. 63A.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) knows as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Date Opened: 2021 Bidg. Type: II (222) Square Footage: 102,826 Smoke Compartments: 15 Floor Levels: 2 Generator: 800 kW diesel 8000-gal fuel tank ATS License Bed: 141 Fully Sprinklered: yes Fire Alarm: yes The following is a description of the deficiencies found at the time of the visit. Doors with Self-Closing Devices	PLAN OF CORRECTIONS IDENTIFICATION NUMBER: FPROVIDER OR SUPPLIER ERON HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A re-licensure survey was conducted on 08/04/2025 at Blue Heron Health and Rehab Center, a nursing home in Wesley Chaple, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of forida State Fire Marshal's Rules and Regulations, Florida Administrative Code (FAC, 98-A3, FAC, 69-A3, FAC, 69-A3, FAC, 69-A4, and Florida Statutes (FS, 1400 Part II, and FS, 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. Date Opened: 2021 Bidg. Type: II (222) Square Footage: 102,826 Smoke Compartments: 15 Floor Levels: 2 Generator: 800 kW diesel 8000-gal fuel tank ATS License Bed: 141 Fully Sprinklered: yes Fire Alarm: yes The following is a description of the deficiencies found at the time of the visit. Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Any door in an ext passageway, stainway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure (exopt boller roms, heater poms, and	A BUIL B. WINC F PROVIDER OR SUPPLIER FRON HEALTH AND REHABILITATION STREET AC 5085 EAGLI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A BILLE HERON HEALTH AND REHABILITATION K0000 A re-licensure survey was conducted on 08/04/2025 at Blue Heron Health and Rehab Center, a nursing home in Wesley Chapel, Florids in secondance with National Fire Preceded of the Chapel State of The Control State Floriding Marshal's Rules and Regulations, Florids Administrative Code (FA. 0) 98-3, FA. C. 58-4, and Florids Statutes (FS.) 400 Part II, and FS. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florids Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Date Opened: 2021 Bidg. Type: III (222) Square Footage: 102,826 Smoke Compartments: 15 Floor Levels: 2 Generator: 800 kW diesel 8000-gal fuel tank ATS License Bed: 141 Fully Sprinklerad: yes Fire Alarm: yes The following is a description of the deficiencies found at the time of the visit. Doors with Self-Closing Devices Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure (except boiler rooms, and	DENTIFICATION NUMBER: A BUILDING 01 - MAIN LIC B. WING F PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) INITIAL COMMENTS A re-licensure survey was conducted on 08/04/2025 at Blue Heron Health and Rehab Center, a nursing home in Vesley Chapel, Florida in accordance with National Fire Preceding outlet and Selection of the Vesley Chapel, Florida in accordance with National Fire Preceding outleteners of Florida State File ion Marshal's Rules and Regulations, Florida Administrative Code (FA.C) 98-3, FA.C. 694-3, FA.C. 694-4, and Florida Statutes (F.S.) 400 Part II, and FS. 633 0215, and foll (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Date Opened: 2021 Bidg. Type: II (222) Square Footage: 102,826 Smoke Compartments: 15 Floor Levels: 2 Generator: 800 kW diesel 8000-gal fuel tank ATS License Bed: 141 Fully Sprinklered: yes Fire Alarm: yes The following is a description of the deficiencies found at the time of the visit. Doors with Self-Closing Devices Any door in an ext passageway, stairway enclosure, horizontal exit, smoke berrier, or hazardous area enclosure (exotep to biler rooms, eader on consume consumers), and	LAN OF CORRECTIONS IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN LIC B. WING F PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A. B-I-ICENSURE WAS TATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A. B-I-ICENSURE SURVEY WAS CONDUCTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) KROOD INITIAL COMMENTS A. B-I-ICENSURE SURVEY WAS CONDUCTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) KROOD KROOD A R-I-I-ICENSURE SURVEY WAS CONDUCTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) KROOD A R-I-I-I-I-I-I-I-I-I-I-I-I-I-I-I-I-I-I-I	LAN OF CORRECTIONS LAN OF CORRECTIONS DENTIFICATION NUMBER: A BUILDING 01 - MAIN LIC B. WING F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5085 EAGLESTON BLVD , WESLEY CHAPPL, Florida, 33944 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) INITIAL COMMENTS A re-licensure survey was conducted on 08/04/2025 at Blue Heron Health and Rehab Center, a runsing home in Vesley Chapel, Florida in accordance with National Fire Preceding Chapter, Florida State File floor Marshal's Rules and Regulations, Florida State File floor Marshal's Rules and Regulations, Florida Administrative Code (FA C) 98-33, FA C, 694-4, and Florida Statulies (F.S.) 400 Part II, and FS, 633 0215, and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Date Opened: 2021 Bidg. 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Event ID: V7M921

Facility ID: 35961089

If continuation sheet Page 1 of 3

Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/IDENTIFICATION NUMBER:		1 ' '			(3) DATE SURVEY COMPLETED 3/04/2025	
F PROVIDER OR SUPPLIER	LITATION	1				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		THE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
complies with 7.2.18.2 The i and the fire alarm system, and 7.2.18.2, shall be arranged t action of all such doors throu compartment or throughout 18.2.2.8, 19.2.2.8, 7.2.1.8 This LICENSURE REQUIRE Based on observations and in failed to maintain Doors with accordance with NFPA 101 (0 acidity bour with the Director and the Administrator. The first Kitchen exit passage leading storage) room that is protect barrier and equipped with a coolean of the Administrator. The first Kitchen exit passage leading storage) room that is protect barrier and equipped with a cobserved held open by a bun door handle and a storage rafform self-closing and latching conducted with the Administr observations and confirmed to the door should be kept close.	tic release device that subtomatic sprinker system of the systems required by o initiate the closhing ghout the smoke he entire facility. 3.2 MENT is NOT MET as evidenced by heterviews, the facility Self-Closhing Devices in 2021 Edition). 1.1 1.2 1.2 1.3 1.3 1.4 1.4 1.5 1.5 1.5 1.5 1.5 1.5		APPROPRIATE DEFICIENCY) Continued from page 1 Administrator, Director of Plant Operations, or designee 08/21/20/25 with staff addressing the maintaining doors with self-osting devices in accordance with NFPA 101 (2012 Edition). 4) The Director of Plant Operations, or designee will audit at random five (5) Fire Rated Doors to observe door is free from devices that would prevent self-close and latch. Audits will be conducted once a week for four weeks, once a month for two months, or until substantial compliance is activeed. The results of the audit will be forwarded to the Quality Assurance Committee for review monthly for at least three months with a goal of 100% compliance. Upon completion and 100% compliance for at least three months is a divisived, frequency of further review and origing need for review will be determined by the QAPI committee.			
Cooking Facilities CFR(s): NFPA 101	ı	K0324			08/31/2025	
Cooking Facilities Cooking facilities shall be prowith 9.2.3, unless otherwise (19.3.2.5.3, or 19.3.2.5.4. Commercial cooking operatic accordance with NFFA 96 un approved existing installation permitted to be continued in 18.3.2.5.1 through 18.3.2.5.5, 9.2.3	permitted by 19.3.2.5.2, one shall be protected in less such installations are s, which shall be service.		to wall attachments located behind app 08/04/2025 at 1:55 PM by Director of or designee. An in-service education was conducte Administrator, Director of Plant Operat designee on 08/21/2025 with dining at commercial cooking equipment in acc 101 (2012 Edition). 4) The Director of Plant Operations, or audit commercial coking equipment in	oliances on Plant Operations of by the ions, or aff addressing the ordance with NFPA designee will accordance with		
	AENT OF DEFICIENCIES LAN OF CORRECTIONS PROVIDER OR SUPPLIER RON HEALTH AND REHABIL SUMMARY STATEME! (EACH DEFICIENCY MUS' REGULATORY OR LSC IDR Continued from page 1 held open only by an automa complies with 7.2.18.2. The and the fire alarm system, an 7.2.1.8.2, shall be arranged 1 action of all such doors throu compartment or throughout it 18.2.2.8, 19.2.2.8, 7.2.1.8 This LICENSURE REQUIRE Based on observations and if failed to maintain Doors with accordance with NFFA 101 (2 On 08/04/2025 between 1:00 facility tour with the Director and the Administrator, the fire Kitchen oxit passage leading storage) room that is protect barrier and equipped with a observed held open by a bun door handle and a storage a from self-dosing and latching conducted with the Administr observations and confirmed it the door should be kept close per NFPA 101 (2021 Edition) Class III Cooking Facilities CFR(s): NFPA 101 Cooking Facilities CFR(s): NFPA 101 Cooking Facilities shall be pro with 9.2.3, unless otherwise [19.3.2.5.3, or 19.3.2.5.4. Commercial cooking operatic accordance with NFFA 96 un approved existing installation permitted to be continued in 18.3.2.5.1 through 18.3.2.5.5, 19.3.2.5.5, 9.2.3	ARITOF DEFICIENCIES LAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: PROVIDER OR SUPPLIER RON HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 1 held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system and the fire alarm system, and the systems required by 7.2.1.8.2. shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the endire facility. 18.2.2.8. 19.2.2.2.8, 7.2.1.8.2 This LICENSURE REQUIREMENT is NOT MET as evidenced by Based on observations and interviews, the facility failed to maintain Doors with Self-Closing Devices in accordance with NFPA 101 (2021Edition). On 08/04/2025 between 1.00 PM - 3.30 PM, during the facility tour with the Director of Maintenance (DOM) and the Administrator, the fire rated door in the Kitchen exit passage leading into the hazardous (dry storage) room that is protected by a 1 hour tire barrier and equipped with a self-closing device owas observed held open by a bungee cord wrapped around the door handle and a storage rack restricting the door from self-closing and latching. An interview was conducted with the Administrator concurrent with the observations and confirmed the findings and slated that the door should be kept closed, per NFPA 101 (2021 Edition) 19.2.2.2.8 Class III Cooking Facilities CFR(s): NFPA 101 Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking Idealities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. Commercial cooking permitted by less such installations are approved existing installations, which shall be permitted to be confinued in service.	ARIT OF DEFICIENCIES LAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PROVIDER OR SUPPLIER RON HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 1 held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkier system and the five alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the endire facility. 18.2.2.8.19.2.2.8, 7.2.1.8.2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to maintain Doors with Self-Closing Devices in accordance with NFPA 101 (2021 Edition). On 08/04/2025 between 1:00 PM - 3:30 PM, during the facility tour with the Director of Maintenance (DOM) and the Administrator, the fire rated door in the Kitchen exit passage leading into the hazardous (dry storage) room that is protected by a 1 hour life barrier and equipped with a self-closing device was observed held open by a bungee cord wrapped around the door handle and a storage rack restricting the door from self-closing and latching. An interview was conducted with the Administrator concurrent with the observations and confirmed the findings and stated that the door should be kept closed, per NFPA 101 (2021 Edition) 19.2.2.2.8 Class III Cooking Facilities Cooking Facilities Cooking Facilities Cooking Tacilities shall be protected in accordance with NFPA 90 unless such installations are approved existing installations, which shall be permitted to be confirmed the service.	ABILTO F DEFICIENCIES LAN OF CORRECTIONS (X1) PROVIDERSUPPLIER A BUILDING 01 - MAIN LIC B. WING STREET ADDRESS, CITY, STATE, ZIP COI 5085 EAGLESTON BLVD, WESLEY CHAR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 1 held open only by an automatic release device that complies with 7.2.1.8.2. The automatic spirinkler system and the fire fallarm system, and the systems required by 7.2.1.8.2. The automatic spirinkler system and the fire fallarm system, and the systems required by 7.2.1.8.2. This LICENSURE RECUIREMENT is NOT MET as evidenced by the substantial Doors with Set-Closing Devices in accordance with NFPA 101 (2021 Edition) On 808/4/2025 between 1:00 PM - 3.30 PM, during the facility but with the Director of Maintenance (DOM) and the Administrator, the fire rated door in the Kitchen exit passage leading into the hazardous (dry storage) room that is protected by a 1 hour fire barrier and equipped with a self-closing device was conducted with the Administrator concurrent with the door should be kept closed. Der NFPA 101 (2021 Edition) PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION)	ART OF DEFICIENCIES LAN OF CORRECTIONS (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN LIC B. WING STREET ADDRESS, CITY, STATE, ZIP CODE SORS EAGLESTON BLVD, WESLEY CHAPEL, Florida, 33544 SULMIARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST'S BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Confinued from page 1 held open only by an automatic release device that complies with 7.2 1.8.2. The automatic sprinkler system and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 18.2.2.2.8, 19.2.2.2.8, 7.2.1.8.2 This LICENSURE REQUIREMENT is NOT MET as evidenced by Based on observations and interview, the facility fielded to maintain boros with Self-Closing Devices in accordance with NFPA 101 (2021 Edition). On 80/04/2025 between 1:00 PM - 3.30 PM, during the facility tour with the Director of Maintenance (DOM) and the Administrator, the fire rated door in the Kitchen edy passage leading into the hazardous (dry storage) room that a protected by a 1 hour fire storage and a storage rack restricting the door from self-closing and latching, An interview was conducted with the Administrator concurrent with the door handle and a storage rack restricting the door from self-closing and latching, An interview was conducted with the Administrator concurrent with the observed held open by a burgue cond wrapped around the door handle and a storage rack restricting the door from self-closing and latching, An interview was conducted with the Administrator concurrent with the observations and palathing, An interview was conducted with the Administrator concurrent with the observations and palathing, An interview was conducted with the Administrator concurrent with the observations and an administrator concurrent with the observations and palathing, An interview was conducted with the Administrator concurrent with the observations and gratialty	

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS			(X3) DATE SURVEY COMPLETED 08/04/2025		
	OF PROVIDER OR SUPPLIER	1747.011	- 1	REET ADDRESS, CITY, STATE, ZIP CO		
BLUE H	ERON HEALTH AND REHABI	LITATION	508	S EAGLESION BLVD , WESLEY CHAP	EL, FIORIGA, 33544	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	N SHOULD BE TO THE	(X5) COMPLETION DATE
K0324	Continued from page 2 accordance with NFPA 101 (On 08/04/2025 between 1:0f actility tour with the Director and the Administrator, if was fed appliances mounted on cooking hood were not limite restraining device to the wall appliances on casters had re observed attached to them in installed wall attachments to appliances. An interview was concurrent with the observat findings by looking behind the that they were not attached to provided. per NFPA 101 (2021 Edition) per NFPA 96 (2021 Edition): Class III) PM - 3:30 PM, during the of Maintenance (DOM) observed that 3 of 3 gas assters under the commercial of in movement 9 at 3 gas assters under the commercial of in movement 9 as yes a start of the start of the commercial of the start of the commercial of the start of the conducted with the DOM lones and confirmed the appliances and stating of the wall attachments 19.3.2.5.1, 9.2.3.13.12.1	K0324	Continued from page 2 four weeks, once a month for two mon authstantial compliance is achieved. The results of the audit will be forward Quality Assurance Committee for reviel least three months with a goal of months is achieved, requency of months is achieved, requency committee.	ths, or until ad to the w monthly for at s compliance. Upon t least three er review and	

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTIONS

(X1) PROVIDER'SUPPLIER'CLIA
10ENTIFICATION NUMBER:
106147

(X2) MULTIPLE CONSTRUCTION
A BUILDING 02 - MAIN FED
B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BLUE HERON HEALTH AND REHABILITATION

5085 EAGLESTON BLVD, WESLEY CHAPEL, Floride, 33544

NAME OF	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
BLUE HE	FRON HEALTH AND REHABILITATION	508	5085 EAGLESTON BLVD , WESLEY CHAPEL, Florida, 33544				
(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			
коооо	INITIAL COMMENTS An unannounced recertification survey was conducted 08/04/2025 at Blue Heron Health and Rehab Center, a nursing home in Westey Chaple, Florids, Blue Heron Health and Rehab Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 483.07, and National Fire Protection Association (NFPA) 101 (2012 Edition) regularments for nursing homes. Initial Plan Review: 2021 New or Existing: New NFPA 220 Construction Type: II (222) Number of beds: 141 The following is description of the noncompliance.	K0000		08/31/2025			
K0223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or hortzontal 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 72.1 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	K0223	1) No residents were identified. 2) No residents were identified. 3) Administrator immediately discarded bungee cord found to be propping fire door open on 08/04/2025. An in-service education was conducted by the Administrator, Director of Part Operations, or designee 08/21/2025 with staff addressing the maintaining door with self-closing devices in accordance with NFPA 101 (2012 Edition). 4) The Director of Plant Operations, or designee will audit at random five (5) Fire Rated Doors to observe door is free from devices that would prevent self-close and latch. Audits will be conducted once a week for four weeks, once a month for two months, or until substantial compliance is achieved. The results of the audit will be forwarded to the Quality Assurance Committee for review monthly for at least three months with a goal of 100% compliance. Upon completion and 100% compliance for at least three months with a goal of 100% compliance.	08/31/2025			

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

Facility ID: 35961089

(X6) DATE

OMB NO. 0938-0391

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 106147	.IA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN FED B. WING	1 ' '	
	F PROVIDER OR SUPPLIER ERON HEALTH AND REHABIL	LITATION			REET ADDRESS, CITY, STATE, ZIP COD 5 EAGLESTON BLVD , WESLEY CHAP		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID REFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
к0223	Continued from page 1 This STANDARD is NOT ME Based on observation and in to maintain doors with self-cla accordance with NFFA 101 (2 On 08/04/2025 between 1:00 facility tour with the Director and the Administrator, the fire Kitchen exit passage leading storage) room that is protect barrier and equipped with a observed held open by a bun door handle and a storage r from self-closing and latching conducted with the Administr observations and confirmed I the door should be kept close per NFFA 101 (2012 Edition)	terview, the facility failed osing devices in 2012 Edilion). I PM - 3:30 PM, during the of Maintenance (DOM) rated door in the into the hazardous (dry db ya 1 hour fire elf-closing device was gee cord wrapped around the ck restricting the door ck restricting the door kh niterior was abor concurrent with the he findings and stated that dd.	к	0223	Continued from page 1 months is achieved, frequency of furthe orgonizing need for review will be determit committee.	r review and ned by the QAPI	
K0324	Cooking Facilities CFR(s): NFPA 101 Cooking equipment is protected for the protection of Commercial Co- *residential cooking equipme such as microwaves, hot plat food warming or limited cook in a cooking facilities open to the compartments with 30 or few conditions under 13.3.2.5.2. *cooking facilities on smoke of the compartments with 30 or few conditions under 13.3.2.5.4. *cooking facilities in smoke of the compartments with 30 or few conditions under 13.3.2.5.4. Cooking facilities protected a 9.2.3 are not required to be a reass, but shall not be open 18.3.2.5.4 in through 18.3.2.5 in through 18.3.2	control and Fire obtained with a properties of times, and appliances es, toasters) are used for ing accordance with a corridor in smoke or patients comply with the 19.3.2.5.3, or ompartments with 30 or another or patients comply and the properties of the corridor in the properties of the corridor of the properties of the corridor.	K	20324	1) No residents were identified. 2) No residents were identified. 3) Restraint tethers immediately attach to wall attachments located behind app 08/04/20/5 at 1:55 PM by Director of P or designee. An in-service education was conducted Administrator, Director of Plant Operation designee on 02/21/20/25 with diring site commercial cooking equipment in accord 10/20/12 Edition). 4) The Director of Plant Operations, or audit commercial cothing equipment in NFFA 101 (2012 Edition) to observe restatched and secured to wall attachmen appliances. Audits will be conducted on our weeks, none a month for two month substantial compliance is achieved. The results of the audit will be forwarded quality Assurance Committee for review least three months with a goal of 100% compliance for all only% compliances for all only% compliances for all only% compliances for all only% compliances for all confidences for all only% compliances for all only and all only% compliances for all only% compliances for all only and all only and all only% compliances for all only and all only and all only% compliances for all only and all only and all only% compliances for all only and all only all only and all only a	islances on lant Operations by the one, or of fladdressing the dance with NFPA designee will ecoordance with straint tethers with coarded behind to a week for rs, or until d to the wronthly for at compliance. Upon	08/31/2025
	This STANDARD is NOT ME Based on observations and it	-			months is achieved, frequency of furthe ongoing need for review will be determi committee.	r review and	

OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	AND PLAN OF CORRECTIONS IDENTIFICATION NUMBER: 108147 NAME OF PROVIDER OR SUPPLIER STRI			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN FED B. WING	(X3) DATE SURVI 08/04/2025	EY COMPLETE	
			STREET ADDRESS, CITY, STATE, ZIP CODE 5085 EAGLESTON BLVD , WESLEY CHAPEL, Florida, 33544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFU TAG		I SHOULD BE TO THE	(X5) COMPLETIO DATE	
K0324	Continued from page 2 failed to maintain the comma accordance with NFPA 101. On 08/04/2025 between 1:0 facility tour with the Director and the Administrator, it was fed appliances mounted on cooking hood were not limit restraining device to the wal appliances on casters had nobserved attached to them the continuation of the	arcial cooking equipment in (2012 Edition). 0 PM - 3:30 PM, during the of Maintenance (DOM) observed that 3 of 3 gas casters under the commercial ad in movement by a line. All 3 of 3 gas existent to the commercial ad in movement by a line. All 3 of 3 gas esteraint tethers that were but not secured to the cated behind each conducted with the DOM tions and confirmed the ne appliances and stating to the wall attachments 1 (3.3.2.5.1, 9.2.3.12.1, 13.2.3.12.1)	K0324				

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 106147			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/04/2025	
	DF PROVIDER OR SUPPLIER IERON HEALTH AND REHABIL	LITATION	1	REET ADDRESS, CITY, STATE, ZIP COL 85 EAGLESTON BLVD , WESLEY CHAP		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETION DATE
E0000	Initial Comments During the recertification sur 08/04/2025 at Blue Heron He Nursing Home, Emergency February Blue Heron Health and Reha with Emergency Preparedne Regulations (CFR) 42, Part Long-Term Care Facilities.	vey conducted on salth and Rehab Center, a reparedness was reviewed. b Center is in compliance ss per Code of Federal 183.7.3, Requirement for	E0000	stitution may be excused from correcting p		08/31/2025

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

(X6) DATE

TITLE