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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105335	A. BUILDING 01 - MAIN FED B. WING ________	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY	2105 SW 11TH COURT DELRAY BEACH, FL 33445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on November 14 and 15, 2016 at Abbey Delray, a nursing home in Delray Beach, Florida 33445. Abbey Delray is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Assocoation (NFPA) 101 (2012 edition) requirements for nursing homes. Intial Plan Review: Type II (111) Existing NFPA 220 Construction Type Census 82 The following renovation and construction project that the facility has currently in review or process with the AHCA Office of Plans and Construction: Project Name: Interior Renovation Client Code/File-Project Sub. Number: 35/95051-102-1 The following is description of noncompliance.	K 000		
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		12/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2016

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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	105335	A. BUILDING **01 - MAIN FED** B. WING	**11/15/2016**

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K 222	Continued From page 1 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 2 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview Abbey Delray failed to comply with NFPA 101 2012 edition 7.2.1.6.1, 19.2.2.2.4. All exits must be accessible at all times. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During a tour of the facility on 11/15/2016 at 12:55 PM with the Maintenance Director it was observed that on the first floor Wing 300 the 15 second delayed egress did not function properly. The alarm did not engage within three seconds under pressure. The Maintenance Director acknowledged that the exit door did not function properly. NFPA 101 (2012) 7.2.1.6.1, 19.2.2.2.4	K 222	The statements made in this plan of correction are not and do not constitute any agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date certain. It is the practice of Abbey Delray to provide that all exits be accessible at all times so not to affect occupants of the facility in case of a fire or other emergency. Corrective actions were accomplished by vendor completing repairs of the first floor wing 300 door. To identify others potentially affected, doors are inspected daily by plant operation director or designee daily times 4 weeks then weekly times 3 months. To avoid reoccurrence,	

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K 222	Continued From page 3	K 222	Audits shall continue on a preventative maintenance schedule for egress doors daily for 4 weeks then weekly times 3 months. The physical plant operations director or designee will re-educate the maintenance team on proper function and reporting of faulty of egress doors. Audit results will be reported to QAPI Committee monthly for three months and trends will be presented with corrective actions as indicated.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for	K 920		12/17/16

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K 920	Continued From page 4 which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview Abbey Delray failed to comply with NFPA 101 (2012) edition, NFPA 99, NFPA 70. Power strip must meet UL requirements. Findings Included: During a tour of the facility on 11/15/2016 at 12:15 PM with the Maintenance Director it was observed that surge protectors were being used with two refrigerators on the first floor in the Administrative offices. The Administrator and Maintenance Director acknowledged the absence of UL rated devices with the refrigerators. NFPA 101 (2012) Edition NFPA 99 (2012) NFPA 70 (2011)	K 920	The statements made in this plan of correction are not and do not constitute any agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date certain. It is the practice of Abbey Delray that power strips/surge protectors used in non-patient rooms meet UL standards and extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed. Corrective actions were accomplished during the survey by removing the observed surge protector that was being used for refrigerator(s) in the administrative offices. Any such appliances or devices continuously used shall be plugged directly into a wall outlet. An audit will be performed by the plant operations director or designee daily times 4 weeks then weekly times 3 months to ensure that surge protectors are not being used.	

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K 920	Continued From page 5	K 920	To avoid reoccurrence, audits shall continue on a preventative maintenance schedule for surge protectors daily for 4 weeks then weekly times 3 months. The administrator or designee will re-educate the office occupants on the regulations concerning the use of power strips/surge protectors. Audit results will be reported to QAPI Committee monthly for three months and trends will be presented with corrective actions as indicated.	

Agency for Health Care Administration

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K 000	Initial Comments This is an unannounced Fire Life Safety State Relicensure Survey conducted on November 14 and 15, 2016 at Abbey Delray (license 121096) a nursing home in Delray Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012 edition) and applicable requirements of Florida State Fire Marshall's Rules and Regulations, Florida Administrative Code F.A.C. 69A-3, F.A.C. 69A-53, F. A.C. and Florida Statutes (F.S.) 400 Part II and F.S. 633.0215, adopting National Fire Protection (NFPA) 1 and 101(2012 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following renovation and construction project that the facility has currently in review or process with the AHCA Office of Plans and Construction: Project Name: Interior Renovation Client Code/File-Project Sub. Number: 35/95051-102-1 The following is a description of the deficiencies, found in the time of the visit.	K 000		
K 043 SS=D	NFPA 101- LSC 2012 SPECIAL LOCKING ARRANGEMENTS Locks shall not be permitted on patient sleeping room doors, unless otherwise permitted by one of the following: (1) Key-locking devices that restrict access to the room from the corridor and that are operable only by staff from the corridor side shall be permitted, provided that such devices do not restrict egress from the room. (2) Locks complying with 18.2.2.2.5 shall be	K 043		12/17/16

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/16

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K 043	Continued From page 1 permitted. Doors not located in a required means of egress shall be permitted to be subject to locking. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 18.2.2.2.5 shall be permitted. (2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted. (3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted. Door-locking arrangements shall be permitted in accordance with either 18.2.2.2.5.1 or 18.2.2.2.5.2. Door-locking arrangements shall be permitted where the clinical needs of patients require specialized security measures or where patients pose a security threat, provided that staff can readily unlock doors at all times in accordance with 18.2.2.2.6. Door-locking arrangements shall be permitted where patient special needs require specialized protective measures for their safety, provided that all of the following criteria are met: (1) Staff can readily unlock doors at all times in accordance with 18.2.2.2.6. (2) A total (complete) smoke detection system is provided throughout the locked space in accordance with 9.6.2.9, or locked doors can be remotely unlocked at an approved, constantly attended location within the locked space. (3)*The building is protected throughout by an approved, supervised automatic sprinkler system in accordance with 18.3.5.1. (4) The locks are electrical locks that fail safely	K 043		

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K 043	Continued From page 2 so as to release upon loss of power to the device. (5) The locks release by independent activation of each of the following: (a) Activation of the smoke detection system required by 18.2.2.2.5.2(2) (b) Waterflow in the automatic sprinkler system required by 18.2.2.2.5.2(3) Doors that are located in the means of egress and are permitted to be locked under other provisions of 18.2.2.2.5 shall comply with both of the following: (1) Provisions shall be made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks from within the locked smoke compartment (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all times (2) Only one locking device shall be permitted on each door. NFPA 101 Life Safety Code (2012) 18.1.1.1.5, 18.2.2.2.2 thru 18.2.2.2.6, 19.1.1.1.5, 19.2.2.2.2 thru 19.2.2.2.6. This Statute or Rule is not met as evidenced by: Based on observation and staff interview Abbey Delray failed to comply with NFPA 101 (2012) edition 7.2.1.6.1, 19.2.2.2.4. All exits must be accessible at all times. This deficiency could affect all occupants of the facility in case of a fire or other emergency.	K 043	The statements made in this plan of correction are not and do not constitute any agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan	

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K 043	Continued From page 3 Findings Included: During a tour of the facility on 11/15/2016 at 12:55 PM with the Maintenance Director it was observed that on the first floor Wing 300 the 15 second delayed egress did not function properly. The alarm did not engage within three seconds under pressure. The Maintenance Director acknowledged that the exit door did not function properly. NFPA 101 (2012) 7.2.1.6.1, 19.2.2.2.4 Class III	K 043	of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date certain. It is the practice of Abbey Delray to provide that all exits be accessible at all times so not to affect occupants of the facility in case of a fire or other emergency. Corrective actions were accomplished by vendor completing repairs of the first floor wing 300 door. To identify others potentially affected, doors are inspected daily by plant operation director or designee daily times 4 weeks then weekly times 3 months. To avoid reoccurrence, Audits shall continue on a preventative maintenance schedule for egress doors daily for 4 weeks then weekly times 3 months. The physical plant operations director or designee will re-educate the maintenance team on proper function and reporting of faulty of egress doors. Audit results will be reported to QAPI Committee monthly for three months and trends will be presented with corrective actions as indicated.	

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K 147	Continued From page 4	K 147		
K 147 SS=D	NFPA 101-LSC2012,NFPA70-11NFPA99-ELECTRICAL SAFETY All requirements for electrical safety shall be complied with per the NFPA 70, National Electrical Code, and NFPA 99, Health Care Facilities Code. NFPA 101 Life Safety Code (2012)18.5.1 & 19.5.1, 9.1, NFPA 70 (2011), NFPA 99 (2012). This Statute or Rule is not met as evidenced by: Based on observation and staff interview Abbey Delray failed to comply with NFPA 101 (2012) edition, NFPA 99, NFPA 70. Power strip must meet UL requirements. Findings Included: During a tour of the facility on 11/15/2016 at 12:15 PM with the Maintenance Director it was observed that surge protectors were being used with two refrigerators on the first floor Administrative offices. The Administrator and Maintenance Director acknowledged the absence of UL rated devices with the refrigerators. NFPA 101 (2012) Edition NFPA 99 (2012) NFPA 70 (2011) Class III	K 147	The statements made in this plan of correction are not and do not constitute any agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date certain. It is the practice of Abbey Delray that power strips/surge protectors used in non-patient rooms meet UL standards and extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed. Corrective actions were accomplished during the survey by removing the observed surge protector that was being used for refrigerator(s) in the administrative offices. Any such appliances or devices continuously used shall be plugged	12/17/16

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K 147	Continued From page 5	K 147	directly into a wall outlet. An audit will be performed by the plant operations director or designee daily times 4 weeks then weekly times 3 months to ensure that surge protectors are not being used. To avoid reoccurrence, audits shall continue on a preventative maintenance schedule for surge protectors daily for 4 weeks then weekly times 3 months. The administrator or designee will re-educate the office occupants on the regulations concerning the use of power strips/surge protectors. Audit results will be reported to QAPI Committee monthly for three months and trends will be presented with corrective actions as indicated.	

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

December 2, 2016

Administrator
Abbey Delray
2105 SW 11th Court
Delray Beach, FL 33445

RE: Health and Life Safety Code Recertification and Licensure surveys; and Complaint CCR# 2016011448

Dear Administrator:

On November 14, 2016-November 17, 2016, Health and Life Safety Code Recertification and Licensure surveys; and Complaint CCR# 2016011448 surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the electronic Form CMS-2567 and State (3020) Form. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than December 17, 2016.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed February 17, 2017 if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on May 17, 2017 if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged

and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. If you have questions, please contact this office at (561) 381-5840.

Sincerely,

Maryanne Salerni for

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosures: CMS-2567 and State 3020 forms

R6WB