03/20/2017

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 03 - MAIN LIC

NAME OF PROVIDER OR SUPPLIER

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

LAKE VIEW CARE CENTER AT DELRAY

95012

5430 LINTON BLVD DEL DAY DE 4 OU EL 20404

LANE VIE	DELRAY E	BEACH, FL 334	84	- 1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 050 SS=F	Initial Comments  An unannounced Fire & Life Safety re-licensure survey was conducted on March 20, 2017 at Lake View Care Center at Delray, State license: 12300962, 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 Marsharls' Rules and Regulations, Florida Administrative Code (F.A.C.) 69 A-3, F.A.C. 69 A-5, F.A.C. 59 A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (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 is description of the deficiencies, found at the time of the visit.  NFPA 101-LSC 2012 FIRE DRILLS & STAFF FAMILIARIZATION.  The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to a reas of refuge, and or their evacuation for met building when necessary. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.  NFPA 101 Life Safety Code (2012) 18.7 & 19.7, 4.7.	K 000		4/7/17

AHCA Form 3020-0001 Electronically Signed

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

03/31/17

TITLE

(X6) DATE

STATE FORM 6890 4FMY21 If continuation sheet 1 of 4

STATEMENT	or Health Care Adminis or DEFICIENCIES or CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION 03 - MAIN LIC	FORM (X3) DATE S COMPLE	ETED
		95012	B. WING		03/2	0/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
LAKE VIE	W CARE CENTER AT DE	LRAY	TON BLVD			
LANE VIE	TO DAILE GENTER AT DE	DELRAY	BEACH, FL 33	484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 050	Based on written doc- interview, the facility if re plan and ensure t according to code rec- practice affects all star Findings include: On March 20, 2017 a written documentation performance of fire dr to confirm that they ai	is not met as evidenced by: ument review and staff ailed to maintain the facility	K 050	The facility Administrator reviewed an updated the 2017 Fire Drill Workshee The worksheet appropriately reflects tsandards of performing drills quarterl all three shifts.  The systematic changes established tensure standards are met include: (1)Review of the facility Life Safety Loensure that the fire drill standard is included. (2) The Maintenance Direct will complete the Life Safety Log mon to reflect the completed fire drills per	t. he yon o g to	
	fire drills, indicates the conducted quarterly of does not meet code in conducted six fire drill the 3-11 shift and five are required quarterly interview was conduct facility Maintenance E that written document the performance of fir requirements. No add	at fire drills are not being in all three shifts, which equirements. The facility is on the 7 - 3 shift, one on e on the 11 - 7 shift. Fire drills on each shift by code. An ted at this time with the birector who acknowledged atton provided in support of e drills was not up to code ditional written ovoided to substantiate		standards.  To ensure the standards are maintain the Maintenance Director will complet Life Safely Log and the Fire Drill Worksheet monthly. The Life Safety L and the Fire Drill Worksheet will be presented to the Quality Assurance an Performance Improvement Committee review and compliance monitoring.	e the og nd	

NFPA LSC 101 (2012) 19.7.1.6 AHCA Form 3020-0001

2017. Class III Actual NFPA Standards:

The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of written documentation review and at the exit conference on March 20.

Agency for Health Care Administration					PRINTED: 04/17/2017 FORM APPROVEE (X3) DATE SURVEY COMPLETED	
	95012 B. WING			03/20/2017		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
LAKE VIE	W CARE CENTER AT DE	LRAY	ITON BLVD BEACH, FL 334	84		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 072 SS=F	The means of egress passageway, corridor location, and access: Chapter 7 unless oth through 18.2.11 & 19 means of egress shal maintained free of all impediments to full in or other emergency, it he extent necessary for occupants having NFPA 101 Life Safety 7.1.10.1 & 4.5.3.2  NOTE: SEE NEW PR K-39 which are applic CMS requirement is reacility has complete	shall be in accordance with arwise modified by 18.2.2 2.2 through 19.2.11. The I be continuously obstructions or stant use in the case of fire and shall be accessible to to ensure reasonable safety	K 072			4/3/17

doors were not signed as required by code to
AHCA Form 3020-0001

residents.

Findings include:

This Statute or Rule is not met as evidenced by: Based on observation and staff interview the

facility failed to maintain the building exit egress.

On March 20, 2017 at 3 p.m. during the facility

tour it was noted that the physical therapy gym

exterior doors, which have the appearance of exit

This deficient practice affects all staff, visitors and

STATE FORM 6990 4FMY21 8f continuation sheet 3 of 4

To ensure standards, the exit door placard

was reviewed and reflects an exit based

upon the facility approved Fire Plan. The

Facility Administrator designee contacted the Local Fire Marshall to conduct an

or leave the exit sign based upon the Fire

inspection to verify the accuracy of the existing exit sign. The facility will remove

The systems the facility has in place to

Marshall findings.

PRINTED: 04/17/2017 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 03 - MAIN LIC B. WING 95012 03/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 LINTON BLVD LAKE VIEW CARE CENTER AT DELRAY DELRAY BEACH, FL 33484 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 072 Continued From page 3 K 072 state NO EXIT to not cause confusion in an ensure standards are met and maintained: emergency. These doors are likely to be The Life Safety Log was reviewed to mistaken for an exit. include inspection of exit doors per the approved Life Safety Plan. Based on interview at these same times, the Maintenance Director acknowledged that the The Maintenance Director will complete required signage was not posted as required by the Life Safety log monthly and report the code. findings to the Quality Assurance and Performance Improvement Committee to The findings were acknowledged by the ensure the standards are met and Administrator and verified by the Maintenance compliance maintained. Director at the time of observation and at the exit conference on March 20, 2017 Class III Actual NFPA Standards: NFPA LSC 101 (2012) Ch. 19 -7.10.8.3.1 NO FXIT

6820

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	:D: 04/17/2011 M APPROVED O: 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN FED	(X3) DAT	E SURVEY PLETED
		105475	B. WING		03	3/20/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE VIE	W CARE CENTER AT DE	LRAY		5430 LINTON BLVD DELRAY BEACH, FL 33484		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 00	0		
K 222 SS+F	2017 at Lake View Carona Invaring home in Delnake View Care Centompliance with 42 Cd 488.307, and Nationa (NFPA) 101 (2012 ed nursing homes.  Initial Plan Review: 1' Existing NFPA 220 Constructi Number of beds: 120 Census: 110  The following is desc. NFPA 101 Egress Doors Doors in a required mequipped with a latch use of a tool or key frusing one of the following in the following is desc. CLINICAL NEEDS OI LOCKING  Where special locking with the special locking devie each door and provise repid repid for the following in the fo	was conducted March 20, are Center at Delray, a ay Beach, Florida.  er at Delray is not in FR 483 Subpart B, 42 CFR If Fire Protection Association ition) requirements for 982 on Type: II (000) ription of the noncompliance. ors	K 22	2		4/3/17
	all times; or other suc	h reliable means available				

18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE

Electronically Signed 03/31/2017 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.

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					0: 04/17/2017 AAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 11 - MAIN FED	(X3) DATE COMP	SURVEY LETED
		105475	B. WING			03/	20/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAVENCE	W CARE CENTER AT DE	PAV		5	430 LINTON BLVD		
LAKE VIE	W CARE CENTER AT DE	LRAT		D	ELRAY BEACH, FL 33484		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 222	Where special locking safety needs of the pr Clinical or Security Lc being met. In addition electrical locks that fa upon loss of power to protected by a supen system and the locke complete smoke dete constantly monitored within the locked spar and detection system doors upon activation 18.2.2.2.5.2, 19.2.2.2 DELAYED-EGRESS ARRANGEMENTS Approved, listed delay installed in accordance permitted on door assordinary hazard content throughout by an app fire detection system automatic sprinkler sy 18.2.2.2.4, 19.2.2.4 ACCESS-CONTROLL ARRANGEMENTS Access-Controlled Eginstalled in accordance permitted.	CKING ARRANGEMENTS a grangements for the stient are used, all of the ocking requirements are the locking requirements are the locking requirements are the device; the blocks must be ill safely so as to release the device; the building is rised automatic sprinkler of space is protected by a citon system (or is at an attended location per special color or is at an attended location per special color or is at an attended location per special color or is at an attended location per special color or is at an attended location per special color or is at an attended location per special color or is at an attended location per special color or is at an attended location special color or in the sprinkler is at an attended location per special color or in approved, supervised automatic or an approved, supervised stem.  LED EGRESS LOCKING press Door assemblies as with 7.2.1.6.2 shall be exit ACCESS LOCKING special color or in approved or in the properties of the	K	222			

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

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAR OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING 01 - MAIN FED 105475 R MING 03/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5430 LINTON BLVD LAKE VIEW CARE CENTER AT DELRAY DELRAY BEACH, FL 33484 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY K 222 | Continued From page 2 K 222 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, the To ensure standards, the exit door facility failed to maintain the building exit egress. placard was reviewed and reflects an exit This deficient practice affects all staff, visitors and based upon the facility approved Fire residents Plan. The Facility Administrator designee contacted the Local Fire Marshall to Findings include: conduct an inspection to verify the accuracy of the existing exit sign. The On March 20, 2017 at 3 p.m. during the facility facility will remove or leave the exit sign tour it was noted that the physical therapy gym based upon the Fire Marshall findings. exterior doors, which have the appearance of exit doors, were not signed as required by code to The systems the facility has in place to state NO EXIT to not cause confusion in an ensure standards are met and emergency. These doors are likely to be maintained: The Life Safety Log was mistaken for an exit. reviewed to include inspection of exit doors per the approved Life Safety Plan. During interview at this same time, the Maintenance Director acknowledged that the The Maintenance Director will complete required signage was not posted as required by the Life Safety log monthly and report the code. findings to the Quality Assurance and Performance Improvement Committee to The findings were acknowledged by the ensure the standards are met and Administrator and verified by the Maintenance compliance maintained. Director at the time of observation and at the exit conference on March 20, 2017. Actual NFPA Standards: NFPA LSC 101 (2012) Ch, 19 -7.10.8.3.1 NO EXIT K 712 NFPA 101 Fire Drills K 712 4/7/17 SS=F

Fire Drills

Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected

Facility ID: 95012

DEPARTMENT OF HEALTH AND HUMAN SERVICES							0: 04/17/2017 MAPPROVED
STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN FED	(X3) DATE	0. 0938-0391 SURVEY LETED
		105475	B. WING			03/	20/2017
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE VIE	W CARE CENTER AT DE	ELRAY		1	430 LINTON BLVD ELRAY BEACH, FL 33484		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
K 712	Continued From page	3	ĸ	712			
		conditions, at least quarterly	'`				
		aff is familiar with procedures					
	and is aware that drill	is are part of established					
	routine. Responsibilit						
		ssigned only to competent					
		lified to exercise leadership.					
		lucted between 9:00 PM and nouncement may be used					
	instead of audible ala						
		'.1.7, 19.7.1.4 through					
	19.7.1.7	Title					
	This STANDARD is a	not met as evidenced by:					
	Based on written doo	cument review and staff	-		The facility Administrator reviewed and	t	
		failed to maintain the facility			updated the 2017 Fire Drill Worksheet		
		e that staff is trained,			The worksheet appropriately reflects the		
		quirements. This deficient			standards of performing drills quarterly	on	
	practice affects all sta	aff, visitors and residents.			all three shifts.		
	Findings include:				The systematic changes established to	)	
					ensure standards are met include:		
		t 1 P.M. when reviewing			(1)Review of the facility Life Safety Log	g to	
		n provided in support of the			ensure that the fire drill standard is		
		rills, the facility was not able re in code compliance.			included. (2) The Maintenance Directo will complete the Life Safety Log month		
		n reviewed of the past 12			to reflect the completed fire drills per	пу	
		at fire drills are not being			standards.		
		on all three shifts, which			- man 1 - man - man		
		equirements. The facility			To ensure the standards are maintaine	d,	
	conducted six fire dril	ils on the 7 - 3 shift, one on			the Maintenance Director will complete	1	
	the 3 -11 shift and five	e on the 11-7 shift. Fire drills			the Life Safety Log and the Fire Drill		
		on each shift by code. An			Worksheet monthly. The Life Safety Lo	g	
		ted at this time with the			and the Fire Drill Worksheet will be		
		Director who acknowledged	-		presented to the Quality Assurance an		
		tation provided in support of			Performance Improvement Committee	tor	
	the performance of fit	re drills was not up to code			review and compliance monitoring.		

requirements. No additional written documentation was provided to substantiate compliance at the exit conference.

## PRINTED: 04/17/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED STA

CENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED	(X3) DATE SURVEY COMPLETED			

105475 03/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

5430 LINTON BLVD

LAKE VIEW CARE CENTER AT DELRAY			5430 LINTON BLVD			
			DELRAY BEACH, FL 33484			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ΙΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 712	Continued From page 4 The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of written documentation review and at the exit conference on March 20, 2017. Actual NFPA Standards: NFPA LSC 101 (2012) 19.7.1.6	к	712			

Facility ID: 95012