Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95012	A. BUILDING: **03 - MAIN LIC** B. WING _____	**03/20/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	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 Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, 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.	K 000		
K 050 SS=F	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 areas of refuge, and for their evacuation from the 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 050		4/7/17

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K 050	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on written document review and staff interview, the facility failed to maintain the facility fire plan and ensure that staff is trained, according to code requirements. This deficient practice affects all staff, visitors and residents. Findings include: On March 20, 2017 at 1 P.M. when reviewing written documentation provided in support of the performance of fire drills, the facility was not able to confirm that they are in code compliance. Written documentation reviewed of the past 12 fire drills, indicates that fire drills are not being conducted quarterly on all three shifts, which does not meet code requirements. The facility conducted six fire drills on the 7 - 3 shift, one on the 3 -11 shift and five on the 11-7 shift. Fire drills are required quarterly on each shift by code. An interview was conducted at this time with the facility Maintenance Director who acknowledged that written documentation provided in support of the performance of fire drills was not up to code requirements. No additional written documentation was provided to substantiate compliance at the exit conference. 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. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.7.1.6	K 050	The facility Administrator reviewed and updated the 2017 Fire Drill Worksheet. The worksheet appropriately reflects the standards of performing drills quarterly on all three shifts. The systematic changes established to ensure standards are met include: (1)Review of the facility Life Safety Log to ensure that the fire drill standard is included, (2) The Maintenance Director will complete the Life Safety Log monthly to reflect the completed fire drills per standards. To ensure the standards are maintained, the Maintenance Director will complete the Life Safety Log and the Fire Drill Worksheet monthly. The Life Safety Log and the Fire Drill Worksheet will be presented to the Quality Assurance and Performance Improvement Committee for review and compliance monitoring.	

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K 072 SS=F	NFPA 101- LSC 2012 EGRESS RELIABILITY The means of egress including every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7 unless otherwise modified by 18.2.2 through 18.2.11 & 19.2.2 through 19.2.11. The means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency, and shall be accessible to the extent necessary to ensure reasonable safety for occupants having impaired mobility. NFPA 101 Life Safety Code (2012) 18.2.1, 19.2.1, 7.1.10.1 & 4.5.3.2 NOTE: SEE NEW PROVISIONS DESCRIBED IN K-39 which are applicable to licensure only. The CMS requirement is more stringent unless the Facility has completed the requirements for the Categorical Waivers in accordance with S&C 13-58 and 12-21.*** 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. This deficient practice affects all staff, visitors and residents. Findings include: 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 doors were not signed as required by code to	K 072	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 inspection to verify the accuracy of the existing exit sign. The facility will remove or leave the exit sign based upon the Fire Marshall findings. The systems the facility has in place to	4/3/17

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K 072	Continued From page 3 state NO EXIT to not cause confusion in an emergency. These doors are likely to be mistaken for an exit. Based on interview at these same times, the Maintenance Director acknowledged that the required signage was not posted as required by code. The findings were acknowledged by the Administrator and verified by the Maintenance 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 EXIT	K 072	ensure standards are met and maintained: The Life Safety Log was reviewed to include inspection of exit doors per the approved Life Safety Plan. The Maintenance Director will complete the Life Safety log monthly and report the findings to the Quality Assurance and Performance Improvement Committee to ensure the standards are met and compliance maintained.	

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	105475	A. BUILDING **01 - MAIN FED** B. WING _____	**03/20/2017**

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LAKE VIEW CARE CENTER AT DELRAY	**5430 LINTON BLVD** **DELRAY BEACH, FL 33484**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted March 20, 2017 at Lake View Care Center at Delray, a nursing home in Delray Beach, Florida. Lake View Care Center at Delray is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes. Initial Plan Review: 1982 Existing NFPA 220 Construction Type: II (000) Number of beds: 120 Census: 110 The following is description of the noncompliance.	K 000		
K 222 SS=F	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, 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	K 222		4/3/17

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

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 facility failed to maintain the building exit egress. This deficient practice affects all staff, visitors and residents. Findings include: 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 doors, were not signed as required by code to state NO EXIT to not cause confusion in an emergency. These doors are likely to be mistaken for an exit. During interview at this same time, the Maintenance Director acknowledged that the required signage was not posted as required by code. The findings were acknowledged by the Administrator and verified by the Maintenance 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 222	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 inspection to verify the accuracy of the existing exit sign. The facility will remove or leave the exit sign based upon the Fire Marshall findings. The systems the facility has in place to ensure standards are met and maintained: The Life Safety Log was reviewed to include inspection of exit doors per the approved Life Safety Plan. The Maintenance Director will complete the Life Safety log monthly and report the findings to the Quality Assurance and Performance Improvement Committee to ensure the standards are met and compliance maintained.	
K 712 SS=F	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	K 712		4/7/17

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K 712	Continued From page 3 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. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on written document review and staff interview, the facility failed to maintain the facility fire plan and to ensure that staff is trained, according to code requirements. This deficient practice affects all staff, visitors and residents. Findings include: On March 20, 2017 at 1 P.M. when reviewing written documentation provided in support of the performance of fire drills, the facility was not able to confirm that they are in code compliance. Written documentation reviewed of the past 12 fire drills, indicates that fire drills are not being conducted quarterly on all three shifts, which does not meet code requirements. The facility conducted six fire drills on the 7 - 3 shift, one on the 3 -11 shift and five on the 11-7 shift. Fire drills are required quarterly on each shift by code. An interview was conducted at this time with the facility Maintenance Director who acknowledged that written documentation provided in support of the performance of fire drills was not up to code requirements. No additional written documentation was provided to substantiate compliance at the exit conference.	K 712	The facility Administrator reviewed and updated the 2017 Fire Drill Worksheet. The worksheet appropriately reflects the standards of performing drills quarterly on all three shifts. The systematic changes established to ensure standards are met include: (1)Review of the facility Life Safety Log to ensure that the fire drill standard is included. (2) The Maintenance Director will complete the Life Safety Log monthly to reflect the completed fire drills per standards. To ensure the standards are maintained, the Maintenance Director will complete the Life Safety Log and the Fire Drill Worksheet monthly. The Life Safety Log and the Fire Drill Worksheet will be presented to the Quality Assurance and Performance Improvement Committee for review and compliance monitoring.	

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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	K 712		