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
	95051	A. BUILDING: **01, 03, 04** B. WING _____	**12/05/2017**

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) COMPLETE DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 12/05/2017 at Abbey Delray, State license: 1201096, a nursing home in Delray Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012) 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) 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 741 SS=F	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.	K 741		1/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95051	A. BUILDING: 01, 03, 04 B. WING _____	12/05/2017

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) COMPLETE DATE
K 741	Continued From page 1 (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 (Note smoking tower disposal receptacles are not ashtrays) This Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the facility smoking policy to code requirements. This deficient practice affected all staff, visitors and residents. Findings include: On 12/05/2017 at 1:30 P.M. accompanied by the maintenance director during the observation tour we observed there is a smoking area outside which is designated for smoking. In this area the required ashtrays of safe design are not available as required by code. An interview was conducted at this time with the maintenance director who acknowledged that the smoking policy is not being observed to meet code requirements. The findings were acknowledged by the Administrator and verified by the maintenance director at the times of observation and at the exit conference on 12/05/2017. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.7.4.	K 741	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 facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by date certain. 1. An ashtray of safe design, as required by code, was placed in the designated smoking area 2. Two residents, who smoke, were identified as having a potential to be affected by the facility not having an ashtray of safe design. 3. Director of Plant Operations or designee will observe during daily rounds to ensure that an ashtray of safe design is available in designated smoking area for use by those residents who smoke.	

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
	95051	A. BUILDING: 01, 03, 04 B. WING _____	12/05/2017

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) COMPLETE DATE
K 741	Continued From page 2	K 741	4. Findings from observation rounds related to having an ashtray of safe design in the designated smoking area will be reported and reviewed at the monthly QAPI meeting for a period of 2 months to ensure compliance.	
K 923 SS=F	NFPA 99 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		1/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95051	A. BUILDING: 01, 03, 04 B. WING _____	12/05/2017

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) COMPLETE DATE
K 923	Continued From page 3 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on observation, testing and staff interview the facility failed to properly store medical gases. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 12/05/2017 between 7:30 A.M. and 3 P.M. accompanied by the maintenance director during the observation tour we observed the facility is improperly storing E-sized Oxygen cylinders including the four rooms where the crash carts are stored in the Gardens, Cobblestone, Gulfstream and Poinciata wings. E-sized Oxygen cylinders in wheel carts were found covered with plastic in the Coblestone and Poinciata rooms as well as all the crash carts which had installed new plastic mesh covers without openings for the E cylinders as required by code. An interview was conducted at the time of observation with the maintenance director who acknowledged that the oxygen cylinders are improperly stored. The findings were acknowledged by the Administrator and verified by the maintenance director at the time of observation and at the exit conference on 12/05/2017.	K 923	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 facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by date certain. 1. Upon notification by Life Safety Inspector, the plastic bags were immediately removed from the E-sized oxygen cylinders, which were stored in Cobblestone & Poinciana clean utility rooms. An opening was cut into the plastic mesh covers to expose the E-sized oxygen cylinders, which are on the crash carts in the clean utility rooms on Gardens, Cobblestone, Gulfstream and Poinciana units. 2. All smoke compartments, staff, visitors and residents have a potential to be affected by improper storage of medical gases.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95051	A. BUILDING: **01, 03, 04** B. WING _____	**12/05/2017**

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) COMPLETE DATE
K 923	Continued From page 4 Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.2.4, and NFPA 99 (2012) Ch. 11.	K 923	3. Health Center staff were in-serviced by Administrator or designee on proper storage of oxygen cylinders and to not cover oxygen cylinders with plastic bags or any type of covering. 4. Administrator, DON, ADONs, Plant Operations Director or designee will observe for proper storage of oxygen cylinders during ongoing daily rounds. Observation findings will be reported and reviewed at monthly QAPI meeting for 2 months to determine if plan of correction is successful in maintaining compliance or needs modification.	

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 _____	**12/05/2017**

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 re-certification survey was conducted 12/05/2017 at Abbey Delray, a nursing home in Delray Beach, Florida. Abbey Delray, is not in substantial compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012) requirements for nursing homes. Deficiencies were found at the time of the visit. Initial Plan Review: 1980/1998 Existing NFPA 220 Construction Type: II (111) Number of beds: 100 Census: 91 The following is description of the deficiencies, found at the time of the visit.	K 000		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not	K 741		1/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/2018

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.

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 _____	**12/05/2017**

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 741	Continued From page 1 responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the facility smoking policy to code requirements. This deficient practice affected all staff, visitors and residents. Findings include: On 12/05/2017 at 1:30 P.M. accompanied by the maintenance director during the observation tour we observed there is a smoking area outside which is designated for smoking. In this area the required ashtrays of safe design are not available as required by code. An interview was conducted at this time with the maintenance director who acknowledged that the smoking policy is not being observed to meet code requirements. The findings were acknowledged by the Administrator and verified by the maintenance director at the times of observation and at the exit conference on 12/05/2017. Actual NFPA Standards: NFPA LSC 101 (2012) 19.7.4.	K 741	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 facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by date certain. 1. An ashtray of safe design, as required by code, was placed in the designated smoking area 2. Two residents, who smoke, were identified as having a potential to be affected by the facility not having an ashtray of safe design. 3. Director of Plant Operations or designee will observe during daily rounds to ensure that an ashtray of safe design is	

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 _____	**12/05/2017**

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 741	Continued From page 2	K 741	available in designated smoking area for use by those residents who smoke. 4. Findings from observation rounds related to having an ashtray of safe design in the designated smoking area will be reported and reviewed at the monthly QAPI meeting for a period of 2 months to ensure compliance.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		1/7/18

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	**12/05/2017**

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 923	Continued From page 3 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, testing and staff interview the facility failed to properly store medical gases. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 12/05/2017 between 7:30 A.M. and 3 P.M. accompanied by the maintenance director during the observation tour we observed the facility is improperly storing E-sized Oxygen cylinders including the four rooms where the crash carts are stored in the Gardens, Cobblestone, Gulfstream and Poinciata wings. E-sized Oxygen cylinders in wheel carts were found covered with plastic in the Coblestone and Poinciata rooms as well as all the crash carts which had installed new plastic mesh covers without openings for the E cylinders as required by code. An interview was conducted at the time of observation with the maintenance director who acknowledged that the oxygen cylinders are improperly stored. The findings were acknowledged by the Administrator and verified by the maintenance	K 923	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 facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by date certain. 1. Upon notification by Life Safety Inspector, the plastic bags were immediately removed from the E-sized oxygen cylinders, which were stored in Cobblestone & Poinciana clean utility rooms. An opening was cut into the plastic mesh covers to expose the E-sized oxygen cylinders, which are on the crash carts in the clean utility rooms on Gardens, Cobblestone, Gulfstream and Poinciana units. 2. All smoke compartments, staff, visitors and residents have a potential to be	

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 _____	**12/05/2017**

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 923	Continued From page 4 director at the time of observation and at the exit conference on 12/05/2017. Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.2.4, and NFPA 99 (2012) Ch. 11.	K 923	affected by improper storage of medical gases. 3. Health Center staff were in-serviced by Administrator or designee on proper storage of oxygen cylinders and to not cover oxygen cylinders with plastic bags or any type of covering. 4. Administrator, DON, ADONs, Plant Operations Director or designee will observe for proper storage of oxygen cylinders during ongoing daily rounds. Observation findings will be reported and reviewed at monthly QAPI meeting for 2 months to determine if plan of correction is successful in maintaining compliance or needs modification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105335	A. BUILDING _____ B. WING _____	12/05/2017

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
E 000	Initial Comments An unannounced Fire & Life Safety re-certification survey was conducted 12/05/2017 at Abbey Delray, a nursing home in Delray Beach, Florida. Abbey Delray, is not in substantial compliance with 42 CFR 483.73 requirements as established by CMS Centers for Medicare & Medicaid Services requirements for nursing homes developing an Emergency Plan. Deficiencies were found at the time of the visit. The following is description of the deficiencies, found at the time of the visit.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a	E 026		1/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105335	A. BUILDING _____ B. WING _____	12/05/2017

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
E 026	Continued From page 1 waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on written document review and staff interview the facility failed to include all of the requirements that the Centers for Medicare & Medicaid Services (CMS) require for the facility emergency plan and policies, which includes the facility's role in providing care and treatment at alternate care sites. This deficient practice affects all staff, visitors and all residents. Findings include: On 12/05/2017 at 11:30 A.M. accompanied by the administrator while going through the facility emergency plan and policy to meet code requirements, the facility was not able to produce requested written documentation. Based on provided written policy and procedures it could not be verified that the facility had included policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. An interview was conducted at this time with the administrator who acknowledged that the documentation requested was not available in the facility emergency written plan. The findings were acknowledged by and verified by the administrator at the time of written document review and at the exit conference on 12/05/2017. Actual code requirements:	E 026	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 facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by date certain. 1. Abbey Delray's emergency preparedness plan was updated to include a policy, which addresses the facility's role in providing care and treatment at an alternate care site under an 1135 waiver. 2. All residents have a potential to be affected if a policy for the facility's provision of care and treatment at an alternate care site were not implemented. 3. The new policy related to providing care and treatment at an alternate care site under an 1135 waiver will be included in the emergency preparedness plan, which is accessible to residents, families, staff & visitors. 4. Emergency preparedness plan, including the policy related to care and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105335	A. BUILDING _____ B. WING _____	12/05/2017

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
E 026	Continued From page 2 (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026	treatment at an alternate care site under an 1135 waiver, will be reviewed at least annually through QAPI meetings and revised as needed based on facility's risk assessment needs.	