PRINTED: 04/23/2018 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: 04 - MAIN LIC B MING 95027 04/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9600 LAWRENCE RD BOYNTON BEACH REHABILITATION CENTER BOYNTON BEACH, FL 33436 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 An unannounced Fire & Life Safety re-licensure survey was conducted on 04/3-4/2018 at Boynton Beach Rehabilitation Center, state license, #14590961, a nursing home in Boynton Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015) 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 (2015) 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 353 NFPA 101 Sprinkler System - Maintenance and K 353 4/29/18 SS=F Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. Standard for the Inspection. Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are

available.

Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

maintained in a secure location and readily

a) Date sprinkler system last checked b) Who provided system test c) Water system supply source

TITLE (X6) DATE 04/19/18 Electronically Signed

STATE FORM if continuation sheet 1 of 4 YUCU21

Agency fo	or Health Care Adminis	tration				: 04/23/2018 APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 04 - MAIN LIC		(X3) DATE SURVEY COMPLETED	
		95027	B. WING		04/04/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
POVNTON	BEACH REHABILITATION	ON CENTER 9600 LAWF	RENCE RD			
BOTHTON	DEACT KETABILITATI	BOYNTON	BEACH, FL 3	3436		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETE	
K 353	Continued From page	1	K 353			
	Based on observation and staff interview the the building automatic code requirements. T all smoke compartmer residents.  Findings include:  On 04/04/2018 at 8 A documentation and o sprinkler heads the or response heads are caround 1996. Quick required to have a sa	is not met as evidenced by:  , written document review, facility failed to maintain fire sprinkler system to his deficient practice affects nts, staff, visitors and all  .M. based on written bservation of the facility fire figinally installed quick tated from somewhere		Responses to the cited deficiencies d constitute an admission or agreement the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan Correction is prepared solely as a ma of compliance with Federal and State K353  A. With respect to specific sprinkler system maintenance cited:  Upon testing from an outside compan was discovered the sprinkler system to actually recalled and replaced in 2004	t by  of tter Law.  y, it was	
	An interview was commaintenance director fire sprinkler heads w manufacture and cod.  The findings were act Administrator and ver	ducted at this time with the who acknowledged that the ere not tested as per e requirements.  Incoveledged by the tifled by the maintenance observation and at the exit		So, the actual maintenance is not due 2024.  B. With respect to how the facility will identify sprinkler system maintenance the potential for the identified concern take corrective action:  An audit is in place to ensure all sprin system maintenance is in place.	with	

Class III Actual NFPA Standards:

NFPA LSC 101 (2012) 19.3.5, and 9-7. NFPA 1 (2012) 7.3.3.9 and NFPA 25 (2011) 5.3.1.1.1.3-NFPA 13.

NFPA 101(2012) 9.7.5, 9.7.7, 9.7.8, NFPA 25 (2011) 5.3.1.1.1.3

D. With respect to how the plan of AHCA Form 3020-0001 STATE FORM caso YUCU21 If continuation sheet 2 of 4

C. With respect to what systemic

measures have been put in place to address stated concern:

Maintenance Director was educated to

ensure all required sprinkler system maintenance is in place.

PRINTED: 04/23/2018 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: 04 - MAIN LIC B MING 95027 04/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAWRENCE RD BOYNTON BEACH REHABILITATION CENTER BOYNTON BEACH, FL 33436 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) K 353 Continued From page 2 K 353 NFPA 101(2015) 9.7.5, 9.7.7, 9.7.8, NFPA 25 corrective measure will be monitored: (2014) 5.3.1.1.1.3 Administrator and/or Designee will conduct random audit. The results of the audit will be brought to QA for further review times 3 months and as needed thereafter K1053 FAC 59A-4.126 Emergency Management Plan K1053 4/29/18 SS≃F A written, comprehensive emergency management plan for emergency care during an internal or external disaster or emergency, which is reviewed and updated annually, shall be maintained. The health care facility shall test the implementation of the emergency management plan semiannually, either in response to a disaster or an emergency or in a planned drill. and shall evaluate and document the health care facility performance to the health care facility safety committee. Florida Administrative Code 59A-4.126. This Statute or Rule is not met as evidenced by: 1053

On 04/03/2018 at 1 P.M. during the facility

visitors and all residents.

Findings include:

Based on written document review and staff interview the facility failed to maintain a current approved written comprehensive emergency

management plan for emergency care during an internal or external disaster or emergency, which

is reviewed and updated annually. This deficient practice affected all smoke compartments, staff,

document review the facility failed to produce a

current approved written comprehensive

STATE FORM VHCU21 If continuation sheet 3 of 4

A. With respect to specific citation for Comprehensive Emergency Management

Immediately, Palm Beach County,

update review. The information was received by Palm Beach County.

states to allow 60 days for review.

Department of Emergency Management was contacted to check the status of the

Department of Emergency Management

on February 6, 2108. The renewal letter

Plan (CEMP) cited:

Agency f	or Health Care Adminis	tration				: 04/23/2018 I APPROVED
AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	CONSTRUCTION D4 - MAIN LIC	(X3) DATE SURVEY COMPLETED		
95027			B. WING		04/04/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
BOYNTON	BEACH REHABILITATION	ON CENTER	RENCE RD NBEACH, FL 3	13436		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	RTEMENT 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
K1053	care during an interns emergency, which is i updated annually. The and was not updated Beach County facilitie their plan for review 6 expiration date. An i this time with the mai acknowledged that the emergency managem or available. The findings were ack Administrator and ver	nent plan for emergency at or external disaster or required to be reviewed and se plan expired 02/01/2018 annually as required. Palm is are required. Palm is are required to submit 0 days prior to the interview was conducted at intenance director who e current copy of the sent plan was not approved knowledged by the fified by the maintenance documentation review and on 04/04/2018.	K1053	B. With respect to how the facility will identify CEMP with potential for the identified concern and take corrective action:  Audit is in place to ensure CEMP is so yearly on or before January 1.  C. With respect to what systemic measures have been put in place to address stated concern:  Administrator was educated to ensure CEMP is updated yearly on or before January 1.  D. With respect to how the plan of corrective measure will be monitored:  Administrator will audit yearly to ensu CEMP is updated yearly on or before January 1.	ent 3	

6590

### DEPARTMENT OF HEALTH AND HUMAN SERVICES OCUTEDO EOD MEDIOADE A MEDIOAIO OF

PRINTED: 04/23/2018 FORM APPROVED

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			ONB NO. 0930-039
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
		105837	B. WING		04/04/2018
	ROVIDER OR SUPPLIER	ON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAWRENCE RD BOYNTON BEACH, FL 33436	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
K 000	INITIAL COMMENTS		K 00	0	
K 353 SS≈F	An unannounced Fire & Life Safety recertification survey was conducted 04/3-4/2018 at Boynton Beach Rehabilitation Center, a nursing home in Boynton Beach, Florida. Boynton Beach Rehabilitation Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 483-307, and National Fire Protection Association (NFPA) 101 (2012) requirements for nursing homes.  Initial Plan Review: 1986 Existing NFPA 220 Construction Type: II (211) Number of beds: 168 Census: 150  The following is description of the noncompliance. Sprinkler System: Maintenance and Testing		К 35		4/29/18
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE	(X6) DATE

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.

Electronically Signed

04/19/2018

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/23/2018 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 REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING 01 - MAIN FED 105837 R MING 04/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAWRENCE RD BOYNTON BEACH REHABILITATION CENTER BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY K 353 Continued From page 1 K 353 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced bv: Responses to the cited deficiencies do Based on observation, written document review. and staff interview the facility failed to maintain not constitute an admission or agreement the building automatic fire sprinkler system to by the provider of the truth of the facts code requirements. This deficient practice affects alleged or conclusion set forth in the all smoke compartments, staff, visitors and all Statement of Deficiencies. The Plan of residents. Correction is prepared solely as a matter of compliance with Federal and State Findings include: Law. On 04/04/2018 at 8 A.M. based on written K353 documentation and observation of the facility fire sprinkler heads the originally installed quick A. With respect to specific sprinkler response heads are dated from somewhere system maintenance cited: around 1996. Quick response heads are required to have a sample tested at least 4 heads Upon testing from an outside company, it which had been in service for 20 years or more. was discovered the sprinkler system was An interview was conducted at this time with the actually recalled and replaced in 2004. maintenance director who acknowledged that the So, the actual maintenance is not due fire sprinkler heads were not tested as per until 2024 manufacture and code requirements. B. With respect to how the facility will The findings were acknowledged by the identify sprinkler system maintenance with Administrator and verified by the maintenance the potential for the identified concern and take corrective action: director at the time of observation and at the exit conference on 04/04/2018 An audit is in place to ensure all sprinkler Actual NEPA Standards: system maintenance is in place. C. With respect to what systemic NFPA LSC 101 (2012) 19.3.5, and 9-7. NFPA 1 (2012) 7.3.3.9 and NFPA 25 (2011) 5.3.1.1.1.3measures have been put in place to NEPA 13. address stated concern: NFPA 101(2012) 9.7.5, 9.7.7, 9.7.8, NFPA 25 Maintenance Director was educated to

(2011) 5.3.1.1.1.3

ensure all required sprinkler system maintenance is in place.

### PRINTED: 04/23/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN FED 105837 R MING 04/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9600 LAWRENCE RD BOYNTON BEACH REHABILITATION CENTER BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH 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 353 Continued From page 2 K 353 D. With respect to how the plan of corrective measure will be monitored: Administrator and/or Designee will conduct random audit. The results of the audit will be brought to QA for further review times 3 months and as needed thereafter.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/23/2018

CENTED	C EOD MEDICADE &	MEDICAID SERVICES				D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	SURVEY PLETED
		105837	B. WING		0.4	/04/2018
	ROVIDER OR SUPPLIER	ON CENTER	91	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LAWRENCE RD OYNTON BEACH, FL 33436		
(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 APPROVIDERICENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
	conducted on 04/3/18 Beach Rehabilitation	iced re-certification survey 3 - 04/04/2018 at Boynton Center, a nursing home in rgency Preparedness plans riewed.				
E 026	Boynton Beach Rehabilitation Center, is not in compliance with Emergency Preparedness Plan, 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. Roles Under a Waiver Declared by Secretary		E 026			4/29/18
SS≖C	develop and impleme policies and procedur plan set forth in parag assessment at paragi and the communication this section. The polic reviewed and updated	edures. The [facilities] must nt emergency preparedness es, based on the emergency rraph (a) of this section, risk aph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be a telest annually. At a and procedures must				
	[facility] under a waive in accordance with se provision of care and	or (9)] The role of the er declared by the Secretary, sction 1135 of the Act, in the treatment at an alternate emergency management				
	procedures. (8) The rewaiver declared by the with section 1135 of A	8.748(b);] Policies and ole of the RNHCI under a e Secretary, in accordance cct, in the provision of care site identified by emergency				***************************************

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

04/19/2018

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.

Electronically Signed

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/23/2018

		ID HUMAN SERVICES					M APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES						D. 0938-0391		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLERICLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:  105837		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING _	B. WING			/04/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DOWNTON	. D	ON GENTED		91	600 LAWRENCE RD			
BUTNION	BEACH REHABILITATI	ON CENTER		В	OYNTON BEACH, FL 33436			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 026	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on written document review and staff interview the facility failed to develop emergency prepardness policies and procedures to address the role of the facility in providing care and treatment at an alternate care site, under a 1135 waiver. This deficient practice affects all staff, visitors and residents.  Findings include:		E	Responses to the cited deficiencia not constitute an admission or agr by the provider of the truth of the falleged or conclusions set forth in it Statement of Deficiencies. The PI Correction is prepared solely as a of compilance with Federal and St Law.		ent of		
	the written facility em the administrator, the produce the requeste Based on the provide not be verified that th policies and procedu role in providing care care sites under an 1 was conducted at this who acknowledged it requested was not a emergency plan.  The findings were ac by the administrator a	knowledged by and verified at the time of documentation conference on 04/04/2018.			E026  A. With respect to specific Policy and Procedure to address the role of the facility in providing care and treatmen an alternate cite, under a 1135 waiver cited:  A Policy and Procedure to address the role of the facility in providing care an treatment at an alternate cite, under a 1135 waiver was established.  B. With respect to how the facility will identify Waiver 1135 with the potential the identified concern and take correct action:  An audit is in place to ensure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure a Policy Procedure is in place to address the nexure and place to address t	e d		
	(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1136 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.				of the facility in providing care and treatment at an alternate cite, under a 1135 waiver.  C. With respect to what systemic measures have been put in place to			

address stated concern:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF PROPIED HUMAN SERVICES CHARGE STATEMENT OF PROPIED HUMAN SERVICES OMB NO. 0938-0391 (X1) PROVIDERS PROPIED HUMAN SERVICES (X2) MULTIPLE CONSTRUCTION ADDITION OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
105837			B. WING			04/04/2018	
NAME OF PROVIDER OR SUPPLIER BOYNTON BEACH REHABILITATION CENTER				96	FREET ADDRESS, CITY, STATE, ZIP CODE 500 LAWRENCE RD OYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 026	Continued From page	0.2	E	026	Administrator was educated to ensure: Policy and Procedure to address the ro of the facility in providing care and treatment at an alternate cite, under a 1135 waiver is in place.  D. With respect to how the plan of corrective measure will be monitored: Administrator and/or Designee will conduct random audit. Results of the audit will be brought to QA for further review times 3 months and as needed thereafter.		