Agency f	or Health Care Adminis	stration				): 05/09/201 1 APPROVE
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: I	ECONSTRUCTION D4 - MAIN LIC	(X3) DATE S COMPL	
		95042	B. WING		04/1	8/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
0704750	RD COURT OF BOCA RA	6343 VIA	DE SONRISA D	EL SUR		
STRAIFU	RD COURT OF BOCA RA	BOCA RA	TON, FL 33433	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETE DATE
K 000	INITIAL COMMENTS		K 000			ALCO DE CONTRACTO DE
K 223 SS=F	survey was conducted Court Of Boca Raton, unrising home in Boca accordance with Native Association (NFPA) 1 applicable requirement Marshal's Rules and I Administrative Code (A-53, F.A.C. 59 A-100 Part II, and F.S. 6 Fire Protection Association was the Code and all NFPA rerequirements adopted The following is described in the time of the Code and all the time of the NFPA 101 Doors with	onal Fire Protection and 101 (2015) and this of Florida State Fire Regulations, Florida F.A. C) 69 A.5, F.A.C. 69 and Florida Statutes (F.S.) 330,2015, adopting National iation (NFFA) 1 and 101 Florida Fire Prevention ferenced standards and 1 per NFFA 101, Chapter 2. ription of the deficiencies, the visit.  Self-Closing Devices	K 223			5/19/18
	or horizontal exit, smo area enclosure are se closed position, unles device complying with closes all such doors compartment or entire * Required manual fir	ageway, stairway enclosure, oke barrier, or hazardous life-folosing and kept in the is held open by a release 1 7.2.1.8.2 that automatically throughout the smoke e facility upon activation of:				

Based on observation and staff interview, the

18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This Statute or Rule is not met as evidenced by:

smoke passing through the opening or a required

smoke detection system; and \* Automatic sprinkler system, if installed; and

\* Loss of power.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Electronically Signed 05/04/18

STATE FORM TPHE21 If continuation sheet 1 of 3

Responses on the enclosed plan of

Agency f	or Health Care Adminis	tration				: 05/09/2018 I APPROVEI
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 04 - MAIN LIC	(X3) DATE S COMPLE	
		95042	B. WING		04/1	8/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
STRATEO	RD COURT OF BOCA RA	570N 6343 VIA	DE SONRISA D	EL SUR		
07704170	TO COOK! OF BOOK!O	BOCA RA	TON, FL 3343:	3		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
K 223	Continued From page	1	K 223			
				correction do not constitute an admiss or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of complied with law.	he	
	maintenance director central supply corrido latch in the door fram the code requirement suitable to keep the d not latch closed in the to the door frame has	oor closed. The door did door frame and or the door an opening which will allow		The facility used an outside vendor, Broward Door Closures, to address th kitchen dry central supply and the mais kitchen dry central supply corridor doc and they were repaired on 4/24/2018.  A member of the Maintenance/Facilitie	in ors	
	the maintenance direktchen dry central su close and latch in the not meet the code rec means suitable to kee door did not latch clos the door to the door fr will allow the spread of	through the door.  45 FM, accompanied by ctor when tested, the main pply corridor door did not door frame. The door did juriement of providing a sp the door closed. The seed in the door frame and or rame has an opening which of smoke through the door.		Department and the Skilled Nursing Administrator conducted walking roun the facility to confirm that smoke door had functioning latches and appropria closed. No issues were identified.  The Maintenance Director/designee w make facility rounds monthly for 3 mo to confirm smoke doors close-flatch properly.  The Maintenance Director or designee report the results of the monthly roun the Quality Assurance and Performan	s tely rill nths e will ds at	

maintenance director who acknowledged and

to keep the door closed. No additional written

for function or providing a smoke barrier was provided at the time of exit.

Administrator and verified by the maintenance

director at the times of observation and at the exit

The findings were acknowledged by the

conference on 04/18/18.

witnessed that the corridor door did not meet the code requirement of providing a means suitable

documentation to support the testing of the doors

Improvement Meetings for 3 months. During and at the conclusion of the three

The Skilled Nursing Administrator or designee is responsible for confirming

with the components of this Plan Of

re-evaluate and initiate necessary action

implementation and ongoing compliance

Correction and addressing and resolving

months, the QAPI committee will

or extend the review period.

variances that may occur.

Agency f	or Health Care Adminis	stration				: 05/09/2018 I APPROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 04 - MAIN LIC		(X3) DATE SURVEY COMPLETED	
		95042	B. WING		04/18/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODE			
STRATFO	RD COURT OF BOCA RA	ATON	A DE SONRISA D ATON, FL 33433				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
K 223	Continued From page	2	K 223			***	
	Class III Actual NFPA Standan NFPA LSC 101 (2012	ds: () 19.3.6.3.3, 19-3.6.3.5		The Skilled Nursing Administrator or designee is responsible for confirmin the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Performance Improvemen meetings and action initiated if neces	s t		

AHCA Form 3020-0001

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/09/2018 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105851	B. WING			04/	18/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STRATFO	RD COURT OF BOCA R	ATON			3343 VIA DE SONRISA DEL SUR BOCA RATON, FL 33433		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	conducted on 04/18/2 Boca Raton, a nursin	nced recertification survey 2018 at Stratford Court Of g home in Boca Raton, Iness plans and policies					
E 004	Code of Federal Reg 483.73, Requirement Facilities.	rgency Preparedness per ulations (CFR), 42 Part s for Long-Term Care		004			5/19/18
SS=C	CFR(s): 483.73(a)	view and Update Annually	E	UU4			5/19/18
	Federal, State and lo preparedness require develop establish and	ements. The [facility] must d maintain a comprehensive ness program that meets the					
	with all applicable Fe emergency prepared [hospital or CAH] mu comprehensive emer	ospital or CAH] must comply deral, State, and local ness requirements. The st develop and maintain a gency preparedness he requirements of this					
	include, but not be lin elements:] (a) Emergency Plan. and maintain an eme	aredness program must nited to, the following The [facility] must develop rgency preparedness plan dd], and updated at least					

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

(X6) DATE

Electronically Signed 05/04/2018 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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/09/2018 FORM APPROVED

CENTED	C COD MEDICADE 9	MEDICAID CEDITICES			OMP NO 2020 2204
		MEDICAID SERVICES		OMB NO. 0938-0391	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105851	B. WING		04/18/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			(	343 VIA DE SONRISA DEL SUR	
STRAIFO	RD COURT OF BOCA RA	ATON		BOCA RATON, FL 33433	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
E 004	Continued From page	e 1	E 004		
	Plan. The ESRD facil maintain an emergen must be [evaluated], annually. This REQUIREMENT by: Based on written do interview the facility for preparedness policies be reviewed, and updeficient practice affe residents. The findings included On 04/18/18 at 2:30 F written facility emerge administrator, the facility emerge administrator, the facility emergency plan, it co facility had included of emergency preparedrupdated at least annual couramental procuramental and commendation with its prepared in the result of the prepared of the prepare	cy preparedness plan that and updated at least is not met as evidenced cument review and staff alied to develop emergency is and procedures that must ated at least annually. This cots all staff, visitors and staff alied to develop emergency is and procedures that must ated at least annually. This cots all staff, visitors and staff with the littly was not able to produce documentation of the Based on the provided uld not be verified that the focumentation that the leass plan was reviewed, and ally. No written e governing board or		Responses on the enclosed plan of correction do not constitute an admiss or agreement of the truth of the facts alleged or the conclusion set forth in it regulatory report. The responses are prepared solely as a matter of complia with law.  The annual statement that the Emerge Plan has been reviewed by the Govern Body or Management Leadership will signed and placed in the Emergency Preparedness Plan manual by 5/19/2  The Administrator confirmed that there are no other emergency plan document that require a Governing Body/Management Leadership signature.	nce ince incy ining be 118.
	available. The written	hip approval or review was documentation for the		The annual meeting agenda and plans	
		al emergency plan and		calendar has been updated to include	a
	policy to meet code re	equirements was not at the time reviewed and		review and sign off on the Emergency Plan annually, either by the Board or	
		oduce requested written		management leadership.	
		oduce requested written estantiate compliance. An		management leadership.	
		ted at this time with the		The Skilled Nursing Administrator or	
	administrator who act			designee is responsible for confirming	
		sted was not available in the		implementation and ongoing complian	ce
	facility emergency pla			with the components of this Plan Of	

Correction and addressing and resolving

PRINTED: 05/00/2018

		ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(MOV MATE	TIEV P	CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				LETED
		105851	B. WING			04/	18/2018
NAME OF P	ROVIDER OR SUPPLIER	•		8	STREET ADDRESS, CITY, STATE, ZIP CODE		
STRATEO	RD COURT OF BOCA RA	NTON		1	343 VIA DE SONRISA DEL SUR		
JIKAIFO	ND COUNT OF BOOK N	TON		E	BOCA RATON, FL 33433		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XIS) COMPLETION DATE
E 004	Continued From page	. 2		004			
		knowledged by and verified	-	004	variances that may occur.		
		at the time of documentation			The Skilled Nursing Administrator or		
		conference on 04/18/2018.			designee is responsible for confirming	that	
					the status of this Plan Of Correction is		
	Actual code requirem	ents:			reviewed and discussed at Quality		
	483.73 (a)				Assurance/Performance Improvement		
E 040	Barriel Carlos	to an of Otoff and Dallanda	-	040	meetings and action initiated if necess	ary.	E(40/40
E 018 SS=C	CFR(s): 483.73(b)(2)	ing of Staff and Patients	-	018			5/19/18
	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 mt emergency preparedness es, based on the emergency praph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cless and procedures must be at least annually.] At a sand procedures must:					
	and sheltered patients an emergency. If on- patients are relocated [facility] must docume	the location of on-duty staff is in the [facility's] care during duty staff and sheltered d during the emergency, the int the specific name and ing facility or other location.					
	ICF/IIDs at §483.475( Policies and procedur location of on-duty sta the [PRTF's, LTC, ICF and after an emergen sheitered residents ar emergency, the [PRT	184(b), LTC at §483.73(b), (b), PACE at §460.84(b);] resc, (2) A system to track the aff and sheltered residents in 7-IIID or PACE] care during toy. If on-duty staff and re relocated during the Fs, LTC, ICF/IID or PACE] pecific name and location of					

the receiving facility or other location.

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

PRINTED: 05/09/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105851	B. WING			04	/18/2018	
	ROVIDER OR SUPPLIER	ATON	•	63	TREET ADDRESS, CITY, STATE, ZIP CODE 343 VIA DE SONRISA DEL SUR OCA RATON, FL 33433			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 018	Policies and procedu (ii) Safe evacuation fincludes considerationeds of evacuese transportation; identification(s) and prima communication with assistance.  (v) A system to track employees' on-duty employees' on-duty employees on-duty employees on-duty employees or elocated during the must document the sithe receiving facility of the procedures. (2) Safe which includes consistreatment needs of essponsibilities; trans evacuation location(easistance).  "[For OPOs at § 486 procedures. (2) A sydocumentation that prodominic assistance.	the at §418.113(b)(6):] res. rom the hospice, which n of care and treatment staff responsibilities; ication of evacuation ry and alternate means of external sources of the location of hospice and sheltered patients in the an emergency. If the rate and treatment research, the hospice pecific name and location of or other location.  5.920(b):] Policies and evacuation from the CMHC, deration of care and vacuees; staff portation; identification of b); and primary and alternate tion with external sources of 360(b):] Policies and teem of medical reserves potential and actual otects confidentiality of tonor information, and is the availability of records.	E	018				
		62(b):] Policies and evacuation from the dialysis s staff responsibilities, and						

needs of the patients.

# PRINTED: 05/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039				
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
	105851	B. WING	04/18/2018				

			A. BUILDING		
		105851	B. WING		04/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1	6343 VIA DE SONRISA DEL SUR	
STRATFO	RD COURT OF BOCA RA	ATON		BOCA RATON, FL 33433	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
				-	
E 018	Continued From page	. 4	E 01	g	
	, ,	is not met as evidenced		~	
	by:	is not met as evidenced			
		cument review and staff		Responses on the enclosed plan of	
		ailed to develop emergency		correction do not constitute an admissi	on
		and procedures to address		or agreement of the truth of the facts	on
		location of on-duty staff and	İ	alleged or the conclusion set forth in th	e
		he [facility's] care during an		regulatory report. The responses are	
	emergency. If on-dut			prepared solely as a matter of complia	nce
		during the emergency, the		with law.	
		ent the specific name and			
		ng facility or other location			
		affects all staff, visitors and		The facility will have a tracking system	
	residents.			and procedure in place by 5/19/18 to	
				document and track the location of	
	The findings included			visitors, team members, residents, or	
				volunteers who are in the building duri	ng
	On 04/18/18 at 3:00 F	M, based on review of the		an emergency and those residents and	i i
	written facility emerge	ency plan and policy with the		team members who have been relocat	ed
	administrator, the faci	lity was not able to produce		during an emergency This system a	nd
	the requested written	documentation of the		procedure will be included in the	
		Based on the provided		emergency preparedness manual by	
	emergency plan, it co	uld not be verified that the		5/19/18.	
		olicies and procedures			
		s role to address a system		The Administrator confirmed that other	
		f on-duty staff and sheltered		required systems and procedures are	
	patients in the facility			included in the current Emergency	
	emergency. If on-dut			Preparedness Plan manual.	
		during the emergency, the			
		t the specific name and		Team members will be trained on this	
		ng facility or other location.		tracking system and process, including	
		licy or procedure or form to		how to access and use the Emergency	'
		tual policy reviewed with the		Plan Manual and tracking sheets, and	
		ritten documentation for the		how to activate and use the tracking	
		al emergency plan and		system and process during an	
	policy to meet code re			emergency. The training will be provid	
		at the time reviewed and		by a Maintenance/Facilities leader and	
		oduce requested written stantiate compliance. An		Skilled Nursing Administrator or design by 5/19/2018, Administrator/designee	
	documentation to sub			by 5/19/2016. Administrator/designee	Will

documentation to substantiate compliance. An interview was conducted at this time with the

maintain the tracking system and have the

PRINTED: 05/00/2018

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	
		105851	B. WING		04/	18/2018
NAME OF PRO	OVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
STRATFOR	D COURT OF BOCA RA	ATON	- 1	3343 VIA DE SONRISA DEL SUR BOCA RATON, FL 33433		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 026 SS=C	racility emergency plasma findings were aci by the administrator are writerial and a service and at the writerial and a service and the communication. The policities and the communication and the communication and the communication and the communication and the communication. The policities and the communication and	cnowledged that the sted was not available in the in.  cnowledged by and verified the time of documentation conference on 04/18/18.  ents:  r Declared by Secretary  edures. The [facilities] must not emergency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, an plan at paragraph (c) of all pass and procedures must be 1 at least annually. At a and procedures must	E 026	sheets ready to be placed at a central location (concierge station) in the faci during an emergency.  The Skilled Nursing Administrator or designee is responsible for confirming implementation and ongoing compliar with the components of this Plan Of Correction and addressing and resolv variances that may occur. The Skilled Nursing Administrator or designee is responsible for confirming the status of this Plan Of Correction the reviewed and discussed at Quality Assurance/Performance Improvemen meetings and action initiated if necessing the status of the province of the	ce ing that	5/19/18

\*[For RNHCIs at §403.748(b):] Policies and

### PRINTED: 05/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES CE STAT

DEPARTMENT OF HEALTH AN	FORM APPROVED		
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED

		105851	B. WING			04/	18/2018
	ROVIDER OR SUPPLIER	TON		63	FREET ADDRESS, CITY, STATE, ZIP CODE 343 VIA DE SONRISA DEL SUR OCA RATON, FL 33433		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ę	(X5) COMPLETION DATE
E 026	waiver declared by the with section 1135 of A at an alternative care management officials. This REQUIREMENT by:  Based on written doc interview, the facility of requirements that Cer Medicaid Services (Cl emergency plan and prequirements. This destaff, visitors and all results of the section of the sectio	ole of the RNHCI under a Secretary, in accordance ct, in the provision of care site identified by emergency is not met as evidenced ument review and staff alided to include all of the tiers for Medicare & MS) require for the facility bolicies to meet code ficient practice affects all seidents.	E	026	Responses on the enclosed plan of correction do not constitute an admissio or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of complian with law.  The facility will obtain the necessary information regarding the process to obtain an 1135 waiver should a state of emergency occur by \$1592018.  The Administrator confirmed that there are no other waivers/waiver instructions that the facility is required to obtain.  The administrator will obtain necessary steps on how to acquire an 1135 waiver and the waiver instructions will be place in the Emergency Preparedness Plan and the waiver that for 1920 in the Emergency Preparedness Plan manual no later than \$6/192018.  The Skilled Nursing Administrator or designee is responsible for confirming implementation and ongoing compliance with the components of this Plan Of Correction and addressing and resolving variances that may occur.  The Skilled Nursing Administrator or designee is responsible for confirming the ordering and the solvent and addressing and resolving variances that may occur.	dd	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLETICIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105851	B. WING			04/	18/2018
	ROVIDER OR SUPPLIER	ATON		STREET ADDRESS. 6 6343 VIA DE SONR BOCA RATON, FI			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
E 026	in accordance with se provision of care and	e 7 er declared by the Secretary, er declared by the Secretary, erction 1135 of the Act, in the treatment at an alternate emergency management	E	reviewed and Assurance/P	this Plan Of Correction is d discussed at Quality Performance improvement d action initiated if necess		

Agency f	or Health Care Adminis	stration	_			D: 05/09/201 MAPPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 04 - MAIN LIC		(X3) DATE SURVEY COMPLETED	
		95042	B. WING		04/1	18/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	ITE, ZIP CODE			
0704750	RD COURT OF BOCA RA	6343 VIA	DE SONRISA D	EL SUR			
STRAIFU	RD COURT OF BOCA RA	BOCA RA	TON, FL 33433				
(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 APPROPS DEFICIENCY)	BE	(X5) COMPLETE DATE	
K 000	INITIAL COMMENTS		K 000			and the same of th	
K 223 SS=F	survey was conducted Court Of Boca Raton, unrising home in Boca accordance with Native Association (NFPA) 1 applicable requirement Marshal's Rules and I Administrative Code (A-53, F.A.C. 59 A-100 Part II, and F.S. 6 Fire Protection Association was the Code and all NFPA rerequirements adopted The following is described in the time of the Code and all the time of the NFPA 101 Doors with	onal Fire Protection and 101 (2015) and this of Florida State Fire Regulations, Florida F.A. C) 69 A.5, F.A.C. 69 and Florida Statutes (F.S.) 330,2015, adopting National iation (NFPA) 1 and 101 Florida Fire Prevention ferenced standards and 1 per NFPA 101. Chapter 2. ription of the deficiencies, ie visit.  Self-Closing Devices	K 223			5/19/18	
	or horizontal exit, smo area enclosure are se closed position, unles device complying with closes all such doors compartment or entire * Required manual fir	ageway, stairway enclosure, oke barrier, or hazardous life-flosing and kept in the is held open by a release 1 7.2.1.8.2 that automatically throughout the smoke e facility upon activation of:					

Based on observation and staff interview, the

18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This Statute or Rule is not met as evidenced by:

smoke passing through the opening or a required

smoke detection system; and \* Automatic sprinkler system, if installed; and

\* Loss of power.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Electronically Signed 05/04/18

STATE FORM TPHE21 If continuation sheet 1 of 3

Responses on the enclosed plan of

Agoney fe	or Hoolth Caro Administr	tration				: 05/09/2018 APPROVE
Agency for Health Care Administration  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION 04 - MAIN LIC	(X3) DATE SURVEY COMPLETED		
		95042	B. WING		04/1	8/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
STRATEO	RD COURT OF BOCA RA	6343 VIA E	DE SONRISA D	EL SUR		
SIKANO	KD COOKT OF BOCA K	BOCA RA	TON, FL 3343	3		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
K 223	Continued From page	1	K 223			
				correction do not constitute an admiss or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of complia with law.	ne	
	maintenance director central supply corrido latch in the door fram the code requirement suitable to keep the d not latch closed in the to the door frame has the spread of smoke the	oor closed. The door did door frame and or the door an opening which will allow through the door.		The facility used an outside vendor, Broward Door Closures, to address th kitchen dry central supply and the mai kitchen dry central supply corridor doc and they were repaired on 4/24/2018.  A member of the Maintenance/Facilitic Department and the Skilled Nursing Administrator conducted walking roun	n ors es ds of	
	the maintenance dire- kitchen dry central su close and latch in the not meet the code rec means suitable to kee door did not latch clos the door to the door fr will allow the spread of	-45 PM, accompanied by ctor when tested, the main pply corridor door did not door frame. The door did upternent of providing a sp the door closed. The sed in the door frame and or rame has an opening which of smoke through the door.		the facility to confirm that smoke door had functioning latches and appropria closed. No issues were identified.  The Maintenance Director/designee w make facility rounds monthly for 3 mo to confirm smoke doors close/latch properly.  The Maintenance Director or designee report the results of the monthly rounds.	tely ill nths will ds at	

maintenance director who acknowledged and

witnessed that the corridor door did not meet the

documentation to support the testing of the doors

code requirement of providing a means suitable

to keep the door closed. No additional written

for function or providing a smoke barrier was provided at the time of exit.

Administrator and verified by the maintenance

director at the times of observation and at the exit

The findings were acknowledged by the

conference on 04/18/18.

STATE FORM caso TPHE21 If continuation sheet 2 of 3

Improvement Meetings for 3 months.

The Skilled Nursing Administrator or designee is responsible for confirming

with the components of this Plan Of

months, the QAPI committee will

or extend the review period.

variances that may occur.

During and at the conclusion of the three

re-evaluate and initiate necessary action

implementation and ongoing compliance

Correction and addressing and resolving

Agency f	or Health Care Adminis	stration				: 05/09/2018 I APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 04 - MAIN LIC			(X3) DATE SURVEY COMPLETED	
		95042	B. WING			4/18/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
STRATEO	RD COURT OF BOCA RA	5343 VIA	DE SONRISA D	EL SUR			
		BOCAR	ATON, FL 33433				
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	CTION SHOULD BE COMPO O THE APPROPRIATE DAT			
K 223	Continued From page	2	K 223				
	Class III Actual NFPA Standar NFPA LSC 101 (2012	ds: t) 19.3.6.3.3, 19-3.6.3.5		The Skilled Nursing Administrator or designee is responsible for confirming the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Performance Improvemen meetings and action initiated if neces	s it		
			1	1			

AHCA Form 3020-0001