

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 95042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 04 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2018
NAME OF PROVIDER OR SUPPLIER STRATFORD COURT OF BOCA RATON		STREET ADDRESS, CITY, STATE, ZIP CODE 6343 VIA DE SONRISA DEL SUR BOCA RATON, FL 33433		
(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	<p>INITIAL COMMENTS</p> <p>An unannounced Fire & Life Safety relicensure survey was conducted on 04/18/2018 at Stratford Court Of Boca Raton, state license: #16170961, a nursing home in Boca Raton, 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.</p> <p>The following is description of the deficiencies, found at the time of the visit.</p>	K 000		
K 223 SS=F	<p>NFPA 101 Doors with Self-Closing Devices</p> <p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.6.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the</p>	K 223	Responses on the enclosed plan of	5/19/18

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Electronically Signed

05/04/18

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K 223	<p>Continued From page 1</p> <p>facility failed to maintain the building door opening assemblies. This deficient practice affects the smoke compartments, staff, visitors and all residents.</p> <p>The findings included:</p> <p>(1) On 04/18/18 at 11:45 AM, accompanied by the maintenance director when tested, the kitchen dry central supply corridor door did not close and latch in the door frame. The door did not meet the code requirement of providing a means suitable to keep the door closed. The door did not latch closed in the door frame and or the door to the door frame has an opening which will allow the spread of smoke through the door.</p> <p>(2) On 04/18/18 at 12:45 PM, accompanied by the maintenance director when tested, the main kitchen dry central supply corridor door did not close and latch in the door frame. The door did not meet the code requirement of providing a means suitable to keep the door closed. The door did not latch closed in the door frame and or the door to the door frame has an opening which will allow the spread of smoke through the door.</p> <p>An interview was conducted at these time with the maintenance director who acknowledged and witnessed that the corridor door did not meet the code requirement of providing a means suitable to keep the door closed. No additional written documentation to support the testing of the doors for function or providing a smoke barrier was provided at the time of exit.</p> <p>The findings were acknowledged by the Administrator and verified by the maintenance director at the times of observation and at the exit conference on 04/18/18.</p>	K 223	<p>correction do not constitute an admission 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 compliance with law.</p> <p>The facility used an outside vendor, Broward Door Closures, to address the kitchen dry central supply and the main kitchen dry central supply corridor doors and they were repaired on 4/24/2018.</p> <p>A member of the Maintenance/Facilities Department and the Skilled Nursing Administrator conducted walking rounds of the facility to confirm that smoke doors had functioning latches and appropriately closed. No issues were identified.</p> <p>The Maintenance Director/designee will make facility rounds monthly for 3 months to confirm smoke doors close/latch properly.</p> <p>The Maintenance Director or designee will report the results of the monthly rounds at the Quality Assurance and Performance Improvement Meetings for 3 months. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.</p> <p>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.</p>	

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K 223	Continued From page 2 Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.6.3.3, 19-3.6.3.5	K 223	The Skilled Nursing Administrator or designee is responsible for confirming that the status of this Plan Of Correction is reviewed and discussed at Quality Assurance/Performance Improvement meetings and action initiated if necessary.	

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

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E 000	Initial Comments During the unannounced recertification survey conducted on 04/18/2018 at Stratford Court Of Boca Raton, a nursing home in Boca Raton, Emergency Preparedness plans and policies were reviewed. Stratford Court of Boca Raton is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR), 42 Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
E 004 SS-C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a).] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.	E 004		5/19/18

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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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E 004	<p>Continued From page 1</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on written document review and staff interview the facility failed to develop emergency preparedness policies and procedures that must be reviewed, and updated at least annually. This deficient practice affects all staff, visitors and residents.</p> <p>The findings included:</p> <p>On 04/18/18 at 2:30 PM, based on review of the written facility emergency plan and policy with the administrator, the facility was not able to produce the requested written documentation of the surveyor procedures. Based on the provided emergency plan, it could not be verified that the facility had included documentation that the emergency preparedness plan was reviewed, and updated at least annually. No written documentation with the governing board or management leadership approval or review was available. The written documentation for the required facility federal emergency plan and policy to meet code requirements was not available in the plan at the time reviewed and when requested to produce requested written documentation to substantiate compliance. An interview was conducted at this time with the administrator who acknowledged that the documentation requested was not available in the facility emergency plan.</p>	E 004	<p>Responses on the enclosed plan of correction do not constitute an admission 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 compliance with law.</p> <p>The annual statement that the Emergency Plan has been reviewed by the Governing Body or Management Leadership will be signed and placed in the Emergency Preparedness Plan manual by 5/19/2018.</p> <p>The Administrator confirmed that there are no other emergency plan documents that require a Governing Body/Management Leadership signature.</p> <p>The annual meeting agenda and planning calendar has been updated to include a review and sign off on the Emergency Plan annually, either by the Board or management leadership.</p> <p>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</p>		

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E 004	Continued From page 2 The findings were acknowledged by and verified by the administrator at the time of documentation review and at the exit conference on 04/18/2018. Actual code requirements: 483.73 (a)	E 004	variances that may occur. The Skilled Nursing Administrator or designee is responsible for confirming that the status of this Plan Of Correction is reviewed and discussed at Quality Assurance/Performance Improvement meetings and action initiated if necessary.		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(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:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		5/19/18	

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E 018	<p>Continued From page 3</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.</p> <p>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.</p> <p>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p>	E 018			

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E 018	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on written document review and staff interview, the facility failed to develop emergency preparedness policies and procedures to address a system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.. This deficient practice affects all staff, visitors and residents.</p> <p>The findings included:</p> <p>On 04/18/18 at 3:00 PM, based on review of the written facility emergency plan and policy with the administrator, the facility was not able to produce the requested written documentation of the surveyor procedures. Based on the provided emergency plan, it could not be verified that the facility had included policies and procedures describing the facility's role to address a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the facility must document the specific name and location of the receiving facility or other location. No written specific policy or procedure or form to be used was in the actual policy reviewed with the administrator. The written documentation for the required facility federal emergency plan and policy to meet code requirements was not available in the plan at the time reviewed and when requested to produce requested written documentation to substantiate compliance. An interview was conducted at this time with the</p>	E 018	<p>Responses on the enclosed plan of correction do not constitute an admission 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 compliance with law.</p> <p>The facility will have a tracking system and procedure in place by 5/19/18 to document and track the location of visitors, team members, residents, or volunteers who are in the building during an emergency and those residents and team members who have been relocated during an emergency. . This system and procedure will be included in the emergency preparedness manual by 5/19/18.</p> <p>The Administrator confirmed that other required systems and procedures are included in the current Emergency Preparedness Plan manual.</p> <p>Team members will be trained on this tracking system and process, including how to access and use the Emergency Plan Manual and tracking sheets, and how to activate and use the tracking system and process during an emergency. The training will be provided by a Maintenance/Facilities leader and the Skilled Nursing Administrator or designee by 5/19/2018. Administrator/designee will maintain the tracking system and have the</p>		

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E 018	Continued From page 5 administrator who acknowledged that the documentation requested was not available in the facility emergency plan. The findings were acknowledged by and verified by the administrator at the time of documentation review and at the exit conference on 04/18/18. Actual code requirements: 483.73 (b)	E 018	sheets ready to be placed at a central location (conierge station) in the facility during an emergency. 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 that the status of this Plan Of Correction is reviewed and discussed at Quality Assurance/Performance Improvement meetings and action initiated if necessary.		
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 RNHCl's at §403.748(b):] Policies and	E 026		5/19/18	

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E 026	<p>Continued From page 6</p> <p>procedures. (8) The role of the RNHC) under a 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:</p> <p>Based on written document review and staff interview, the facility failed to include all of the requirements that Centers for Medicare & Medicaid Services (CMS) require for the facility emergency plan and policies to meet code requirements. This deficient practice affects all staff, visitors and all residents.</p> <p>The findings included:</p> <p>On 04/18/18 at 3:15 PM, 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.</p> <p>The findings were acknowledged by and verified by the administrator at the times of written document review and at the exit conference on 04/18/18.</p> <p>Actual code requirements: (8) [(6), (6)(C)(iv), (7), or (9)] The role of the</p>	E 026	<p>Responses on the enclosed plan of correction do not constitute an admission 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 compliance with law.</p> <p>The facility will obtain the necessary information regarding the process to obtain an 1135 waiver should a state of emergency occur by 5/19/2018.</p> <p>The Administrator confirmed that there are no other waivers/waiver instructions that the facility is required to obtain.</p> <p>The administrator will obtain necessary steps on how to acquire an 1135 waiver and the waiver instructions will be placed in the Emergency Preparedness Plan manual no later than 5/19/2018.</p> <p>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 that</p>		

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E 026	Continued From page 7 [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	the status of this Plan Of Correction is reviewed and discussed at Quality Assurance/Performance Improvement meetings and action initiated if necessary.		

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K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Fire & Life Safety relicensure survey was conducted on 04/18/2018 at Stratford Court Of Boca Raton, state license: #16170961, a nursing home in Boca Raton, 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.</p> <p>The following is description of the deficiencies, found at the time of the visit.</p>	K 000		
K 223 SS=F	<p>NFPA 101 Doors with Self-Closing Devices</p> <p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.6.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the</p>	K 223	Responses on the enclosed plan of	5/19/18

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Electronically Signed

05/04/18

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 95042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 04 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2018
NAME OF PROVIDER OR SUPPLIER STRATFORD COURT OF BOCA RATON		STREET ADDRESS, CITY, STATE, ZIP CODE 6343 VIA DE SONRISA DEL SUR BOCA RATON, FL 33433		
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K 223	<p>Continued From page 1</p> <p>facility failed to maintain the building door opening assemblies. This deficient practice affects the smoke compartments, staff, visitors and all residents.</p> <p>The findings included:</p> <p>(1) On 04/18/18 at 11:45 AM, accompanied by the maintenance director when tested, the kitchen dry central supply corridor door did not close and latch in the door frame. The door did not meet the code requirement of providing a means suitable to keep the door closed. The door did not latch closed in the door frame and or the door to the door frame has an opening which will allow the spread of smoke through the door.</p> <p>(2) On 04/18/18 at 12:45 PM, accompanied by the maintenance director when tested, the main kitchen dry central supply corridor door did not close and latch in the door frame. The door did not meet the code requirement of providing a means suitable to keep the door closed. The door did not latch closed in the door frame and or the door to the door frame has an opening which will allow the spread of smoke through the door.</p> <p>An interview was conducted at these time with the maintenance director who acknowledged and witnessed that the corridor door did not meet the code requirement of providing a means suitable to keep the door closed. No additional written documentation to support the testing of the doors for function or providing a smoke barrier was provided at the time of exit.</p> <p>The findings were acknowledged by the Administrator and verified by the maintenance director at the times of observation and at the exit conference on 04/18/18.</p>	K 223	<p>correction do not constitute an admission 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 compliance with law.</p> <p>The facility used an outside vendor, Broward Door Closures, to address the kitchen dry central supply and the main kitchen dry central supply corridor doors and they were repaired on 4/24/2018.</p> <p>A member of the Maintenance/Facilities Department and the Skilled Nursing Administrator conducted walking rounds of the facility to confirm that smoke doors had functioning latches and appropriately closed. No issues were identified.</p> <p>The Maintenance Director/designee will make facility rounds monthly for 3 months to confirm smoke doors close/latch properly.</p> <p>The Maintenance Director or designee will report the results of the monthly rounds at the Quality Assurance and Performance Improvement Meetings for 3 months. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.</p> <p>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.</p>	

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K 223	Continued From page 2 Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.6.3.3, 19-3.6.3.5	K 223	The Skilled Nursing Administrator or designee is responsible for confirming that the status of this Plan Of Correction is reviewed and discussed at Quality Assurance/Performance Improvement meetings and action initiated if necessary.	