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
	95041	A. BUILDING: **03 - CLOSED - MAIN LIC** B. WING _____	**04/25/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRINGTON TERRACE OF BOYNTON BEACH	**1425 S CONGRESS AVE BOYNTON BEACH, FL 33426**

(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 State relicensure survey conducted on April 25, 2018 at Barrington Terrace Of Boynton Beach, license #1616096, a nursing home in Boynton Beach, Florida, in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012 edition) and applicable requirements of Florida State Fire Marshall's Rules and Regulations, Florida Administrative Code F.A.C. 69A-3, F.A.C. 69A-53, F.A.C. and Florida Statutes (F.S.) 400 Part II and F.S. 633.0215, adopting National Fire Protection (NFPA) 1 and 101(2012 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies, found in the time of the visit.	K 000		
K 345 SS=E	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72 This Statute or Rule is not met as evidenced by: Based on record review and staff interview, Barrington Terrace Of Boynton Beach failed to comply with NFPA 101 and NFPA 72 14.4.3.2 . Duct detector differential annual testing. The deficient practice would affect all smoke compartments, all occupants of the facility.	K 345	K345 SS=E Fire Alarm System – Testing and Maintenance CFR9s): NFPA 101 Barrington Terrace's fire alarm system is tested and maintained in accordance with	5/25/18

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/18

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K 345	Continued From page 1 The findings included: During record review and staff interview, on 04/25/18 at 11:00 AM, with the Director of Facilities, the facility failed to produce documentation the the duct detectors had an annual differential test on the duct detectors. The Director of Facilities acknowledged the absence of documentation. Class III	K 345	an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. Fire and Life Safety of America Inc. on May 10, 2018 conducted the Duct Detector Differential Testing at Barrington Terrace. Documentation has been provided that all Duct Detectors passed testing successfully. Fire and Life Safety of America Inc. will be conducting Duct Detector Differential Testing on a yearly basis. Executive Director and/or Designee will ensure that Duct Detector Differential Testing is conducted on a yearly basis ingoing.	

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	105850	A. BUILDING **01 - MAIN FED** B. WING _____	**04/25/2018**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on April 25, 2018 at Barrington Terrace Of Boynton Beach, a nursing home, in Boynton Beach, Florida 33426. Barrington Terrace Of Boynton Beach is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes. Initial Plan Review: 1993 Existing NFPA 220 Construction Type II (000) Census 18 The following is description of noncompliance.	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, Barrington Terrace Of Boynton Beach failed to comply with NFPA 101 and NFPA 72 14.4.3.2 . Duct detector differential annual testing. The deficient practice would affect all smoke compartments, all occupants of the facility.	K 345	K345 SS=E Fire Alarm System – Testing and Maintenance CFR9s): NFPA 101 Barrington Terrace's fire alarm system is tested and maintained in accordance with	5/25/18

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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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	105850	A. BUILDING **01 - MAIN FED** B. WING _____	**04/25/2018**

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K 345	Continued From page 1 The findings included: During record review and staff interview, on 04/25/18 at 11:00 AM, with the Director of Facilities, the facility failed to produce documentation the the duct detectors had an annual differential test on the duct detectors. The Director of Facilities acknowledged the absence of documentation.	K 345	an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. Fire and Life Safety of America Inc. on May 10, 2018 conducted the Duct Detector Differential Testing at Barrington Terrace. Documentation has been provided that all Duct Detectors passed testing successfully. Fire and Life Safety of America Inc. will be conducting Duct Detector Differential Testing on a yearly basis. Executive Director and/or Designee will ensure that Duct Detector Differential Testing is conducted on a yearly basis ingoing.	

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E 000	Initial Comments During the Life Safety recertification survey conducted on April 25, 2018 at Barrington Terrace Of Boynton Beach, a nursing home, Emergency Preparedness was reviewed. Barrington Terrace Of Boynton Beach is not in compliance with 42 CFR Part 483.73, Requirements for Emergency Preparedness for Long Term Care Facilities. The following is a description of the noncompliance.	E 000		
E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire;	E 013		5/25/18

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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 013	Continued From page 1 equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document and identify through a risk assessment an all hazards approach in their Emergency Preparedness Program (EPP). This in the event of a disaster or other emergency would leave the facility and its occupants vulnerable to the hazards of the event. The findings included: During record review and staff interview, on 04/25/18 4:30 PM, with the Director of Facilities and Administrator, it was revealed the facility failed to document a facility and community based all hazards approach with strategies for addressing emergency events identified by the risk assessment. The Administrator	E 013	E013 SS=D Development of EP Policies and Procedures CFR9s):483.73(b) Barrington Terrace has developed and implemented emergency preparedness policies and procedures, identified through a risk assessment of all hazards approach in their Emergency Preparedness Program (EPP) Manual. Barrington Terrace's Management Team have been in-serviced on the Emergency Preparedness Program Manual. The Development of the Emergency Preparedness Program will be the responsibility of the Executive Director	

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E 013	Continued From page 2 acknowledged this absence of documentation.	E 013	and/or designee. The Emergency Preparedness Program will be kept current and reviewed annually or as needed.	
E 018 SS=D	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. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.	E 018		5/25/18

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E 018	Continued From page 3 (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. (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. *[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. *[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. *[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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document a system to track the location	E 018	E018 SS=D Procedures for Tracking of Staff and Patients	

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E 018	Continued From page 4 of on duty staff and sheltered patients in their Emergency Preparedness Program (EPP). This in the event of a disaster or other emergency would leave the facility and its occupants vulnerable to the hazards of the event. The findings included: During record review and staff interview, on 04/25/18 at 4:45 PM, with the Director of Facilities and Administrator, it was revealed the facility failed to document a system to track the location of staff and patients. They did not address specific names and locations. The Administrator acknowledged this absence of documentation.	E 018	CFR9s): 483.73(b)(2) Barrington Terrace has developed a system to track the location of on-duty staff and sheltered patients in their Emergency Preparedness Program. Policies and Procedures as well as forms to assist for the tracking of Staff & Residents can be located in Section D of Barrington's Emergency Preparedness Program. Barrington Terrace's Management Team and staff have been in-serviced on the procedures for tracking Staff and Patients during a disaster situation. The Development of the Emergency Preparedness Program will be the responsibility of the Executive Director and/or designee. The Emergency Preparedness Program will be kept current and reviewed annually or as needed.	
E 029 SS=D	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on documentation and staff interview, Barrington Terrace Of Boynton Beach failed to comply with Emergency Preparedness Plan, develop and maintain comprehensive	E 029	E029 SS=D Development of Communication Plan CFR9s):483.73(c)	5/25/18

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E 029	Continued From page 5 communication plan. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The finding included: During documentation review and staff interview, on 04/25/18 at 4:15 PM, with the Director of Facilities and the Administrator, it was revealed that the facility's Emergency Preparedness Plan failed to include all essential elements, including but not limited to, a comprehensive communication plan. The Director of Facilities and the Administrator acknowledged the absence of documentation.	E 029	Barrington Terrace has developed and maintains an emergency preparedness communication plan that complies with Federal, State, and local laws. This plan is located in the Emergency Preparedness Plan (EPP) Manual. Policies and Procedures regarding Internal and External Communications during and after the occurrence of a disaster are dictated in Barrington Terrace's Communication Plan. The Communication Plan is located in Section B of Barrington's Emergency Preparedness Program (EPP). The Development and updating of the Communication Plan will be the responsibility of the Executive Director and/or designee. The Communication Plan will be kept current and reviewed annually or as needed.	