PRINTED: 09/27/2018 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: 05 - MAIN LIC B MING 95019 08/31/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 OLD ROYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEA 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 DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (K 000) INITIAL COMMENTS EK 0003 An unannounced Fire & Life Safety revisit survey was conducted on 08/31/2018 at Heartland Health Care Center Boynton Beach, License #1210096, a nursing home in Boynton Beach, Florida. This was a follow-up to the Annual Fire & Life Safety Relicensure survey completed on 07/18/2018. Previously cited Fire & Life Safety deficiencies were found corrected. There was a new deficiency identified at the time of the visit (K 200). K 200 NFPA 101 Means of Egress Requirements -K 200 9/24/18 SS=F Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included. 18.2. 19.2 This Statute or Rule is not met as evidenced by: Based on written document review, and staff It is the practice of this facility to maintain interview, the facility failed to maintain the the building exit egress. building exit egress. This deficient practice affects all smoke compartments, staff, visitors The facility has contracted with a licensed

and residents.

Findings include:

On 08/31/2018 at 5 P.M. while conducting the facility documentation review of the required Fire and Smoke door annual testing done on 08/01/2018, the documentation provided indicated that 30 openings of 30 openings inspected failed and are not in compliance.

and certified vendor to complete the work identified as a result of the inspection report.

repairs have been brought through QA&A.

Results of the inspection report and

TITLE

(X6) DATE

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

09/21/18 Electronically Signed

PRINTED: 09/27/2018 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: 05 - MAIN LIC B. WING 95019 08/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEA BOYNTON BEACH, FL 33436 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 200 | Continued From page 1 K 200 When requested, no documentation was provided to show that any of the 30 openings had been repaired to meet NFPA 80 requirements. Additionally, the facility could not show any documentation indicating the Maintenance Director or a qualified person followed the code requirements to repair the issues documented. No additional documentation was provided at the The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of record review and at the exit conference on 08/31/2018. Class III Actual NFPA Standards: NFPA LSC 101 (2015) Chapters; 4, 7, 19 and NFPA 80 (2010)

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PRINTED: 00/27/2018

| | | ID HUMAN SERVICES | | | FORM | APPROVED |
|---|---|--|---------------------|---|-----------|----------------------------|
| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (V2) MUI TIQUE | CONSTRUCTION | (X3) DATE | 0.0938-0391 |
| | | IDENTIFICATION NUMBER: | 1 | O1 - MAIN FED | | LETED |
| | | | | | | 3 |
| | | 105755 | B. WING | | 08/ | 31/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HEARTI A | ND HEALTH CARE CEN | TER BOYNTON BEACH | 3 | 8600 OLD BOYNTON ROAD | | |
| HERITIER | TO THE PETT OF THE OFTE | TER DOTATION DEAGN | E | BOYNTON BEACH, FL 33436 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {K 000} | INITIAL COMMENTS | | {K 000} | | | |
| K 200 SS=F | was conducted on 08 Health Care Center E home in Boynton Bee follow-up to the Annu Recertification survey Previously cited Fire were found corrected There was a new def of the visit (K 200). Means of Egress Rec (ER(s): NFPA 101 Means of Egress Rec List in the REMARKS 18.2 and 19.2 Means are not addressed by deficient. This informs applicable Life Safety | completed on 07/18/2018. & Life Safety deficiencies | K 200 | | | 9/24/18 |
| | by: Based on written doc interview, the facility to building exit egress. | is not met as evidenced cument review and staff ailed to maintain the This deficient practice partments, staff, visitors | | It is the practice of this facility to main the building exit egress. The facility has contracted with a licen and certified vendor to complete the w identified as a result of the inspection report. | sed | |
| | On 08/31/2018 at 5 P | .M. while conducting the | | Results of the inspection report and | | |

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

(X6) DATE

Electronically Signed 09/21/2018 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 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (x2) MULTIPLE CONSTRUCTION (x3) DATE SURVEY (x3) MULTIPLE CONSTRUCTION (x3) DATE SURVEY

| CENTERS FOR MEDICARE & MEDICAID SERVICES CONTROL OF THE SERVICES | | | | |
|--|------------------------|--|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | IDENTIFICATION NUMBER. | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED | (X3) DATE SURVEY COMPLETED | |
| | | | l R | |

| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
|--|---|---------------------|--|----------------------------|--|
| HEARTLAND HEALTH CARE CENTER BOYNTON BEACH | | | 3600 OLD BOYNTON ROAD | | |
| | | | BOYNTON BEACH, FL 33436 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 200 | Continued From page 1 facility documentation review of required Fire and Smoke door annual testing done on 08/01/2018, the documentation provided indicated that 30 openings of 30 openings inspected failed and are not in compliance. When requested, no documentation was provided to show that any of the 30 openings had been repaired to meet NFPA 80 requirements. Additionally, the facility could not show any documentation indicating the Maintenance Director or a qualified person followed the code requirements to repair the issues documented. No additional documentation was provided at the time of exit. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of record review and at the exit conference on 08/31/2018. Actual NFPA Standards: NFPA LSC 101 (2012) Chapters: 4, 7, 19 and NFPA 80 (2010) | к 200 | repairs have been brought through QA&A. | | |

Facility ID: 95019

PRINTED: 09/27/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

| CENTERS FOR MEDICARE & | MEDICAID SERVICES | | | OMB NO. 0938-039 |
|---|---|---------|---------------------------------------|-------------------------------|
| FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED |
| | | | | R |
| | 105755 | B. WING | | 08/31/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |

| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
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| WEART AND WEATH CARE OF STATES BOWNTON BEACH | | | 3600 OLD BOYNTON ROAD | | | |
| HEARTLAND HEALTH CARE CENTER BOYNTON BEACH | | | BOYNTON BEACH, FL 33436 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| {E 000} | Initial Comments | {E 0€ | 0} | | | |
| | An unannounced Fire & Life Safety revisit survey for Emergency Preparedness was conducted on 08/31/2018, at Heartland Health Care Center Boynton Beach, a nursing home in Boynton Beach, Florida. This was a follow-up to the annual Fire & Life Safety survey for Emergency Preparedness completed on 07/18/2018. All previously cited Fire & Life Safety deficiencies for Emergency Preparedness were corrected. There were no additional deficiencies found at the time of the follow-up visit. | | | | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 09/21/2018

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.