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
	95008	A. BUILDING: **04 - MAIN LIC** B. WING _____	**09/26/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES OF LAKE WORTH CARE CENTER	**1711 6TH AVENUE SOUTH LAKE WORTH, FL 33460**

(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 was conducted on a September 26, 2018 at Terrace of Lake Worth, license #1133096, a nursing home in Lake Worth, Florida, in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015 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 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222		10/26/18

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/08/18

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K 222	Continued From page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

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K 222	Continued From page 2 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to comply with NFPA 101 (2015) delayed egress access. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During a tour of the facility on 09/26/18 at 5:30 PM with the Maintenance Director, the 2nd floor South egress exit door with a 30 second delay did not alarm and did not open in 30 seconds. The Maintenance Director acknowledged and observed that the door would not open and the alarm did not engage. NFPA 101(2015) 7.2.1.6.1.1 Class III	K 222	K222 Egress Doors 1. Residents on the 2nd Floor have the potential to be affected by the alleged deficient practice. 2. The second exit door on 2nd Floor was checked to ensure compliance. 3. Maintenance Director fixed door in question on 9/26/18. 4. Maintenance Director and or designee will conduct random 2nd Floor Exit Door Audits to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	
K 345 SS=D	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	K 345		10/26/18

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K 345	Continued From page 3 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, the facility 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. The findings included: During record review and staff interview on 09/26/18 at 11:00 AM with the Maintenance Director, the facility failed to produce documentation the the duct detectors had an annual differential test on the duct detectors. The Maintenance Director acknowledged the absence of documentation. Class III	K 345	K345 Fire Alarm System – Testing and Maintenance 1. All Residents have the potential to be affected by the alleged deficient practice. 2. All Fire Alarm System Testing Paper Work was reviewed to ensure compliance. 3. Maintenance Director scheduled vendor to conduct the annual differential test on the duct detectors. 4. Maintenance Director and or designee will continue to monitor paper work to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	
K 918 SS=D	NFPA 99 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		10/26/18

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K 918	Continued From page 4 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Statute or Rule is not met as evidenced by: Based on document review and staff interview, the facility failed to comply with NFPA 101 (2015) 8.4.9.5.2. That all generators and ancillary equipment were tested and certified at an optimal state in accordance with NFPA 101 and NFPA 110 "Standard for Emergency and Standby Power Systems" NFPA 110-8.4.2: Level 1 EPSS shall be exercised once a month under load for a minimum of 30 minutes. Main & Feeder Breaker exercise performed. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During the record review and staff interview on 09/26/18 at 10:35 AM with the Maintenance Director, it was revealed that at the time of this	K 918	K918 NFPA 99 Electrical Systems 1. All Residents have the potential to be affected by the alleged deficient practice. 2. All other mandated paperwork was reviewed to ensure compliance. 3. Maintenance Director scheduled vendor to exercise the Main Service Breaker. 4. Maintenance Director and or designee will continue to monitor paper work to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	

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K 918	Continued From page 5 survey there was no documentation to show that the Main and Feeder Circuit Breakers were inspected annually as required, including periodic exercise in accordance with manufacture's recommendations. Interview with the Director of Environmental Services revealed and acknowledged that the facility did not have a system in place or preventative maintenance program to ensure compliance with NFPA 99 (2015). NFPA 101 (2015) edition NFPA 99 (2015) 6.4.4 NFPA 110 (2013) edition 8.4.2	K 918		
K 921 SS=D	NFPA 99 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed	K 921		10/26/18

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K 921	Continued From page 6 operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on documentation review, observation and staff interview, the facility failed to comply with Life Safety 101 (2015) NFPA 99 Chapter 10. All electrical equipment used must be inspected and tested yearly. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During documentation review, observation and staff interview on 09/26/18 at 11:30 AM with the Maintenance Director, the facility failed to provide documentation that the electrical equipment used on the residents was inspected annually The Administrator acknowledged the absence electrical equipment testing documentation. Class III	K 921	K921 Electrical Equipment – Testing and maintenance 1. All Residents have the potential to be affected by the alleged deficient practice. 2. All other mandated paperwork was reviewed to ensure compliance. 3. Vendor came to facility on 10/5/18 to conduct annual equipment testing. 4. Maintenance Director and or designee will continue to monitor paper work to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	
K1053 SS=D	FAC 59A-4.126 Emergency Management Plan 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	K1053		10/26/18

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K1053	Continued From page 7 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: Based on record review and staff interview, the facility failed to ensure that an approved disaster preparedness plan was in place per Florida Administrative Code 59A-4.126. This could, in the event of an internal or external disaster, cause confusion and/or panic from a lack of staff knowledge, and raises the potential for negative outcomes to the patients and staff. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During record review and staff interview on 09/26/18 at 1:00 PM with the Maintenance Director and the Administrator, it was revealed that there was no documentation to show that the disaster plan has been approved within the last twelve months. Supporting documentation that was provided revealed that the plan expired on 09/01/18. The plan was submitted on 08/15/18. This absence of documentation approval was acknowledged by the Administrator. Class III	K1053	K1053 Emergency Management Plan 1. Administrator was not actively practicing in the facility when plan was due. Once Administrator identified that the CEMP Plan was due, it was submitted on 8/15/18. 2. All residents have the potential to be affected by the alleged deficient practice. 3. All other mandated paperwork was reviewed to ensure compliance. 4. Administrator and or designee will continue to monitor paper work to ensure compliance. Findings will be reviewed in morning meeting and at Monthly QA Meeting.	

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	105125	A. BUILDING **01 - MAIN FED** B. WING _____	**09/26/2018**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on 09/26/2018 at Terraces of Lake Worth Care Center, a nursing home in Lake Worth, Florida. The facility 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: 1955 Existing NFPA 220 Construction: Type II (000) Census: 80	K 000		
K 222 SS=D	The following is description of noncompliance Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222		10/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/08/2018

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.

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K 222	Continued From page 1 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to comply with NFPA 101 (2012) delayed egress access. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During a tour of the facility on 09/26/18 at 5:30 PM with the Maintenance Director, the 2nd floor South egress exit door with a 30 second delay did not alarm and did not open in 30 seconds. The Maintenance Director acknowledged and observed that the door would not open and the alarm did not engage. NFPA 101 (2012) 7.2.1.6.1.1	K 222	K222 Egress Doors 1. Residents on the 2nd Floor have the potential to be affected by the alleged deficient practice. 2. The second exit door on 2nd Floor was checked to ensure compliance. 3. Maintenance Director fixed door in question on 9/26/18. 4. Maintenance Director and or designee will conduct random 2nd Floor Exit Door Audits to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	
K 345 SS=D	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, the facility failed to comply with NFPA 101 and NFPA 72 14.4.3.2 . Duct detector differential annual testing. The deficient practice would affect all	K 345	K345 Fire Alarm System – Testing and Maintenance 1. All Residents have the potential to be	10/26/18

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K 345	Continued From page 3 smoke compartments, all occupants of the facility. The findings included: During record review and staff interview on 09/26/18 at 11:00 AM with the Maintenance Director, the facility failed to produce documentation that the duct detectors had an annual differential test on the duct detectors. The Maintenance Director acknowledged the absence of documentation.	K 345	affected by the alleged deficient practice. 2. All Fire Alarm System Testing Paper Work was reviewed to ensure compliance. 3. Maintenance Director scheduled vendor to conduct the annual differential test on the duct detectors. 4. Maintenance Director and or designee will continue to monitor paper work to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		10/26/18

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TERRACES OF LAKE WORTH CARE CENTER	**1711 6TH AVENUE SOUTH LAKE WORTH, FL 33460**

(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 918	Continued From page 4 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to comply with NFPA 101 (2012) 8.4.9.5.2. That all generators and ancillary equipment were tested and certified at an optimal state in accordance with NFPA 101 and NFPA 110 "Standard for Emergency and Standby Power Systems" NFPA 110-8.4.2: Level 1 EPSS shall be exercised once a month under load for a minimum of 30 minutes. Main & Feeder Breaker exercise performed. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During the record review and staff interview on 09/26/18 at 10:35 AM with the Maintenance Director, it was revealed that at the time of this survey there was no documentation to show that the Main and Feeder Circuit Breakers were inspected annually as required, including periodic exercise in accordance with manufacture's recommendations. Interview with the Director of Environmental Services revealed and acknowledged that the	K 918	K918 NFPA 99 Electrical Systems 1. All Residents have the potential to be affected by the alleged deficient practice. 2. All other mandated paperwork was reviewed to ensure compliance. 3. Maintenance Director scheduled vendor to exercise the Main Service Breaker. 4. Maintenance Director and or designee will continue to monitor paper work to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105125	A. BUILDING **01 - MAIN FED** B. WING _____	**09/26/2018**

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K 918	Continued From page 5 facility did not have a system in place or preventative maintenance program to ensure compliance with NFPA 99 (2015). NFPA 101 (2012) edition NFPA 99 (2012) 6.4.4 NFPA 110 (2010) edition 8.4.2	K 918		
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.	K 921		10/26/18

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K 921	Continued From page 6 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on documentation review, observation and staff interview, the facility failed to comply with Life Safety 101 (2012) NFPA 99 Chapter 10 (2012). All electrical equipment used must be inspected and tested yearly. This deficiency could affect all occupants of the facility in case of a fire or other emergency. The findings included: During documentation review, observation and staff interview on 09/26/18 at 11:30 AM with the Maintenance Director, the facility failed to provide documentation that the electrical equipment used on the residents was inspected annually The Administrator acknowledged the absence electrical equipment testing documentation.	K 921	K921 Electrical Equipment – Testing and maintenance 1. All Residents have the potential to be affected by the alleged deficient practice. 2. All other mandated paperwork was reviewed to ensure compliance. 3. Vendor came to facility on 10/5/18 to conduct annual equipment testing. 4. Maintenance Director and or designee will continue to monitor paper work to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting. Completion Date: 10/26/18	

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E 000	Initial Comments During the Fire & Life Safety Recertification survey conducted on 09/26/18 at Terraces of Lake Worth Care Center, Emergency Preparedness was reviewed. The facility is not in compliance with Code of Federal Regulations (CFR) 42, Part 483.73, Requirements for Long Term Care Facilities. The following is a description of noncompliance.	E 000		
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 RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI 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.	E 026		10/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/08/2018

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.

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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 policies and procedures to address the role of the facility under a 1135 waiver. This deficient practice affects all staff, visitors and all residents. The findings included: On 09/26/18 at 12:00 PM, based on an interview with the Administrator, there is no written documentation to address the role of the facility under the waiver declared by the secretary in accordance with section 1135 of the Act. An interview was conducted at this time with the administrator who acknowledged that the documentation requested was not available in a written facility federal emergency plan. No additional documentation was provided at the time of exit. The findings were acknowledged by and verified by the Administrator at the times of written document review and at the exit conference on 09/26/18. Actual code requirements: 483.475	E 026	E026 Roles Under a Waiver Declared by Secretary 1. No residents were identified by the alleged deficient practice. 2. All other Emergency Management Plan Policies was reviewed to ensure compliance. 3. The Emergency Preparedness Plan was updated to include policies and procedures to provide care at an alternative site under an 1135 Waiver. 4. Administrator and or designee will review Emergency Preparedness Plan annually to ensure compliance. Findings reviewed at Monthly Risk/QA Meeting.	