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
	95024	A. BUILDING: **04 - MAIN LIC** B. WING _____	**01/14/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	**1130 NW 15TH STREET** **BOCA RATON, FL 33486**

(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 Relicensure survey was completed on 01/14/2019 at Avante at Boca Raton, Inc., 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. (Lic. #1023095) The facility is not in substantial compliance.	K 000		
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building exit egress. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings included: 1. On 01/14/2019 at 1:00 PM during the facility tour the following doors which have the	K 211	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. K211 NFPA 101 Means of Egress	2/8/19

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/19

Agency for Health Care Administration

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K 211	Continued From page 1 appearance of exit doors were not signed as required by code to state NO EXIT so as to not cause confusion in an emergency. These doors are likely to be mistaken for an exit but, lead to a patio on the 2nd floor with no means of exit to the ground level. Examples include, the 2nd floor main dining room 3 sliding glass doors and the 2nd floor restorative dining room which has 1 sliding glass door. 2. On 01/14/2019 at 11:00 AM during the facility tour the 2nd floor corridor fire doors hardware was found damaged, and did not function as required by code. Based on interview at these same times, the Maintenance Director acknowledged that the required signage was not posted as required by code and fire door hardware was not functional. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 01/14/2019. Class III Actual NFPA Standards: NFPA LSC 101 (2015) 4.5.3.2, 7.2.1.15, 7.3.2.2., 19.1.1.3.2 and 7.10.8.1 NO EXIT.	K 211	1) On 1/21/2019 Proper signage stating NO EXIT was posted on non-egress doors in main dining room and restorative dining room that lead to a patio. On 1/18/2019 the 2nd floor corridor fire doors damaged hardware was inspected and found to not be repairable. A proposal from an independent door company to replace the fire doors was received. On 1/21/19 the payment was made. The door company is to complete the install of new fire doors by 2/8/2019. 2) Maintenance Director completed an audit of facility non-egress doors for proper signage. No other doors located without proper signage. Audit was completed by the Maintenance Director on the other facility fire doors. No other fire doors hardware was found to not be functional. 3) Maintenance Director was retrained by Corporate Director of Facility Maintenance on proper signage of non-egress doors as No Exit and on proper functioning of fire doors hard door on 1/21/2019. 4) Audits will be completed on fire doors for properly functioning hardware and non-egress doors for proper signage weekly for four weeks and monthly for 2 months and reviewed with QA team. Monthly checks will continue no fire doors as preventative maintenance.	

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K 363	Continued From page 2	K 363		
K 363 SS=F	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations (only for Federal survey citation) only on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 2012 NEW	K 363		2/8/19

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K 363	Continued From page 3 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with self-latching and positive latching hardware. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations (only for Federal survey citation) on corridor doors and rooms containing flammable or combustible materials. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the building doors. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings included: On 01/14/2019 at 10:00 AM during the facility tour the following doors were found damaged and not maintained. The kitchen pot sink door frame is rusted and not attached to the wall. The dry storage room is missing the door. Based on interview at this time the Maintenance Director acknowledged that the doors are not maintained.	K 363	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. K 0363 Maintenance, Inspection & Testing Doors 1) On 1/18 /2019 the damaged doors and missing door were inspected and unable to be repaired and will be replaced. On 1/21/19 the payment was made. The door company is to complete the install of new smoke doors by 2/8/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95024	A. BUILDING: **04 - MAIN LIC** B. WING _____	**01/14/2019**

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K 363	Continued From page 4 The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 01/14/2019. Class III Actual NFPA Standards: NFPA LSC 101 (2015) 4.5.3.2, 7.2.1.15, 7.3.2.2., 19.1.1.3.2.	K 363	2) On 1/18/2019 the other corridor smoke doors were inspected and repaired. Those unable to be repaired will be replaced. A proposal from an independent door company to replace the unrepairable smoke doors was received. On 1/21/19 the payment was made. The door company is to complete the install of new smoke doors by 2/8/2019. 3) Maintenance Director was retrained by Corporate Director of Facility Maintenance on proper functioning of smoke doors on 1/21/2019. 4) Audits will be completed on corridor smoke doors for proper function weekly for four weeks and monthly for 2 months and reviewed with QA team. Monthly checks will continue on corridor smoke doors as preventative maintenance.	
K1051 SS=F	FAC 59A-4. 133 FBC (2014) 5th Ed. 450 Plans Submittal PRIOR to Work No health care facility construction work, including demolition, shall be started until prior written approval has been given by the Office of Plans and Construction. This includes all construction of new facilities and any and all additions, modifications, or renovations to existing facilities. When construction is required, either for new buildings or additions, alterations or renovations to existing buildings, the plans and specifications shall be prepared and submitted to the Office of Plans and Construction for approval by a Florida-registered architect and a Florida-registered professional engineer.	K1051		2/8/19

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K1051	Continued From page 5 Florida Administrative Code 59A-4.133 & Florida Building Code (2014) 5th edition Section 450.1. This Statute or Rule is not met as evidenced by: Based on observation, documentation review and staff interview the facility failed to notify the Agency of changes made to the building from the original approved plans. Work was not approved or reviewed by the Agency. This deficient practice affects all smoke compartments, staff, visitors and residents. Findings included: On 01/14/2018 at 11:30 AM, based on the facility tour of the 2nd floor, in the kitchen food storage room it was discovered that the room had a wall and door that doesn't show on the building drawing plans. This wall and door were added without going through the Office of Plans and Construction. The walls do not appear to be properly rated for the use including the stairwell wall. No documentation for approval by the Agency for Health Care Administration (AHCA) Office of Plans and Construction (OPC) was provided. Based on interview of the Maintenance Director no documentation to substantiate the installation had been reviewed or that plans were approved for the installation of these changes. No additional paperwork was provided at the time of exit from the facility. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of document review and at the exit conference on 01/14/2019. Class III	K1051	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. K1051 Plans submitted Prior to Work 1) The partition wall and door in the kitchen dry storage room were removed to match the approved facility floor plans. The existing walls were reviewed and are properly rated. 2) Maintenance Director completed on 1/23/2019, a review of the facility based on the approved floor plans. There are no other unidentified walls or doors were noted. 3) Maintenance Director was retrained by Corporate Director of Facility Maintenance on 1/21/2019, no health care facility construction including demolition shall be started prior to receiving written approval by office of plans and construction. 4) Maintenance Director will review monthly in QAA meeting of new or ongoing projects to ensure involvement with the Office of Plans and Construction.	

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K1051	Continued From page 6 Actual NFPA Standards: NFPA LSC 101 (2015) Chapter 19 - Chapter 4.	K1051		

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	105521	A. BUILDING **11 - MAIN FED** B. WING _____	**01/14/2019**

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AVANTE AT BOCA RATON, INC.	**1130 NW 15TH STREET** **BOCA RATON, FL 33486**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on 01/14/2019 at Avante at Boca Raton, Inc., a nursing home in Boca Raton, Florida. Avante at Boca Inc., is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012) requirements for nursing homes. Initial Plan Review: 1988/2003/2009 Existing NFPA 220 Construction Type: II (111) Number of beds: 144 Census: 78 The facility is not in substantial compliance.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building exit egress. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings included: 1. On 01/14/2019 at 1:00 PM, during the facility tour the following doors which have the	K 211	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. K211 NFPA 101 Means of Egress	2/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/2019

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 211	Continued From page 1 appearance of exit doors were not signed as required by code to state NO EXIT so as to not cause confusion in an emergency. These doors are likely to be mistaken for an exit but, lead to a patio on the 2nd floor with no means of exit to the ground level. Examples include, the 2nd floor main dining room 3 sliding glass doors and the 2nd floor restorative dining room which has 1 sliding glass door. 2. On 01/14/2019 at 11:00 AM, during the facility tour the 2nd floor corridor fire doors hardware was found damaged, and did not function as required by code. Based on interview at these same times, the Maintenance Director acknowledged that the required signage was not posted as required by code and the fire door hardware was not functional. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 01/14/2019. Actual NFPA Standards: NFPA LSC 101 (2012) 4.5.3.2, 7.2.1.15, 7.3.2.2., 19.1.1.3.2 and 7.10.8.1 NO EXIT.	K 211	1) On 1/21/2019 Proper signage stating NO EXIT was posted on non-egress doors in main dining room and restorative dining room that lead to a patio. On 1/18/2019 the 2nd floor corridor fire doors damaged hardware was inspected and found to not be repairable. A proposal from an independent door company to replace the fire doors was received. On 1/21/19 the payment was made. The door company is to complete the install of new fire doors by 2/8/2019. 2) Maintenance Director completed an audit of facility non-egress doors for proper signage. No other doors located without proper signage. Audit was completed by the Maintenance Director on the other facility fire doors. No other fire doors hardware was found to not be functional. 3) Maintenance Director was retrained by Corporate Director of Facility Maintenance on proper signage of non-egress doors as No Exit and on proper functioning of fire doors hard door on 1/21/2019. 4) Audits will be completed on fire doors for properly functioning hardware and non-egress doors for proper signage weekly for four weeks and monthly for 2 months and reviewed with QA team. Monthly checks will continue no fire doors as preventative maintenance.	

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building doors. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings included: On 01/14/2019 at 10:00 AM, during the facility tour the following doors were found damaged and not maintained. The kitchen pot sink door frame is rusted and not attached to the wall. The dry storage room is missing the door. Based on interview at this time the Maintenance Director acknowledged that the doors are not maintained. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit	K 761	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. K 761 Maintenance, Inspection & Testing Doors 1) On 1/18 /2019 the damaged doors and missing door were inspected and unable to be repaired and will be replaced. On 1/21/19 the payment was made. The door company is to complete the install of new smoke doors by 2/8/2019. 2) On 1/18/2019 the other corridor	2/8/19

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K 761	Continued From page 3 conference on 01/14/2019. Actual NFPA Standards: NFPA LSC 101 (2012) 4.5.3.2, 7.2.1.15, 7.3.2.2., 19.1.1.3.2.	K 761	smoke doors were inspected and repaired. Those unable to be repaired will be replaced. A proposal from an independent door company to replace the unrepairable smoke doors was received. On 1/21/19 the payment was made. The door company is to complete the install of new smoke doors by 2/8/2019. 3) Maintenance Director was retrained by Corporate Director of Facility Maintenance on proper functioning of smoke doors on 1/21/2019. 4) Audits will be completed on corridor smoke doors for proper function weekly for four weeks and monthly for 2 months and reviewed with QA team. Monthly checks will continue on corridor smoke doors as preventative maintenance.	

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E 000	Initial Comments During the Fire & Life Safety Recertification survey conducted on 01/14/2019 at Avante at Boca Raton, Inc., a nursing home, Emergency Preparedness Program was reviewed. Avante at Boca Inc., is not in compliance with the Emergency Preparedness rule per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities. The following is a description of the deficiency.	E 000		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact	E 009		2/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105521	A. BUILDING _____ B. WING _____	01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

(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 009	Continued From page 1 the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the Administrator, the facility failed to develop emergency preparedness procedures to include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' and efforts to maintain an integrated response during a disaster or emergency situation in accordance with CFR 483.73. Failure to have documented cooperation and collaboration will result in delays with assistance from emergency preparedness authorities. The findings included: On 01/14/2019 at 4:00 PM review of the emergency plan procedures with the Administrator revealed that the plan did not include a procedure for cooperation and collaboration. The plan further failed to show the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Interview with the Administrator who acknowledged that the documentation requested was not available in the facility emergency plan. The findings were further acknowledged by the administrator at the exit conference on 01/14/2019.	E 009	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. E 009 Local, State, Tribal collaboration 1) 1/22/19 Maintenance Director contacted Palm Beach Emergency Management Officer and Florida Division of Emergency Management creating the call log ensuring the collaboration occurred. Direct phone numbers were received and placed into emergency plan for use during an emergency. 2) Audit and Review of Emergency Management Plan was completed by Maintenance Director and Corporate Director of Facility Maintenance on 1/22/2019. 3) Maintenance Director was retrained by Corporate Director of Facility Maintenance on 1/21/2019 on emergency plan and the collaboration process. 4) Maintenance Director will review sections of the Emergency management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 009	Continued From page 2	E 009	plan monthly through the facility TELS system.	