| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | : 12/19/2014 APPROVED : 0938-0391 | | |
|--------------------------|---|--|--|-----|---|---------|---|--|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SLIPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN FED | | TE SURVEY MPLETED | | |
| | | 105021 | B. WING | · | | 12 | /11/2014 | | |
| NAME OF P | ROVIDER OR SUPPLIER | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| HOLLYW | OOD HILLS REHABI | LITATION CENTER, LLC | | 1 | 200 N 35TH AVE IOLLYWOOD, FL 33021 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAC | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | AULD BE | (XIS) COMPLETION DATE | | |
| K 000 | INITIAL COMMEN | rs . | к | 000 | | | | | |
| | conducted at Holly Hollywood, Florida December 11, 201 as a result of the n facility is not in cor 42 CFR Pan 485, Care Facilities. The conducted to deterwish the NFPA Life including all Chaptererence the facility as the conducted to the conducted to the conducted to the conducted to determine the conducted to | 1964/1972/1989 | A CONTRACTOR OF THE CONTRACTOR | | | | | | |
| | life safety features and generator sys indicated there are | ychiatric Hospital and shares all including fire alarm, sprinkler tems. The facility Administrator e no Fire Safety Evaluation walvers, Administration | | | | | | | |
| LABORATOR | NY DIRECTOR'S OF PROPERTY | IDEMSURPLIER REPRESENTATIVE'S SIG | NATURE | | TITLE | | (XB) DATE | | |

Any deficiency statement entire, with an advertisk (*) 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 musting homes, the findings stated above are disclosable 90 days to claim or on a report of musting homes, the findings stated above are disclosable 90 days to claim or on a plan of correction is provided. For musting homes, the above findings and plans of correction 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.

PRINTED: 12/19/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (V2) MILITIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER A BUILDING 01 - MAIN FED R WING 105021 12/11/2014 STREET ACCRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIES 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTER, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL BEGLII ATORY OR LISC IDENTIFYING INFORMATION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE PREFIX TAR TAC DESICIENCY K 000 Continued From page 1 KOOO indicated that no construction or modifications were made to the building since last year's survey which would change the original approved building blueprint plans. On the date of survey the facility was not able to provide blue prints of the facility construction. Special features of this facility include sharing the building with a Psychiatric Hospital and having a temporary emergency generator for a number of years. including last years survey. Resident room bed count check was done. Based on the findings of this survey, this facility is not in compliance with NFPA LSC (2000) Existing Life Safety Code and referenced standards and publications as mandated by the Center for Medicare and Medicaid Services. (CMS). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 K-012- Life Safety Code Standard- fire wall 01/11/2015 senarations SS=F Building construction type and height meets one 1. Fire stopping materials (3M) will be reapplied of the following. 19.1,6,2, 19.1,6,3, 19.1,6,4, in strict accordance with the appropriate tested 19351 UL penetration detail to all areas where improper fire stop penetrations were observed. The UL tested detail used for each penetration will also be available for review to inspect how the 3M product has been used in strict This STANDARD is not met as evidenced by: accordance with the UL tested detail. Photos Based on observation, written document review. are attached.) and staff interview, the facility failed to maintain 2. The Director of Engineering/ designee will the building fire wall separations. This deficient conduct environmental rounds to assess all practice affects all smoke compartments, staff, smoke berriers for similar concerns visitors and all residents. The facility has the

the census was 134.

capacity for 152 beds and at the time of survey

semi-annually

3. A preventive maintenance schedule will be

implemented to ensure that all ceiling and wall penetrations are sealed with fire rated caulking.

PRINTED: 12/19/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED EDENTIFICATION NUMBER A RUILDING 01 - MAIN FED R WING 12/11/2014 105024 STREET ADDRESS CITY STATE 719 CODE NAME OF PROVIDER OR SUPPLIES 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTER, LLC HOLLYWOOD, FL 33021 PROMPER'S PLAN OF CORRECTION CUMMARY STATEMENT OF DEFICIENCIES COMPLETION (D (X4) ID JEACH CORRECTIVE ACTION SHOULD BE FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREEIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION TAG DESIGNEDATA 01/11/2015 K 012 4. All findings will be reported by the K 012 : Continued From page 2 Maintenance Director or his designee to the Quality Assurance committee on its On December 10-11, 2014 between 8:30 a.m. monthly meeting and will be monitored by and 4 n.m., accompanied by the Maintenance the QA committee for the next three Director during the observation tour it was noted months, and semi-annually thereafter. that there were improper and/or unsealed fire-stop penetrations observed. Examples 5. The Administrator / designee will include but are not limited to the following: conduct quarterly and semi-annual rounds (1) In at least 2-6 areas where piping through the fire wall, fire-stop material occurred in the fire walls above fire doors in fire compartment division walls. (2) In a least 4 areas where piping through the fire wall fire-stop material occurred in the air handler room number 1 fire wall (3) In at least 2 areas where piping through the fire wall, fire-stop material occurred in the fire wall above the communications room (4) In at least 6 areas where piping through the fire wall, fire-stop material occurred in the flammable liquid storage room fire wall. (5) In at least 3 areas where piping through the fire wall, fire-stop material occurred in the main electrical room fire wall. Improper fire stopping voids a fire barrier rating and is considered a zero hour rating. An interview with the maintenance director at the time of observation(s) revealed he could not produce any type of documentation showing the

fire stopping was installed per the manufactures specifications for the fire walls. No documentation of meeting manufacture specifications, UL or nationally recognized products to seal the hole penetrations to the

PRINTED: 12/19/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MINITIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER A BUILDING DI . MAIN FED 105021 B WING 12/11/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTER, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID (KS) COMPLETION PREFIX FACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY K 012 | Continued From page 3 K 012 required fire barrier ratings were provided. No additional written documentation to support the fire rated protection by fire-stopping of the fire-stop penetrations was provided at the time of The census was verified by the Administrator. The findings were acknowledged by the Administrator and was verified by the Maintenance Director at the time of observation and at the exit conference on December 11. 2014 Actual NEPA Standards NEPA LSC 101 (2000) 19.1.6., 8.2.3.2.4.2. 8.2.4.4, and 8.3.6 - Penetration opening protection, NFPA LSC 101 (2000) 19-3.7 and 4.6.9 Conditions for occupancy. NFPA 101 LSC (2000) 8.2.3.2.4.2 requires nines, conduits, bus ducts, cables wires, air ducts, pneumatic tubes and ducts, and similar building service that pass through fire barriers shall be protected ... need documentation of meeting NFPA 251 standard methods of tests of fire endurance of building construction and materials, as part of a rated assembly. Protection is to be by an approved through penetration system that has been tested in accordance with ASTM E 814. Methods for fire tests of through-penetration fire stops. NFPA 1 (2000) 7-1.1 The authority having jurisdiction shall have the authority to require that shop drawings for all fire protection systems be submitted for review, and approval and permit be issued for installation, rehabilitation, or modification, K 015 NFPA 101 LIFE SAFETY CODE STANDARD K 015 K-015-NFPA 101- LSC -flame spread rating 01/11/2015

FORM CMS-2587(02-89) Previous Versions Obsolete

Interior finish for rooms and spaces not used for

SSEF

Event ID: 269C21

Facility ID: 100911

(Continued)

If continuation sheet Page 4 of 14

| | DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | FORM / | 12/19/2014 APPROVED 0938-0391 |
|--------------------------|--|---|--|-----|--|-------------------|-------------------------------------|
| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CL(A IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN FED | (X3) DATE COME | SURVEY |
| | | 105021 | B. WING | · | | 12/1 | 1/2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HOLLYW | OOD HILLS REHABII | LITATION CENTER, LLC | | l l | 200 N 36TH AVE HOLLYWOOD, FL 33021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAC | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | 38 | COMPLETION DATE |
| K 015 | surfaces of building walls, partitions, co flame spread rating fully sprinklered bu Class A, Class B, c | is, including exposed interior is such as fixed or movable furms, and ceilings, has a i of Class A or Class B. (In lidings, flame spread rating of r Class C may be continued in eparated in accordance with | K | 015 | The closet doors, 36 out of 39 rooms in the sec floor, will be removed and a self-content wardrobe will be installed inside the risk wardrobe will be installed inside the risk. | ond ined | 01/11/2015 |
| | Based on observa facility failed to mai for various interior deficient practice a compartments, sta The facility has the | is not met as evidenced by: tion and staff interview, the intain the flame spread ratings finishes in the facility. This flects all smoke ff, visitors and all residents, capacity for 152 beds and at the census was 134. | | | | | |
| | and 4 p.m., accom Director during the that the facility has type doors on the r closets were noted rooms on the first on the second floo documentation of t not produced by th interior finish's that flame spread rating toxic smoke, quick occupants in the er | e: 11, 2014 between 8:30 a.m. paried by the Maintenance observation tour it was noted un-rated plastic folding panel seldent room closets. The in approximately 36 out of 39 foor and 21 out of 30 rooms r. When requested, written he flame spread ratings were facility. The use of un-rated do not meet the required ys could generate excessive y spread fire, and endanger vent of a fire. An interview was me with the Maintenance | THE REAL PROPERTY OF THE PROPE | | | | |

| CENTER | S FOR MEDICARE | & MEDICAID SERVICES | | | OMB | NO. | 0938-0391 |
|--------------------------|--|--|--------------------|--------------|---|---|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION (X3 | 030 DATE SURVEY COMPLETED 12/11/2014 12/11/2014 12/11/2014 12/11/2014 0014 0014 0014 0017 001/11/20 | |
| | | 105021 | B. WING | | | TOMPLETED 12/11/2014 N SE COMPLETED N SE COMPLETED OFFICE OFFICE | |
| | OVIDER OR SUPPLIER OOD HILLS REHABII | LITATION CENTER, LLC | | 12 | REET ADDRESS, CITY, STATE, ZIP CODE 100 N 35TH AVE DLLYWOOD, FL 33021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEPICIENCY) | Œ | (XS) COMPLETION DATE |
| K018 SS≃F | not produce documerating. The census was very the findings were a Administrator and Director at the time conference on Dec Actual NFPA Stand NFPA Stand NFPA LSD 101 (20 requires compliance Section 10.2 Interior NFPA 101 LET S | widedged that the facility could entation of the flame spread wrifled by the Administrator, acknowledged by the entitled by the Maintenance of observations and at the exit ember 11, 2014. ards: 00) 19.3.3.1 or 21.3.3.1, which e with the requirements of register of the properties of the register of the properties of the properties of the the state of the properties of the state of the properties of the properties propertie | | - The second | K-018- NFPA 101- LSC 2009 – Corrido Doors All the doors observed not to latch automatically and not functioning propriad the locks replaced. The other doors, including the laundry room doors, were assessed and were repaired by an outside company (Big Land Key), (Plesses see attached invoice The Director of Engineering (Maintena will regularly assess as part of a preve maintenance schedule, all fire doors differ drills, Photos are attached. The Administrator / designee will spot check all doors on a monthly basis, the quarterly thereafter, to ensure compilia | ock ince) ntive uring | 01/11/2015 |

| | | AND HUMAN SERVICES | | | | FORM A | 12/19/2014 APPROVED |
|---------------|---|--|--|-----|--|---------------------------------------|------------------------|
| | S FOR MEDICARE OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (V2) No | TiO | E CONSTRUCTION | OMB NO. 0938-0391 (X3) DATE SURVEY | |
| | F CORRECTION | IDENTIFICATION NUMBER: | | | 01 - MAIN FED | COMP | PLETED |
| | | 105021 | B. WING | _ | | 12/1 | 1/2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| HOLLYW | OOD HILLS REHABII | ITATION CENTER, LLC | | | 200 N 36TH AVE HOLLYWOOD, FL 33021 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD | | (XS) COMPLETION |
| PRÉFIX TAG | REGULATORY OR L | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF | | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | | DATE |
| K 018 | Continued From pa | ge 6 | к | 018 | | | |
| | Based on observar facility falled to mai assemblies. This of smoke compartme residents. The faci | s not met as evidenced by: tion and staff interview, the ntain the building door opening leficient practice affects all nts, staff, visitors and all lity has the capacity for 152 e of survey the census was | | | | | |
| | The findings includ | e: | | | | | |
| | and 4 p.m. accomp Director during the that when tested, v close and latch in t meet the code requisuitable to keep the not latch closed in to the door frame hithe spread of smooth | 1, 2014 between 8:30 a.m., sanied by the Maintenance observellon four it was noted arious corridor doors did not he door frame. Doors did not itsment of providing a means edoor closed. The door did the door frame and/or the door sa an opening which will allow the through the door. Some out are not limited to: | | | | | |
| | (3) Kitchen to corri | ast activity room corridor door. | | | , | | |
| | the Maintenance D witnessed that the code requirement of to keep the door of documentation to s | onducted at these times with irector who acknowledged and corridor doors did not meet the of providing a means suitable osed. No additional written support the testing of the doors lding a smoke barrier was e of exit. | And the state of t | | | | |

| CENTER | & MEDICAID SERVICES | | | OM | IB NO. 0 | 938-0391 | |
|--------------------------|--|---|-------------------|-----|---|--------------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION (01 - MAIN FED | (X3) DATE : COMPI | SURVEY LETED |
| | | 106021 | B. WING | _ | | 12/1 | 1/2014 |
| | PROVIDER OR SUPPLIER DOOD HILLS REHABI | LITATION CENTER, LLC | | | STREET AODRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL. 33021 | | |
| (X4) ID PREFIX TAG | (EACH DEPICIENC | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 8E i | (XS) COMPLETION DATE |
| | The findings were Administrator and Director at the time conference on Dec Conferenc | arified by the Administrator, acknowledged by the verified by the Maintenance of observation and at the exit tember 11, 2014. Jards: 100) 19.3.2.4 and 19.3.6.3.2, 1.1 installation and maintenance devices used to prolect devices used to prolect officers, and cellings against the smoke within, inc, or out of more, and cellings against the smoke within, inc, or out of the provided bits for keeping the door AFETY CODE STANDARD its prinkler systems are tained in reliable operating inspected and tested 7.8, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by; alton, and staff interview, the aintain the bullding automatic mit to code requirements. This affects all smoke first size of 152 beds and at the census was 134. | K | 016 | 2 K-062- NFPA 101 Life Safety Stand automatic fire sprinkler system. The closet doors, including the she the rod, will be removed. A sell-contained wardrobe will be inside the niche. When this work is completed, the wardrobes will not a sprinklering in accordance with CM C letter #5-38. (Please see attache and photo). | of and nestalled require | 02/11/2015 |

| OCITIEIL | O T OIL MEDIONIC | O MICEIONID OCITIOCO | | - | | | _ |
|--------------------------|--|--|-------------|-----|--|--|--------------------|
| STATEMENT OF | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN FED | (X3) DATE COMP | \$URVEY LETED |
| | | 105021 | B. WING | | | 12/1 | 1/2014 |
| | ROVIDER OR SUPPLIER OOD HILLS REHABI | LITATION GENTER, LLC | | 1 | reet address, city, state, zip code 200 n 35th ave Ollywood, FL 33021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE : | COMPLETION DATE |
| | Director during the that in 36 out of 3 21 out of 30 rooms no automatic increase and a second conducted at this tier resident room clos conducted at this tier resident room clos conducted at this tier code requirements. The census was withe findings were and birector at the time conference on Developer and Director at the time conference on Developer and Director at the time. NFPA 15an. NFPA 15an. NFPA 15an. NFPA 15an. NFPA 15an 115E S. Medical gas atoray protected in according to the conference on Developer and Deve | panied by the Maintenance observation four it was noted 9 rooms on the first floor and on the second floor, there is prinkler protection in the ets. An interview was me with the Maintenance owiedged that the fire sprinkler stated, as per manufacture and the exit per stated to the stated of the stated that th | к | 076 | K-076- NFPA 101- Life Safety Stand medical gases. Plastic covers found covering the E oxygen cylinder in the oxygen cart w removed. E sized oxygen cylinders found to be and freestanding were all taken out the maintenance shop and stored at secured in the oxygen storage room first and second floors. There will more than 3,000 cu. Ft. of oxygen as in these rooms because an E cylind holds 25 cu. Ft. of oxygen and the fi | size vere e loose from nd as in the ever be torage er only | |

PRINTED: 12/19/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (Y2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A RUN DING OF . MAIN FED 105024 R WING 12/11/2014 STREET ADDRESS CITY STATE ZIP CODE NAME OF BROWNER OR SUPPLIES 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTER, LLC HOLLYWOOD EL 33021 PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX YAG SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) TAG DERICHENCY K 076 Continued From page 9 Environmental rounds will include 01/11/2015 observing for any other oxygen cylinder not properly stored and secured, by the Director of Engineering. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store medical gases. This Findings of these rounds will be part of a report from the Director of Engineering to deficient practice affects all smoke the OA committee on a monthly basis. compartments, staff, visitors and all residents. and to be monitored for the next three The facility has the capacity for 152 bads and at months by the QA committee members. the time of survey the census was 134. The findings include: 1, On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was observed that: in at least 3 areas where crash type cart's with an E sized oxygen cylinder were found to have a plastic cover, which completely covered the oxygen. An interview was conducted at this time with the Maintenance Director who acknowledged that the oxygen was improperly stored 2. On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was observed that: in the maintenance shop area at least 11 E sized oxygen cylinders were found to be loose and freestanding. An interview was conducted at this time with the Maintenance Director who acknowledged that the oxygen was improperly stored.

The census was verified by the Administrator. The findings were acknowledged by the Administrator and verified by the Maintenance Director the time of observations and at the exit conference on December 11, 2014.

PRINTED: 12/19/2014 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | O | MB NO. 0 | 938-0391 | |
|--|------------------------|---|---|-------------|-----|--|----------------------|--------------------|
| STAT | EMENT O | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION 1 - MAIN FED | (X3) DATE S COMPL | SURVEY |
| | | | 105021 | B. WING | | | 12/11 | 1/2014 |
| | | ROVIDER OR SUPPLIER DOD HILLS REHABI | LITATION CENTER, LLC | | 12 | REET ADDRESS, CITY, STATE, ZIP CODE 80 N 35TH AVE DLLYWOOD, FL 33021 | | |
| PF | (4) ID REFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | PREP TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | 38 i | GOMPLETION DATE |
| and the second s | | oxygen cylinder sh material such as h NFPA 99 (1999) 4- and containers. N requires a precaut 5.1.13.5.2 requires segregated from fi full cylinders were (1999) 4-3.5.2.1 re Liquefied Gases ir shall be attached to | | | 076 | | | |
| | K 106 SS=F | or supported in a NFPA 101 LIFE S. Hospitals, and nu- life support equipr Electrical System transfer switch an | oroper cylinder stand or cart. AFETY CODE STANDARD sign homes and hospices with ment, have a Type I Essential powered by a generator with a d separate power supply. The nce with NFPA 99, 3.4.2.2, | K | 106 | K-106- NFPA 101- Life Safety star emergency generator. An outside company was called in the panel working on the remote generator alarm. The company will come out to hot to the portable generator. | to get | 01/11/2015 |
| | | Based on observed facility failed to manufacture and deficient practice compartments, store facility has the | is not met as evidenced by: ation and staff interview, the aintain the emergency generato nd code requirements. This affects all smoke aff, visitors and all residents. e capacity for 152 beds and at the census was 134. | 7 | | | | |

PRINTED: 12/19/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED 105021 a wind 12/11/2014 HAVE OF PROVINCE OF STIRELIES STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 26TH AVE HOLLYWOOD HILLS REHABILITATION CENTER, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SHIMMARY STATEMENT OF DESICIENCIES (X5) COMPLETION DATE (X4) ID PREFIX 10 (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATIONS TAG DEFICIENCY K 106 | Continued From page 11 K 106 The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 n.m. accompanied by the Maintenance Director during the observation tour it was noted that when tested, the remote generator alarm located near the nurses ' station failed to function. An interview was conducted at this time with the Maintenance Director who acknowledged that the remote alarm was not functional. If not maintained, the emergency generator may fail without staff being aware of the generator malfunction. No additional written documentation to substantiate compliance was received at the evit conference The census was verified by the Administrator. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on December 11, 2014 Actual NEDA Standards NFPA LSC 101 (2000) 4.5.6. System design and installation, NFPA 99 (1999) 3-4,1,1 and NFPA 110 (1999) 3-5.5.2 require and NFPA 99 (2000) 3-4.1.15 Alarm Annunciation. Code requires a remote annunciator, storage battery powered. shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station ... K 211 NEPA 101 LIFE SAFETY CODE STANDARD K 211 K-211-NFPA 101- alcohol-based hand-rub |01/11/2015 SS=F dispenser Where Alcohol Based Hand Rub (ABHR)

dispensers are installed in a corridor:

o The maximum individual fluid dispenser

o The corridor is at least 6 feet wide

The alcohol-based hand-rub dispensers

observed to be installed directly over or

adjacent to the electrical switches were all

| CENT | ERS FOR MEDICAR | E & MEDICAID SERVICES | | | Olino | 3040 555 |
|-----------------------|--|--|--|---|---|----------------------------|
| STATEME | ENT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION IG 01 - MAIN FED | (X3) DATI | E SURVEY PLETED |
| | | 105021 | B. WING_ | | | 11/2014 |
| | OF PROVIDER OR SUPPLIE YWOOD HILLS REHAI | R BILITATION CENTER, LLC | | STREET ADDRESS, CITY, STATE, ZIF 1200 N 35TH AVE HOLLYWOOD, FL 33021 | CODE | |
| (X4) I PREF TAG | IX (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL B LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| K 2 | rooms) o The dispensers from each other o Not more than smoke compart o Dispensers are an ignition sourc o if the floor is of sprinklered. 1 460.72, 482.41, | 1.2 liters (2 liters in suites of shave a minimum spacing of 4 ft 10 gallons are used in a single nent outside a storage cabinet. en to int saidled over or adjacent to e, specific control of the said over or adjacent to e, specific control of the said over the building is fully 9.3.2.7, CFR 403.744, 418.100, 483.70, 483.823, 485.623 | К2 | All other dispensers found adjacent to ignition source out and installed away fro source. The Director of Engineeric rounds to ensure compilar | es will be taken in any ignition ing will conduct | 01/11/2015 |
| | Based on obset facility failed to p following the rec hand-rub disper incorrectly install and occupants. |) is not met as evidenced by valion and slift interview, the property install dispensers julierments for Alcohol-based seer installation. Dispensers led may endanger staff, visitors The facility has the capacity for the time of survey the census lude: | And the state of t | | | |
| | and 4 p.m., acc Director during that: throughout Alcohol-based I installed directly ignition sources acknowledged Alcohol-based | 0-11, 2014 between 8:30 a.m. ompanied by the Maintenance the observation tour it was noted the facility, in resident room, and-rub dispensers were over or adjacent to electrical . The Maintenance Director he facility had installed and-rub dispensers directly over lectrical ignition sources. | | | | |

| AND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING 01 - MAIN FED | |
|--|----------------------|
| NAME OF PROVIDER OR SUPPLIER HOLLYWOOD HILLS REHABILITATION CENTER, LLC 1200 N 38TH AVE 1200 N 38TH AVE | re survey Apleted |
| HOLLYWOOD HILLS REHABILITATION CENTER, LLC 1200 N 3 STH AVE | /11/2014 |
| HOLLYWOOD HILLS REHABILITATION CENTER, LLC MOLLYWOOD, FL 33024 | |
| REGULATORY OR LSC IDENTIFYING INFORMATION) K 211 Continued From page 13 The census was verified by the Administrator. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on December 11, 2014. Actual NFPA Standards: NFPA LSC 101 (2000) 18.32.7, CFR 403.744, 418.100, 480.72, 482.41, 483.70, 483.623, 485.623. Disponsers shall not be installed over | |
| The census was verified by the Administrator. The findings were acknowledged by the Administrator and verified by the Malhienance Director at the time of observation and at the exit conference on December 11, 2014. Actual NFPA Standards: NFPA LSC 101 (2000) 19.3.2.7, CFR 403.744, 418.100, 480.72, 482.41, 483.70, 483.623, 495.623. Disponsers shall not be installed over | COMPLETION DATE |
| | |

| STATEMEN AND PLAN | for Health Care Adm IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: 0. | CONSTRUCTION 2 - MAIN LIC | COME | SURVEY LETED |
|----------------------|---|---|----------------------------------|---|--------------------------|--|
| | | 100611 | B. WING | | 12/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| HOLLYW | OOD HILLS REHAB | | ISTH AVE VOOD, FL 3302 | 24 | | |
| (X4) ID | CI MANADY ST | ATEMENT OF DEFICIENCIES | PROVIDER'S PLAN OF | | RECTION | (X5) |
| PREFIX TAG | · (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE APPROPRIATE | COMPLETE DATE |
| K 000 | Initial Comments | | K 000 | | | |
| | State Licensure K 3 Building: 0101 K 6 Plan Approval K 7 Survey Under K 8 SNF/NF | : 1964/1973/1979 | | | | |
| | December 10-11, Hollywood Hills R | vey was conducted on 2014. ehabilitation Center had noies found at the time of the | | | | A planta la constitución de la c |
| | Licensure survey compliance with I 101 (2009) Chapt requirements add applicable Florida Regulations, 69 A | annual fire and Life Safety Sta was conducted to determine FIFPA Life Safety Code (LSC) ler 2; all NFPA mandatory pited per NFPA 101, and state Fire Marshal's Rules an 43.012; 69 A-53; FS 633.022, da Building Code. | | | | STATE OF THE STATE |
| | with a building ch Building may be a story, 152 bed nu compartments. I include a comple a complete autor temporary emerg connected to a P life safety feature | ed was built or licensed in 196 anges in 1972 and 1989. of Type II (111) construction. to trising home and has (10) smot building features and protection to supervised fire alarm system matching sychiatric Hospital and shares sincluding fire alarm, sprinkle | roce n, n, aa is | | | |
| | indicated there a System (FSES) of indicated that no were made to the which would chat building blueprin | stems, The facility administrate re no Fire Safety Evaluation or waivers. Administration construction or modifications publiding since lest year's survinge the original approved t plans. On the date of survey of able to provide blue prints of the safety | rey | | | |
| AHCA For | m 3020-0001 PRY DIRECTOR'S OR PRO | ANDERSON PROPRESENTATIVE'S | SIGNATURE | Administrator | | (X6) DATE 12/3/120 |

| SATESUARY OF DEPICEMENTS AND PLAN OF CORRECTION STREET ADDRESS. CITY, STATE, ZP CODE 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTE SAMMARY STATEMENT OF DEFICIENCES [EXAMARY STATEMENT OF DEFICIENCES] [EXAMINED OF CORRECTION OF CONSTRUCTION OF CROSS-REPERSPONT OF CONSTRUCT | | or Health Care Adm | inistration | | | WW DATE C | OWEV |
|--|------------|------------------------|---------------------------------|----------------|-------------------------------------|---------------------|------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE 120 N 35TH AVE MOLLYWOOD HILLS REHABILITATION CENTE! SAMAMAY STATEMENT OF DEFICIENCES PREFIX TAG SAMAMAY STATEMENT OF DEFICIENCES (CACH DEPICIENCY MANY BE PRECEDED BY FILL TAG REGULATORY OR LSC DEATH-PING MFORMATION) K 000 Continued From page 1 the facility construction. Special features of this facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including least years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as k tags as result of these areas of non-compliance: K 013 NFPA 101 - LSC 2009 Construction Type SSS=F (Existing) The structure meets the Standards for EXISTING construction for type and helphi, if built before 12/3/11. MFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by, Based on observation, written document review, and staff inherview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | COMPLI | ETED |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTE! O(N) ID PREFIX EXAMARY STATEMENT OF DEFICIENCES (EXAMARY STATEMENT OF DEFICIENCES) (EXAMINE OF THE OUTCOMES OF THAT OF CORRECTION OF CORRECTION OF CORSELANCES (EXAMINE OF THE OUTCOMES OF THAT OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF T | AND PLAN C | IF GURRECTION | JUEN IFJURION NUMBER: | A. BUILDING: | DZ - MAIN LIC | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 1200 N 35TH AVE HOLLYWOOD HILLS REHABILITATION CENTE! O(N) ID PREFIX EXAMARY STATEMENT OF DEFICIENCES (EXAMARY STATEMENT OF DEFICIENCES) (EXAMINE OF THE OUTCOMES OF THAT OF CORRECTION OF CORRECTION OF CORSELANCES (EXAMINE OF THE OUTCOMES OF THAT OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF THE OUTCOMES OF THAT OUTCOMES OF THE OUTCOMES OF T | | | | 1 | | | - 1 |
| HOLLYWOOD HILLS REHABILITATION CENTE: AND D SUMMARY STATEMENT OF DEFICIENCIES ELOCAN DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG. | | | 100611 | B. WING | | 12/11 | /2014 |
| HOLLYWOOD HILLS REHABILITATION CENTE: AND D SUMMARY STATEMENT OF DEFICIENCIES ELOCAN DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG. | | | L | | | | |
| HOLLYWOOD HILLS REHABILITATION CENTER AND LYWOOD FILES A CONTINUED TO PERCEIVED BY FILE. FROM DEPOSITION SHOULD BE CONTINUED FOR THE PROPERTY OF THE PROPERY | NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, 8 | TATE, ZIP CODE | | 1 |
| MAIL SUMMARY STATEMENT OF DEFICIENCES COURT CO | | | 1200 N 35 | TH AVE | | | |
| PREFIX TAG REGULATORY OR LSC DEATHPHING INFORMATION) K 000 Continued From page 1 the facility construction. Special features of this facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including least years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliances: K 013 NFPA 101 L SC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 123/111. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff inherview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | HOLLYW | DOD HILLS REHABI | LITATION CENTER HOLLYWI | OOD, FL 330 | 21 | | |
| PREFIX TAG REGULATORY OR LSC DEATHPHING INFORMATION) K 000 Continued From page 1 the facility construction. Special features of this facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including least years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliances: K 013 NFPA 101 L SC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 123/111. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff inherview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | OURSELS DV CT | AZENTANT OF DESIGNATED | 10 | PROVIDER'S PLAN OF CORRECTE | ON : | 0(5) |
| K 000 Continued From page 1 the facility construction. Special features of this facility include sharing the building with Psychiatric Nospital and having a temporary emergency generator for a number of years including last years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tage as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 12/3/1/1. NFPA 101 Life Safety Code (2009) 19.1.6.1. This statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire well separations. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation turn twas noted that there were improper and/or unsealed | PREFIX | | | | (EACH CORRECTIVE ACTION SHOUL | DBE | COMPLETE |
| the facility construction. Special features of this facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including last years survey. Resident room bed court check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and height, if built before 12/31/11. MFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | | CROSS-REFERENCED TO THE APPROI | PRIATE | DATE |
| the facility construction. Special features of this facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including last years survey. Resident room bed court check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and helght, if built before 12/3/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | | DEFICIENCY) | | |
| the facility construction. Special features of this facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including last years survey. Resident room bed court check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 12/3/11/1. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation but it was noted that there were improper and/or unsealed | K 000 | Cantinuad Esom as | nno 1 | K 000 | | | |
| facility include sharing the building with Psychiatric Hospital and having a temporary emergency generator for a number of years including last years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101- LSC 2009 Construction Type SSB=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 12/3/11, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for it was noted that there were improper and/or unsealed | 1,000 | | | | | 1 | |
| Psychiatric Nospital and having a temporary emergency generator for a number of years including last years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPALSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This statute or Rule is not met as evidenced by, Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for twas noted that there were improper and/or unsealed | t | the facility construct | ction. Special features of this | | | | |
| mergency generator for a number of years including last years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101- LSC 2009 Construction Type SSB=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 123/111, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by. Based on observation, written document review, and staff inherview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation to riv was noted that there were improper and/or unsealed | , | facility include shar | ring the building with | 1 | | | 1 |
| including last years survey. Resident room bed count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliances: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and height, if built before 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This statute or Rule is not met as avidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tor it was noted that there were improper and/or unsealed | | Psychiatric Hospita | al and having a temporary | 1 | | Ì | - 1 |
| count check was done. Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101- LSC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 123/111, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff inherview, the facility failed to maintain the building fire well separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for trues noted that there were improper and/or unsealed | i | emergency general | ator for a number of years | 1 | | í | 1 |
| Based on the findings this facility is not in compliance with NFPA LSC (2009). The following deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and height, if built before 12/31/11, NFPA 101 Life Safety Code (2009) 19.1.6.1. This statute or Rule is not met as avidenced by, Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for unsealed | 1 | including last years | s survey. Resident room bed | i | | - 1 | - 1 |
| compliance with NFPA LSC (2009). The following deficiencies were clied as K tags as result of these areas of non-compliance: K 013 NFPA 101- LSC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 12/31/11, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation turn twas noted that there were improper and/or unsealed | | count check was d | ione. | 1 | | | - 1 |
| compliance with NFPA LSC (2009). The following deficiencies were clied as K tags as result of these areas of non-compliance: K 013 NFPA 101- LSC 2009 Construction Type SS=F (Existing) The structure meets the Stendards for EXISTING construction for type and height, if built before 12/31/11, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation turn twas noted that there were improper and/or unsealed | 1 | | | 1 | | | 1 |
| deficiencies were cited as K tags as result of these areas of non-compliance: K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and height, if built before 12/31/11. MFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation turt was noted that there were improper and/or unsealed | - | Based on the findi | nas this facility is not in | 1 | | | - 1 |
| these areas of non-compliance: K 013 NFPA 101- LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and height, if built before 12/31/11, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as avidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility flate to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility flate to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility flate to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility flate to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility flate to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | compliance with N | IFPA LSC (2009). The following | i | | | 1 |
| K 013 NFPA 101-LSC 2009 Construction Type SS=F (Existing) The structure meets the Standards for EXISTING construction for type and height, if built before 123/111. MFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | | | 1 | | | 1 | |
| Type Trype The structure meets the Stendards for EXISTING construction for type and height, if built before 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by, Based on observation, written document review, and staff interview, the facility failed to maintain the building fire well separations. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for it was noted that there were improper and/or unsealed | | these areas of nor | n-compliance; | 1 | | | . 1 |
| Type Trype The structure meets the Stendards for EXISTING construction for type and height, if built before 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by, Based on observation, written document review, and staff interview, the facility failed to maintain the building fire well separations. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for it was noted that there were improper and/or unsealed | | | • | 1 | | | |
| Type Trype The structure meets the Stendards for EXISTING construction for type and height, if built before 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by, Based on observation, written document review, and staff interview, the facility failed to maintain the building fire well separations. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation for it was noted that there were improper and/or unsealed | K 043 | NEDA 101. I SC 2 | 009 Construction Type | K 013 | K-013-NEPA 101-J SC 2009 Cons | truction | 01/11/2015 |
| The structure meets the Standards for EXISTING construction for type and height, if built before 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility fallest for maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | | | oos construction type | 1 | | | |
| construction for type and height, if built before 123/111, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The fedicient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation bur it was noted that there were improper and/or unsealed | | (Existing) | | | Туре | | 1 |
| construction for type and height, if built before 123/111, NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The fedicient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation bur it was noted that there were improper and/or unsealed | | The etructure mee | ate the Standards for FXISTING | | 1 Fire etopoing materials (3M) Wi | ll be | |
| 12/31/11. NFPA 101 Life Safety Code (2009) 19.1.6.1. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | | | | 1 | reapplied in strict accordance with | the | |
| If a lareas where improper fire stop penetrations were observed. The UL tested detail used for each penetration will also be available for review to inspect how the 3M product has been used in strict accordance with the UL tested detail. (Photos are attached. This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. The deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation bour it was noted that there were improper and/or unsealed | | | | 1 | engraphed in strict accordance in | detail to | |
| penetrations were observed. The UL tested detail used for each penetration will also be available for review to inspect how the 3M product has been used in strict accordance with the UL tested detail. (Photos are attached. Based on observation, written document review, and staff interview, the facility falled to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | O) Life Galety Code (2009) | 1 | appropriate tested of period atom | detail to | 1 |
| iested detail used for each penetration will also be available for review to inspect how the 3M product has been used in strict accordance with the U.L tested detail. (Photos are attached. 2. The Director of Engineering designee will conduct environmental rounds to practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation bour it was noted that there were improper and/or unsealed | | 13. 1.0, 1. | | | all areas where improper me stop | 10 | |
| also be available for review to inspect how the 3M product has been used in strict accordance with the UL tested detail. (Photos are attached. Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | | penetrations were observed. The | orthographic | |
| This Statute or Rule is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | | | | 1 | tested detail used for each periell | auon wiii | |
| This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failest for maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | 1 | also be available for review to ins | pect now | |
| This Statute or Rule is not met as evidenced by Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | | 1 | | 1 | the 3M product has been used in | Strict | |
| Based on observation, written document review, and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | The Challeton on D. | | | | tali. | |
| and staff Interview, the facility failed to maintain the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | | | | [| (Photos are attached. | | |
| the building fire wall separations. This deficient practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | (| | | |
| practice affects all smoke compartments, staff, visitors and all residents. The facility has the capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | l | | | 1 | 2. The Director of Engineering/ di | esign ee | |
| visitors and all residents. The facility has the capacity for 152 beds and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | 1 | | | 1 |
| capacity for 152 bads and at the time of survey the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | 1 | | | i | | lar | |
| the census was 134. The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | | | | 1 | concerns. | | 1 |
| The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation bur it was noted that there were improper and/or unsealed | | | | 1 | | | |
| The findings include: On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation tour it was noted that there were improper and/or unsealed | l | the census was 1 | 34. | | 3. A preventive maintenance sch | edule will | |
| On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | 1 | The feedbase back | .da. | 1 | be implemented to ensure that all | ceiling | İ |
| On December 10-11, 2014 between 8:30 a.m. and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | 1 | i ne imaings inclu | ige; | i | | with fire | i |
| and 4 p.m., accompanied by the Maintenance Director during the observation four it was noted that there were improper and/or unsealed | l | On December 40 | 15 2014 hohuson 8:30 | į | rated caulking, semi-annually. | | 1 |
| Director during the observation tour it was noted that there were improper and/or unsealed | 1 | | | } | | | ł |
| that there were improper and/or unsealed | l | | | 1 | | | 1 |
| | | | | 1 | 1 | | 1 |
| AHCA Form 3020,0001 | 1 | that there were in | nproper anu/or unsealed | 1 | 1 | | i |
| | AHCA Form | 3020-0001 | | | | | |

| Agency f | or Health Care Adm | inistration | | | FURWI APPRO | VEO |
|--------------------------|---|--|---------------------|--|--|------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AUND PICK | OF CORRECTION | DENTINGATION NORDEN. | A. BUILDING | : 02 - MAIN LIC | Oom LEVED | |
| | | 100611 | B. WING | · | 12/11/2014 | |
| NAME OF F | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, | STATE, ZIP CODE | | |
| HOLLYW | OOD HILLS REHABI | LITATION CENTE 1200 N 35 | | | | |
| | ALAV | HOLLYWO | OD, FL 3 | | | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | REMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE COMPL | EYE |
| | include but are not (1) In at least 2-8 a division walls, fire-stop re walls above fire dod division walls. (2) In a least 4 are fire wall, fire-stop rhandler room num (3) In at least 0 are fire wall, fire-stop rabove the community (4) In at least 6 are fire wall, fire-stop rabove the community | ns observed. Examples imited to the following: reas where piping through the naterial occurred in the fire ors in fire compartment as where piping through the naterial occurred in the fire best have piping through the naterial occurred in the fire wall ications room. | K 013 | A. Alf findings will be reported by the Maintenance Director or his design the Quality Assurance committee monthly meeting and will be moith the QA committee for the next thr months, and semi-annually theres The Administrator / designee w conduct quarterly and semi-annual | nee to on its ored by se fter. | 2015 |
| | (6) In at least 3 areas where piping through the fire well, fire-stop material occurred in the main electrical room fire wall. Improper fire stopping voids a fire barrier rating and is considered a zero hour rating. An interview with the maintenance director at the time of observation(s) revealed he could not produce any type of documentation showing the fire stopping was installed per the manufactures specifications for the fire walls. No documentation of meeting manufacture specifications of the fire value for the products of the fire value of the fire rating and products to seal the hole penetrations to the required fire barrier ratings were provided. No additional written documentation to support the fire rated protection by fire-stopping of the fire-stop penetrations was provided at the time of exit. | | | | | |
| | 3020-0004 | | | | | |

STATE FORM

| Agency for Health Care Adminis STATEMENT OF DEFICIENCIES (X1 WID PLAN OF CORRECTION | (X1) PROVIDER/BUPPLIE IDENTIFICATION NU | |) MULTIPLE C | ONSTRUCTION - MAIN LIC | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|------------------------|--|---------------------|--------------------------|
| | , | 100611 | В. | WING | | 12/11/2 | 2014 |
| NAME OF PRO | OVIDER OR SUPPLIER | 1 134411 | STREET ADDRE | | TE, ZIP CODE | | |
| HOLLYWO | OD HILLS REHABI | LITATION CENTER | 1200 N 35TH HOLLYWOOD | | | | |
| (X4) ID PREFIX TAG | FACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL : | ID PRÉFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| T | The findings were Administrator and Maintenance Dires and at the exit con 2014. Class III Actual NFPA Stan NFPA 101 LSC (2 design/installation building service er or safeguard provode shall be des accordance with referenced in the documents or per be considered pa document. Includ test method for fire stops, 2002. which requires st and 4.510, which requires st and 4.6.10, which requires st and 4.6.10, which requires st and 4.6.10, which requires st and 4.2.2.2.1 required 12.3.2.1 required 13.3.2.1 required | erified by the Administ acknowledged by the was verified by the other at the time of ob- ference on December | strator, e servation er 11, system, protection, goals of this approved in standards peneral. The e and shall as of this standard speneral for meintaining speneral for speneral spe | 013 | | | |
| | to location on pro roof coverings, s properly repaired | perty, draft stops pa hall be maintained an l, restored, or replace d, breached, remove | ntitions, and nd shall be ed where | | | | 04/44/2004 |
| K 015 SS≃F | | 2009 Interior Finish | 1 | K 015 | K-015- NFPA 101 Life Safety S flame spread rating of interior fi (Continued) | tandard - nishes | 01/11/201 |

| | or Health Care Adm | (X1) PROVIDER/SUPPLIER/CLIA | (N2) MORTIES | E CONSTRUCTION | (X3) DATE | DINDVCV |
|--------------------------|---|---|---------------------|---|-----------------|--------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER | | 02 - MAIN LIC | COMP | |
| | | | | | | |
| | | 100611 | B. WING | | 12/1 | 1/2014 |
| NAME OF F | RÖVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| 1011104 | OOD HILLS REHABI | 1200 N 35 | TH AVE | | | |
| TOLL! V | OUD HILLS RENABI | HOLLYW | OOD, FL. 330 | 021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX YAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE) | DBE | (X5) COMPLETE DATE |
| K 015 | spread rating as re interior surfaces of movable partitions, | ge 4 dt ways, shall have a flame quired; including exposed bulldings, such as, fixed or columns, and ceilings. NFPA de) (2009) 18.3.3, 19.3.3 | K 015 | The closet doors, 36 out of 39 roo first floor and 21 out of 30 rooms is second floor, will be removed and -contained wardrobe will be install the niche. | n the a self | 01/11/2015 |
| | Based on observat facility failed to mai for various interior deficient practice a compartments, sta The facility has the | ff, visitors and all residents, capacity for 152 beds and at the census was 134. | | | ; | |
| | and 4 p.m., accom Director during the that the facility has type doors on the r closets were noted rooms on the first f on the second flood documentation of t not produced by thin interior finish's that flame spread rating toxic smoke, quick occupants in the ev conducted at this Director who ackno | 11, 2014 between 8.30 a.m. panied by the Maintenance observation tour it was noted un-rated plastic folding panel esident room closets. The in approximately 36 out of 39 loor and 21 out of 30 rooms. When requested, written he flame spread ratings were facility. The use of un-rated do not meet the required so could generate excessive y spread fire, and endanger vent of a fire. An Intensieve was me with the Maintenance whedged that the facility could enentation of the flame spread | | | | |
| ICA Form | The census was ve | erified by the Administrator. | <u></u> | | | |

| Agency t | or Health Care Adm | | | | | | |
|-----------|---------------------|---|--------------|----------------|--------------------------------------|-------------|------------------|
| STATEMEN | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | | | CONSTRUCTION | (X3) DATE S | URVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NU | MUSIK: | A. BUILDING: (| 22 - MAIN LIC | COMPL | |
| | | | 1 | | | i | 1 |
| | | 100611 | | B. WING | | 12/11 | 1/2014 |
| | ROVIDER OR SUPPLIER | | Avodey Las | APPRO APPLY C | TATE, ZIP CODE | | |
| NAME OF F | KONINEK OK SUPPLIEK | | | | IAI E, ZIF CODE | | 1 |
| HOLLYW | OOD HILLS REHAB! | LITATION CENTE | 1200 N 35 | | | | - |
| | | | | OD, FL 330 | | - | |
| (X4) ID · | SUMMARY STA | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY | \$ | 1D | PROVIDER'S PLAN OF CORRECTION SHOUL | DN : | (XS) COMPLETE |
| PRÉFIX | | SC IDENTIFYING INFORM | | PREFIX | CROSS REFERENCED TO THE APPROX | PRIATE | DATE |
| ,,,,,, | | | | | DEFICIENCY | 1 | |
| V 046 | A | | | K 015 | | | |
| פוטא | Continued From pa | age o | | KUID | | | |
| . ' | The findings were | acknowledged by the | | 1 | | i | 1 |
| | | verified by the Mainte | | | | | 1 |
| | | of observations and | at the exit | | | - | 1 |
| | conference on Dec | ember 11, 2014. | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Class III | | | | | | |
| | Actual NFPA Stand | tarde: | | | | | |
| | | 009) 19.3.3.1 or 21.3. | 3.1 which | | | | |
| | | e with the requireme | | | | | |
| | Section 10.2 Interi | | | | | | |
| | | -, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | |
| K 018 | NEDA 101-1 90 00 | 009 Alcohol Based H | and Rub | K 016 | K-016-NFPA 101- alcohol-based h | and-rub | 01/11/2015 |
| SS≕F | | JOS AUGITOI DEBEG 11 | and Nub | 10.0 | dispenser installation. | | 0., |
| | : Alcohol-based har | d-rub dispensers sh | all be | 1 | | | i ! |
| ļ | | dance with 8.7.3, unl | | i l | The alcohol-based hand-rub dispe | ensers | ! |
| | | itions are met: When | | 1 | observed to be installed directly or | | |
| 1 | dispensers are ins | talled in a corridor, ti | ne corridor | | adjacent to the electrical switches | were all | |
| | | num width of 6 ft; The | | 1. | removed. | | |
| i | | al dispenser fluid cap | | 1 | | | |
| | |) for dispensers in ro | | 1 | All other dispensers found directly | | |
| 1 | corridors, and are | as open to corridors; | 0.53 gal | | adjacent to ignition sources will be | | l |
| 1 | | ers in suites of rooms | | 1 | out and installed away from any ig | inition | 1 |
| | | ave a minimum horiz | | 1 | source. | | į. |
| 1 | | m each other; Not m al of alcohol-based h | | ł | The - Director of Fincoming will as | | i |
| Į. | | ial of Biconol-Dased f I use in a single smo | | ł | The Director of Engineering will co | muuci | į |
| | | i use in a single smo ilde of a storage cabi | | 1 | rounds to ensure compliance. | | |
| | | ies greater than 5 ga | | | P . | | İ |
| 1 | | ent shall meet the re- | | i | | | |
| | | mable and Combusti | | 1 | | | 1 |
| 1 | Code, The dispen | sers shall not be inst | alled within | | | | |
| 1 | | ove, to the side, or b | | | | | |
| 1 | | locations with carpe | | | | | |
| 1 | | sers installed directly | | | | | |
| İ | | shall be permitted o | | | | | i . |
| | | compartments. NFI | | 1 | 1 | | |
| 1 | Safety Code (200 | 9) 18.3.2.6 &19.3.2.6 | | | | | |
| 1 | 4.5 | | | \$ | 1 | | 1 |

AHCA Farm 3020-0001

| Agency for Health Care Ad | ministration | | | | |
|---|---|--|--|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: 0 | CONSTRUCTION 12 - MAIN LIC | (X3) DATE SURVEY COMPLETED | |
| | 100611 | B. WING | | 12/11/2014 | |
| NAME OF PROVIDER OR SUPPLIE HOLLYWOOD HILLS REHAE | ULITATION CENTE: 1200 N 3 | DDRESS, CITY, S' ISTH AVE VOOD, FL 330 | | | |
| PREFIX : (EACH DEFICIEN | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LO BE COMPLETE | |
| K 016: Continued From | page 6 | K 016 | | | |
| Based on observing facility faled to predict for following the requestion of the fale fale fale fale fale fale fale fal | 11. 2014 between 8:30 a m. mpanied by the Maintenance e observation tour it was noted be facility, in esticient rooms, not-rub dispensers were rever or adjacent to electrical. The Maintenance Director facility had installed nd-rub dispensers directly over circial ignition sources, verified by the Administrator, acknowledged by the verified by the Maintenance el of observation and at the exit comber 11, 2014. | | | | |

| Agency f | or Health Care Adm | inistration | | | .,,, | | |
|--|--|---------------------------|-----------------------------------|-----------------------------------|--------------------------------------|-------------|------------|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | | E CONSTRUCTION | (X3) DATE S | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUI | warsc | A. BUILDING: | 02 - MAIN LIC | SOME | 2.100 |
| | | | | | | | i |
| | | 100611 | | B. WING | | 12/1 | 1/2014 |
| | | 100011 | | | | | |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET ADD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | | 1200 N 35 | TH AVE | | | 1 |
| HOLLYW | OOD HILLS REHABI | LITATION CENTER | HOLLYWO | OOD, FL 330 | 21 | | |
| 240.15 | DI ILIMADO OTA | ATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTI | 'N | (X5) |
| (X4) ID : PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY | FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | DBE | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMA | (TION) | TAG | CROSS-REFERENCED TO THE APPRO | PRIATE | DATE |
| | | | | | DEFICIENCY) | | |
| K 018 | Continued From pr | 200.7 | | K 018 | | | |
| KOIO | Continued From page 7 | | | | _ | | |
| | NFPA 101- LSC 20 | 09 Corridor Doors | | K 018 | K-018- NFPA 101- LSC 2009 Co | rridor | 01/11/2015 |
| SS=F | | | | ĺ | Doors | | |
| | Corridor doors sha | II be 1 3/4 inch solid I | conded | ł | | | |
| | wood core doors or they shall have a 20 minute | | | 1 | All the doors observed not to latch | | |
| | fire resistive rating (Existing only). If the building | | building | ĺ | automatically and not functioning | properly | |
| | | ment is fully sprinkler | | 1 | had the locks replaced. | | |
| | door shall only resist the passage of smoke. There shall be no impediment to the closing of the door, and latching devices shall be provided | | | 1 | | | |
| | | | | 1 | The other doors, including the lau | | |
| | | | | | room doors, were assessed and v | rere | |
| | which keep the door tightly closed in the frame. For NEW doors, roller latches are prohibited. | | i | repaired by an outside company (| Big Lock | | |
| | | | 1 | and Key). (Please see attached in | voice) | | |
| NFPA 101 Life Safety Code (2009), 18,3,6,3 & 19,3,6,3. | | i | ļ ,, , | | | | |
| | | i | The Director of Engineering (Main | tenance) | i l | | |
| | | | | i | will regularly assess as part of a | | 1 |
| | i | | | 1 | preventive maintenance schedule | . all fire | |
| | This Statute or Ru | le is not met as evide | enced by: | ļ | doors during fire drills. Photos are | | |
| | Based on observa | tion and staff intervier | w, the | į | attached. | | |
| | facility failed to ma | intain the building do | or opening | 1 | | | |
| | assemblies. This | deficient practice affe | cts all | | The Administrator / designee will | spot | |
| | smoke compartme | ents, staff, visitors and | ila b | - | check all doors on a monthly basi | | |
| | residents. The fac | cility has the capacity | for 152 | 1 | quarterly thereafter, to ensure cor | | |
| | beds and at the tir | ne of survey the cens | us was | İ | qualitary tropediter, to enour our | | i |
| | i 134. | • | | 1 | 1 | | i |
| | 1 | | | 1 | ľ | | |
| | The findings include | de: | | | | | |
| | , | | | 1 | | | 1 |
| | On December 10- | 11, 2014 between 8:3 | 0 a.m. | 1 | | | |
| | | panied by the Mainte | | 1 | | | 1 |
| | | observation tour it w | | | | | 1 |
| | that when tested, | various corridor doors | did not | | | | 1 |
| | | the door frame. Doo | | | 1 | | 1 |
| | | uirement of providing | | 1 | 1 | | |
| | | e door closed. The | | | | | į |
| | | the door frame and/o | | | | | |
| | | has an opening which | | 1 | 1 | | i |
| | the spread of smo | ke through the door. | Some | 1 | | | |
| | examples include | but are not limited to: | : | | | | - |
| | | | | 1 | | | |
| | (1) Laundry room | | | 1 | 1 | | |
| | (2) The first floor I | East activity room cor | ridor door. | 1 | 1 | | l |
| AHCA Form | 3020-0001 | | | | | | |

| Agency fo | or Health Care Adm | inistration | | | | |
|--------------------------|---|--|---------------------------------|--|--|--------------------------|
| STATEMENT AND PLAN | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: (| CONSTRUCTION . | (X3) DATE SI COMPLE | |
| | | 100611 | B. WING | | 12/11/2014 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | 1 |
| HOLLYW | OOD HILLS REHABII | LITATION CENTE: 1200 N 35 HOLLYWI | TH AVE DOD, FL 330 | | | |
| (X4) ID PREFIX TAG | ÉFIX . (EACH DEFICIENCY MUST BE PRECEDED BY FULL.) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE ! | (XS) COMPLETE DATE |
| K 018 | Continued From pa | ige 8 | K 018 | | | |
| Ì | (3) Kitchen to corrid (4) First floor smok | dor door. e compartment doors times 3. | | | | |
| | the Maintenance D witnessed that the code requirement of to keep the door of documentation to s | onducted at these times with irector who acknowledged and corridor doors did not meet the of providing a means suitable osed. No additional written support the testing of the doors iding a smake barrier was e of exit. | | | | |
| | The findings were a | erified by the Administrator. acknowledged by the verified by the Maintenance of observation and at the exit sember 11, 2014. | | | | |
| | Class III | | | | | I |
| | Actual NFPA Stand | dards; | | | | |
| | installation and ma devices used to pr and cellings agains within, into, or out | 009) 19.3.8.3.3, 19-3.6.3.5 intenance of assemblies and olect openings in waits, floors, st the spread of fire and smoke of buildings. NFPA 80, corridor ed with a means suitable for losed. | | | and the second s | |
| | NFPA 101- LSC 20 Inspection-Testing | | K 062 | K-062- NFPA 101 Life Safety Sta automatic fire sprinkler system | ndard- | 02/11/2015 |
| | required by this Co and maintained in (2008 edition Stan Testing, and Maint | ikler and standpipe systems ade shall be inspected, tested, accordance with NFPA 25 dard for the inspection, tenance of Water-Based Fire is). NFPA 101 Life Safety Code | | The closet doors, including the si the rod, will be removed. (Contin | nelf and ued) | |

AHCA Form 3020-0001

STATE FORM

| Agency f | or Health Care Adm | inistration | | | | | |
|--------------------------|---|---|---|---------------------|--|----------------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM | | | CONSTRUCTION 02 - MAIN LIC | (X3) DATE : COMPI | SURVEY LETED |
| | ** | 100611 | | B. WING | | 12/1 | 1/2014 |
| NAME OF F | ROVIDER OR SUPPLIER | | | | TATE, ZIP CODE | | |
| HOLLYW | OOD HILLS REHABI | | 1200 N 351 HOLLYWO | H AVE OD, FL 330 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SCIDENTIFYING INFORMAT | FULL FIGN) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | DBE | (X6) COMPLETE DATE |
| K 062 | Continued From pa (2009) 18.3.5, 19.3 | - | | | A self-contained wardrobe will be inside the niche. When this work is completed, the wardrobes will not sprinklering in accordance with Cf. C letter #5-38. (Please see attach and photo). | require ISS& | 02/11/2015 |
| | Based on observation facility falled to ma fire sprinkler system deficient practice a compartments, state The facility has the | e is not met as evider tion, and staff interview intain the building auto m to code requirement ffects all smoke Iff, visitors and all reside capacity for 152 beds the census was 134. | v, the omatic ts. This | | We will be working with the Office and Construction to request for a review or a project number to allow time to complete this project. | desk | |
| | and 4 p.m. accom Director during the that: in 36 out of 3 21 out of 30 rooms no automatic fire s resident room clos conducted at this in Director who acknowledges | 11, 2014 between 8:30 penied by the Mainten observation tour if was 9 rooms on the first fits on the second floor, sprinkler protection in tests. An interview was irme with the Maintena owledged that the fire stalled, as per manufa | ance as noted oor and there is the unce sprinkler | | | | |
| | The findings were Administrator and | erified by the Administ acknowledged by the verified by the Mainte e of observation and a cember 11, 2014. | nance | | | | |
| | : (2009) 7.3.3.9. N | dards: 009) 19.3.5, and 9-7. FPA LSC 101 (2009) 1 3.2.10. NFPA 13 (20 | 19.1., | | | | |

| Ananau | for Health Care Adm | inietration | | | FORINI | APPROVED. |
|--------------------------|--|---|---------------|--|--|------------------|
| STATEMEN | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. | | E CONSTRUCTION 92 - MAIN LIC | (X3) DATE COMP | SURVEY LETED |
| | | 100611 | B, WING | | 12/11/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| HOLLYM | OOD HILLS REHABI | LITATION CENTER 1200 N 35 | | | | |
| | | HOLLTWI | OOD, FL 33 | PROVIDER'S PLAN OF CORRECTION | TA1 | (X(5) |
| (X4) ID PREFIX TAG | EACH DEFICIENCY | (TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE 1 | COMPLETE DATE |
| K 062 | Continued From pa | | K 062 | | | FA: LV |
| | installation of fire s | prinkler systems. | | | | |
| K 065 SS=F | 59A-4.133 FAC, 42 Convert | 0,1.4 FBC Addition, Alter & | K 085 | K-065-59A-4.133 FAC, 420.1.4 FE Addition, Alter, and Convert | BC . | 06/11/2015 |
| | When construction buildings or for add renovations, or alte the plans and spec construction shall the plans and spec contemplated addition and the AHCA Office of approval or exemp process. Plans and review shall be subt | architects and engineers. All | | This deficient practice has been addressed with the attached revier approval letter showing a project from the Office of Plans and Cons dated January 7, 2015 (see attach Therefore, no time waiver is need satisfy K-65 as it was written. The nursing home will be working Office of Plans and Construction to design, build and install a permangenerator. 2. The metal shed found without it proper paperwork was removed frourent location. | w and number truction red). ed to with the or ant | |
| | Based on observat interview the facility changes to the buil approved plans. The smoke compartme residents. The face beds and at the tim 134. The findings includ On December 10-1 and 4 p.m. accomp | e is not met as evidenced by: ion, record review and staff reliated hority the Agency of ding made from the original is deficient practice affects all his, staff, visitors and all lith has the capacity for 152 e of survey the census was e: e: 11, 2014 between 8:30 a.m., sanied by the Maintenance observation tour the following | | 3. An AHCA letter dated Septemb 2012, is attached as evidence that installations of the exit egrees do been approved (please see attach from AHCA dated Sept. 17, 2012) RECEIVED JAN I 5 2015 BY: | t the rs have led letter | |
| | 1 | | 1 | | | 1 |

| Agency fo | r Health Care Adm | inistration | | | FURM APPROVED |
|--------------------------|----------------------------------|--|---------------------|---|-------------------------------|
| STATEMENT | OF DEFICIENCIES IF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | | A. BUILDING: | 02 - MAIN LIC | |
| | | 100611 | B. WING | | 12/11/2014 |
| NAME OF PE | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | |
| HOLLYWO | OD HILLS REHABI | ITATION CENTE: 1200 N 38 | TH AVE | | |
| | | HOLLYW | DOD, FL 330 | 21 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERCY) | D BE COMPLETE |
| K 065 | Continued From page 11 | | K 065 | | |
| 1 | Examples are note | below of changes that were | 1 | | |
| | made from the orig | inal approved plans that | 1 | • | Ì |
| | | changes, where approval | | | |
| | | not done through the office of | | | |
| | | tion. On the dates of survey | | | |
| | | able to produce any ubstantiate that plans were | | | |
| | | ency for Health Care | | | |
| | | CA) office of plans and | | | |
| | | for work done at the facility. | | | |
| | (1) The facility has | a temporary 100 KW | | | İ |
| i | generator on a trail | er which is the second | | | İ |
| | | or in at least 3 or more years | | | |
| | | any approval blue-prints and | | | |
| | | was provided showing this e was approved, reviewed or | 1 | | ļ |
| | | e was approved, reviewed or compliance on the date of exit. | | | |
| 4 | No additional page | work was provided at the time | i - 1 | | 1 |
| | of exit from the fac | lity. | | | 1 |
| 1 | (2) The facility has | a metal shed measuring about | | | |
| | | ithin 4 feet of the window | | | |
| | | ding. This shed is not | | | |
| | installed with hurric | ane straps and no written | | | |
| | | provided when requested | | | 1 |
| 1 | anowing the installa | tion was approved, reviewed ditional paperwork was | | | |
| 1 | provided at the time | of exit from the facility. | | | |
| - | (3) The facility has | installed special locking | | | 1 |
| | | xit egress doors. The facility | | | |
| | | approval of revised | | | |
| | construction docum | ents or shop drawings which | | | i |
| | | nd submitted for review and | | | |
| | | te corrections or modifications d conditions or other | | | 1 |
| | | o conditions or other ved plans. During interview | | | |
| | | ce Director he was unable to | | | |
| | produce any writter | | | | |
| HCA Form 3 | 020-0001 | | 1 | | |

STATE FORM

6866 269C21

If continuation sheet 12 of 17

| Agency | for Health Care Adm | inistration | | | FORM | APPROVED |
|--------------------------|--|--|---------------------|--|-----------|--------------------------|
| STATEMEN AND PLAN | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE | |
| | | IDENTIFICATION NUMBER. | A. BUILDING | 02 - MAIN LIC | COMP | LEYED |
| | | 100611 | 8. WING | | 1914 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY. | STATE, ZIP CODE | 1 127 | 112014 |
| HOLLVIA | OOD HILLS REHABI | 4555 1) 65 | | | | |
| | OOD HILLS REMABI | HOLLYW | DOD, FL 33 | 021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER OF THE | D 8E | (X5) COMPLETE DATE |
| K 065 | Continued From pa | ge 12 | K 065 | | | |
| | substantiate the ins or that plans were a these changes. No provided at the time these changes were the findings were a Administrator and very the findings were a Administrator and birrector at the time conference on Dec | tallations had been approved, approved for the installation of additional papervork was of exit from the facility. Iffied by the Administrator, exhonowledged by the erifled by the Maintenance of observation and at the exit ember 11, 2014. ards: 193 4.2.1 Occupant Protection, or observation and at the exit ember 11, 2014. ards: 193 4.2.1 Occupant Protection, or observation AFPA 1 (2009) 7.1. NFPA LSC 101 (2009) 8.5.3.2. 19.1.3.2 and 7.2.1.6.2 (1) 1.1 requires exits shall be reseas shall be arranged so that existing the armander of the conditions or other red plans, NFPA LSC 101 vise or alarm installed to ruse of a means of agrees of the stall red or other care of the st | K 065 | · | | |
| | not require the use knowledge or effort | 1.5.2 locks if provided, shall of a key, a tool, or special for operation from the egress | | , | | |
| | side. | | | | | |

AHCA Form 3020-0001

STATE FORM

Agency for Health Care Administration

| STATEME AND PLAN | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION S; 02 - MAIN LIC | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|---|---|--------------------------|
| | | 100611 | B. WING | | 12/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY | STAYE, ZIP CODE | 120 | NAU14 |
| HOLLYV | YOOD HILLS REHABIJ | LITATION CENTEL 1200 N 38 | OOD, FL 3: | 3021 | | |
| (X4) ID PREFIX TAG | : (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY) | DBE | (X5) COMPLETE DATE |
| SS≖F | shall be protected in (Standard for Healt NFPA 101 Life Safe 19.3.2.4 & NFPA 98 Based on obsarvati facility failed to proy deficient practice at compartment, staff The facility has the term of survey if The findings include 1. On December 10 and 4 p.m., accomp Director during the colored that in at 50 purchased that in at 50 purchased that in at 50 purchased that in at 50 purchased that in at 50 purchased that in at 50 purchased that in at 50 purchased that in at 50 purchased that in the 50 | e and administration areas n accordance with NFPA 99 n Care Facilities 2006 edition, ty Code (2009) 18.3.2.4, (2005). a is not met as evidenced by: on and staff interview, the perly store medical gases. This fects all smoke f, visitors and all residents. capacity for 15b bets and at the census was 134. | K076 | K-076-NFPA 101-LSC 2009-Mergases Plastic covers found covering the loxygen cylinders in the oxygen caremoved. E sized oxygen cylinders found to loose and freestanding were all tal from the maintenance shop and stand secured in the oxygen storage in the first and secured informs. Then ever be more than 3000 cu. Ft. of storage in these rooms because at cylinder only holds 25 cu. Ft. of storage in these rooms because at cylinder only holds 25 cu. Ft. of storage in these rooms because at cylinder only holds 25 cu. Ft. of storage in these rooms because at 120 Etanks in any storage room at time. Environmental rounds will include the control of the property of the cylinder only holds of these rounds will be party from the Director of Engineering. Findings of these rounds will be party from the Director of Engineering the QA committee on a monthly be to be monitored for the next the other party from the Director of the next the other party from the Director of the next the other party from the Director of Engineering. | E size the were be ken out ored r rooms e will f oxygen n E tygen t tone inder y the art of a rring to sisis, and | 01/11/2015 |
| HCA Form (| | | 189 | 269C21 | f continues so | thee) 14 of 17 |

| Agenc | for Health Care Adm | inistration | | | FORN | APPROVED |) |
|--------------------------|--|---|----------------------|--|------------|--------------------------|---|
| AND PLA | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G: 02 - MAIN LIC | | E SURVEY PLETED | |
| | | 100811 | B. WING _ | | 12/11/2014 | | |
| NAME OF | PROVIDER OR SUPPLIER | STREETA | DORESS, CITY | , STATE, ZIP CODE | - | 1110011 | 7 |
| HOLLY | WOOD HILLS REHABIL | | STH AVE OOD, FL 3 | 3021 | | | |
| (X4) ID PREFIX TAG | | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFILE OF THE A | DRE | (X5) COMPLETE DATE | 1 |
| K 076 | Continued From pa | ge 14 | K 078 | | | + | 4 |
| | The findings were a Administrator and vi | erified by the Maintenance | | | | | |
| | Actual NFPA Standa | arda. | | | | | I |
| | NFPA LSC 101 (200 (2005) 5.3.13.1.2 (3 shall never be 5,3 shall never be shall never be hospital gowns, mae (2009) 19.3.2 4, sho hospital gowns, mae (2009) 19.3.2 4, sho stored within the sar oylinders shall be se Empty cylinders shall be se confusion and delay hurriedly. NFPA LSV NFPA 98 (2005) 5.3. 5.3.1 Cylinders in be individually sending knoci failing or being knoci | (9) 19.3.2.4, and NFPA 99 of states an oxygen cylinder d with any materials such as its, or caps. NFPA LSC 101 NFPA 99 (2005) requires secured, vented and not FPA 99 (2005) 5.3.13.2.2 if ne enclosure, empty gregated from full cylinders. Ibe marked to avoid if a full cylinder is needed 2 101 (2009) 19.3.2.4, and 13.1.2 (3) NFPA 99 (2005) service and in storage shall ed and located to prevent ked over. | | | | | |
| K 109 SS≃F | Emergency generate shall meet the stands Code (2009) 9.1.3. N | 9 Emergency Generator or maintenance and testing ords in NFPA 101 Life Safety IFPA 110 (2005) 8.3.8, (A be performed at least | K 109 | K-109- NFPA 101- LSC 2009- Eme generator. An outside company was called in the panel working on the remote ge alarm. | o get | 01/11/2015 | |
| ICA Form 5 | annually using tests a standards.) | approved by ASTM | | The company will come out to hook to the portable generator. | it up | | |

47LA Form 3020-000

STATE FORM

essa 259C21

If continuation sheet 15 of 17

| Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (UMBER- | | (X2) MULTIPLE | (X3) DATE SURVEY | | | |
|--|---|--|------------------------------|--|--------------|------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING; 02 - MAIN LIC | | COMPLETED | |
| | | 100611 | | | | |
| | | | DRESS, CITY, STATE, ZIP CODE | | 12/11/2014 | |
| | | 4000 N 0 | STH AVE | TATE, ZIP CODE | | |
| OLLYW | OOD HILLS REHABI | | OOD, FL 330 | 21 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID I | PROVIDER'S PLAN OF CORRECTION | RECTION (X5) | |
| PRÉPIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | DBE COMPL | |
| | | | 140 | DEFICIENCY) | FRANCE | DAIS |
| K 109 | Continued From page 15 | | K 109 | | | |
| | | | | | | |
| | This Statute or Rule | s is not met as evidenced by: | 1 | | | |
| | Based on observat | on and staff interview, the | 1 | | | |
| | facility failed to maintain the emergency generator | | 1 1 | | | |
| a de Albania (Albania | to manufacture and code requirements. This deficient practice affects all smoke | | 1 1 | | | |
| | compartments etal | f vicitors and all regidents | 1 | | | |
| | compartments, staff, visitors and all residents. The facility has the capacity for 152 beds and at | | 1 | | | |
| | the time of survey t | he census was 134. | | | | |
| | The findings include | ₽; | | | | |
| | 0. 5 | | | | | |
| | On December 10-1 | 1, 2014 between 8:30 a.m. | 1 1 | | | |
| | Director during the | panied by the Maintenance observation tour it was noted | | | | |
| | that; when tested it | he remote generator alarm | 1 1 | | | |
| | located near the nu | rses ' station failed to | } | | | |
| | function. An intervi | ew was conducted at this time | 1 | | | |
| | with the Maintenand | e Director who acknowledged | 1 | | | |
| - | that the remote alar | m was not functional. If not | | | | |
| | maintained, the em | ergency generator may fail | | | | |
| | malfunction No ad | aware of the generator distinguished written documentation | 1 | | | |
| | to substantiate com | pliance was received at the | 1 1 | | | |
| | exit conference. | pliance was received at the | | | | |
| | The concus was un | rified by the Administrator. | | | | |
| | The findings were | rilled by the Administrator, icknowledged by the | 1 1 | | | |
| | Administrator and v | erified by the Maintenance | 1 | | į | |
| | Director at the time | of observation and at the exit | 1 | | - | |
| | conference on Dece | ember 11, 2014. | | | | |
| | Class III | | | | | |
| | Actual NFPA Standa | ards: | | | | |
| | NFPA 99 and NFPA | 110 (2005) 5.6.6 require a | 1 1 | | | |
| | remote annunciator | storage battery powered. | | | i | |
| | shall be provided to | operate outside of the | !! | | j | |
| 1 | generating room in | a location readily observed by | ([| | | |

| Agency (| or Health Care Adm | inistration | | Agency for Health Care Administration | | | | | | | | | | |
|---|---|-------------------------------|----------------------------|--|-------------------------------|------------------|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES (X | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | | | | | | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | IDENTIFICATION HOMBER. | A. BUILDING: 02 - MAIN LIC | | COMPLETED | | | | | | | | | |
| | | | B. WING | | -01-4 | ma. | | | | | | | | |
| | | 100611 | B. WING | | 12/11/ | 2014 | | | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | | | | | |
| HOLLYWOOD HILLS REHABILITATION CENTER 1200 N 35TH AVE HOLLYWOOD, FL 33021 | | | | | | | | | | | | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON | (X5) COMPLETE | | | | | | | | |
| PRÉFIX | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LISC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | DATE | | | | | | | | |
| | | | | DEFICIENCY) | | | | | | | | | | |
| K 109 | Continued From pa | ige 16 | K 109 | | | | | | | | | | | |
| | operating personnel at a regular work station. | | | | | 1 | | | | | | | | |
| | operating personne | at at a regular work station. | | | - 1 | | | | | | | | | |
| | | | 1 | | | | | | | | | | | |
| | | | ! | | | | | | | | | | | |
| | <i>'</i> | | | | | i | | | | | | | | |
| | | | | | 1 | 1 | | | | | | | | |
| | | | | | 1 | | | | | | | | | |
| | | | | | į | - | | | | | | | | |
| | | | | | i | | | | | | | | | |
| | | | | | 1 | | | | | | | | | |
| | | | | | į | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | 1 | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | 1 | | 1 | | | | | | | | | |
| | | | 1 | | İ | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | ì | | ì | | - 1 | | | | | | | | | |
| | : | | 1 | | | | | | | | | | | |
| | | | i | | | | | | | | | | | |
| | . | | | | - | | | | | | | | | |
| | | | 1 | | ļ | | | | | | | | | |
| | i | | 1 | | į | | | | | | | | | |
| | İ | | 1 | | 1 | | | | | | | | | |
| | i . | | | | | | | | | | | | | |
| ĺ | Ì | | ì | | į. | | | | | | | | | |
| | 1 | | | | i | | | | | | | | | |
| 1 | | | | | | | | | | | | | | |
| | į. | | | | | | | | | | | | | |



December 19, 2014

Administrator Hollywood Hills Rehabilitation Center, LLC 1200 N 35th Ave Hollywood, FL 33021

RE: Recertification. Relicensure & Life Safety Code Surveys

Dear Administrator:

On December 8, 2014 through December 11, 2014, Recertification, Relicensure and Life Safety Code surveys were conducted in your facility by representatives of this office. The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit. You will not receive a copy of this letter and attachments in the mail; you will only receive this faxed report.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies** shall be corrected no later than January 11, 2015.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to
 ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place.



Hollywood Hills Rehabilitation Center, Llc December 19, 2014 Page 2

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- . Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed March 11, 2015 if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on June 11, 2015 if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Attention: IDR Coordinator Agency for Health Care Administration 2727 Mahan Drive, Mail Stop 9-A Tallahassee, Florida 32308 FAX (850) 414-6946

Phone number: (850) 412-4301 IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Hollywood Hills Rehabilitation Center, Llc December 19, 2014 Page 3

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.my/florida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. If you have questions, please contact this office at (561) 381-5840.

Sincerely.

Arlene Mayo-Davis

AMD Enclosure