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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105021	A. BUILDING 01 - MAIN FED B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLYWOOD HILLS REHABILITATION CENTER, LLC	1200 N 35TH AVE HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

42 CFR 483.70 (e)
K 3 Building: 0101
K 6 Plan Approval: 1964/1972/1989
K 7 Survey Under: 2000 Existing
K 8 SNF/NF

An unannounced Recertification survey was conducted at Hollywood Hills Nursing Home in Hollywood, Florida on December 10, 2014 to December 11, 2014. Deficiencies were identified as a result of the recertification survey. The facility is not in compliance with the regulations at 42 CFR Part 483, Requirements for Long Term Care Facilities. This annual survey was conducted to determine the facility's compliance with the NFPA Life Safety Code (LSC) 101 (2000) including all Chapter 2 referenced codes, and referenced standards and publications as mandated by the Center for Medicare and Medicaid Services (CMS). At the entrance conference the facility did not formally advise of electing any LSC categorical waivers allowed S&C: 13-58-LSC dated August 30, 2013.

The facility as surveyed was built or licensed in 1964 with a building changes in 1972 and 1989. Building may be of Type II (111) construction. two story, 152 bed nursing home and has (10) smoke compartments. Building features and protection include a complete supervised fire alarm system, a complete automatic fire sprinkler system and a temporary emergency generator. The building is connected to a Psychiatric Hospital and shares all life safety features including fire alarm, sprinkler and generator systems. The facility Administrator indicated there are no Fire Safety Evaluation System (FSES) or waivers. Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/31/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 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 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD 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:	K 012	K-012- Life Safety Code Standard- fire wall separations 1. Fire stopping materials (3M) will be reapplied in strict accordance with the appropriate tested 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 accordance with the UL tested detail. Photos are attached.) 2. The Director of Engineering/ designee will conduct environmental rounds to assess all smoke barriers for similar concerns. 3. A preventive maintenance schedule will be implemented to ensure that all ceiling and wall penetrations are sealed with fire rated caulking, semi-annually.	01/11/2015

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K 012	Continued From page 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 noted that there were improper and/or unsealed fire-stop penetrations observed. Examples include but are not limited to the following: (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	K 012	4. All findings will be reported by the Maintenance Director or his designee to the Quality Assurance committee on its monthly meeting and will be monitored by the QA committee for the next three months, and semi-annually thereafter. 5. The Administrator / designee will conduct quarterly and semi-annual rounds.	01/11/2015

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K 012	Continued From page 3 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. 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 NFPA Standards: NFPA 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 pipes, 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 012		
K 015 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for	K 015	K-015-NFPA 101- LSC –flame spread rating (Continued)	01/11/2015

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K 015	Continued From page 4 corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the flame spread ratings for various interior finishes in the facility. 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 the facility has un-rated plastic folding panel type doors on the resident room closets. The closets were noted in approximately 36 out of 39 rooms on the first floor and 21 out of 30 rooms on the second floor. When requested, written documentation of the flame spread ratings were not produced by the facility. The use of un-rated interior finish's that do not meet the required flame spread ratings could generate excessive toxic smoke, quickly spread fire, and endanger occupants in the event of a fire. An interview was conducted at this time with the Maintenance	K 015	The closet doors, 36 out of 39 rooms in the first floor and 21 out of 30 rooms in the second floor, will be removed and a self -contained wardrobe will be installed inside the niche.	01/11/2015

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K 015	Continued From page 5 Director who acknowledged that the facility could not produce documentation of the flame spread rating. The census was verified by the Administrator. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observations and at the exit conference on December 11, 2014. Actual NFPA Standards: NFPA LSC 101 (2000) 19.3.3.1 or 21.3.3.1, which requires compliance with the requirements of Section 10.2 Interior Finish.	K 015		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K-018- NFPA 101- LSC 2009 –Corridor Doors All the doors observed not to latch automatically and not functioning properly had the locks replaced. The other doors, including the laundry room doors, were assessed and were repaired by an outside company (Big Lock and Key). (Please see attached invoice) The Director of Engineering (Maintenance) will regularly assess as part of a preventive maintenance schedule, all fire doors during fire drills. Photos are attached. The Administrator / designee will spot check all doors on a monthly basis, then quarterly thereafter, to ensure compliance.	01/11/2015

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K 018	Continued From page 6	K 018		

This STANDARD is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain the building door opening assemblies. 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 when tested, various corridor doors did not close and latch in the door frame. Doors did not meet the code requirement of providing a means suitable to keep the door closed. The door did not latch closed in the door frame and/or the door to the door frame has an opening which will allow the spread of smoke through the door. Some examples include but are not limited to:

(1) Laundry room doors times 3.
(2) The first floor East activity room corridor door.
(3) Kitchen to corridor door.
(4) First floor smoke compartment doors times 3.

An interview was conducted at these times with the Maintenance Director who acknowledged and witnessed that the corridor doors did not meet the code requirement of providing a means suitable to keep the door closed. No additional written documentation to support the testing of the doors for function or providing a smoke barrier was provided at the time of exit.

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K 018	Continued From page 7 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) 19.3.2.4 and 19-3.6.3.2, NFPA 1 (2000) 5-4.1 installation and maintenance of assemblies and devices used to protect openings in walls, floors, and ceilings against the spread of fire and smoke within, into, or out of buildings, NFPA 80, corridor doors to be provided with a means suitable for keeping the door closed.	K 018		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the building automatic fire sprinkler system to code requirements. 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.	K 062	K-062- NFPA 101 Life Safety Standard-automatic fire sprinkler system The closet doors, including the shelf and the rod, will be removed. A self-contained wardrobe will be installed inside the niche. When this work is completed, the wardrobes will not require sprinklering in accordance with CMS S & C letter #5-38. (Please see attached letter and photo).	02/11/2015

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K 062	Continued From page 8 and 4 p.m. accompanied by the Maintenance Director during the observation tour it was noted that: in 36 out of 39 rooms on the first floor and 21 out of 30 rooms on the second floor, there is no automatic fire sprinkler protection in the resident room closets. An interview was conducted at this time with the Maintenance Director who acknowledged that the fire sprinkler heads were not installed, as per manufacture and code requirements. 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) 19.1. NFPA 1 (2000) 7-1 and NFPA 13 (1999) 8.5 installation of fire sprinkler systems.	K 062		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K-076- NFPA 101- Life Safety Standard- medical gases. Plastic covers found covering the E size oxygen cylinder in the oxygen cart were removed. E sized oxygen cylinders found to be loose and freestanding were all taken out from the maintenance shop and stored and secured in the oxygen storage rooms in the first and second floors. There will never be more than 3,000 cu. Ft. of oxygen storage in these rooms because an E cylinder only holds 25 cu. Ft. of oxygen and the facility will never store more than 120 E tanks in any storage room at one time.	01/11/2015

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K 076	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store medical gases. 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: 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.	K 076	Environmental rounds will include observing for any other oxygen cylinder not properly stored and secured, by the Director of Engineering. Findings of these rounds will be part of a report from the Director of Engineering to the QA committee on a monthly basis, and to be monitored for the next three months by the QA committee members.	01/11/2015

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K 076	Continued From page 10 Actual NFPA Standards: NFPA 99 (1999) 4-3.5.2.1 (7) requires that an oxygen cylinder shall never be draped with any material such as hospital gowns, mask, or caps. NFPA 99 (1999) 4-3.5.2.2. Storage of cylinders and containers. NFPA 99 (1999) 8-3.1.11.3 requires a precautionary sign. NFPA 99 (1999) 5.1.13.5.2 requires that empty cylinders shall be segregated from full cylinders. The empty and full cylinders were not segregated. NFPA 99 (1999) 4-3.5.2.1 requires gases in Cylinders and Liquefied Gases in Containers - (b) (25) Cylinders shall be attached to a cylinder stand. (27) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.	K 076		
K 106 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals, and nursing homes and hospices with life support equipment, have a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the emergency generator to manufacture and code requirements. 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.	K 106	K-106- NFPA 101- Life Safety standard- emergency generator. An outside company was called in to get the panel working on the remote generator alarm. The company will come out to hook it up to the portable generator.	01/11/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 106	Continued From page 11 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: 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 exit 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 NFPA 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 106		
K 211 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser	K 211	K-211-NFPA 101- alcohol-based hand-rub dispenser The alcohol-based hand-rub dispensers observed to be installed directly over or adjacent to the electrical switches were all removed. (Continued)	01/11/2015

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105021	A. BUILDING 01 - MAIN FED B. WING _____	12/11/2014

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HOLLYWOOD HILLS REHABILITATION CENTER, LLC	1200 N 35TH AVE HOLLYWOOD, FL 33021

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K 211	Continued From page 12 capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to properly install dispensers following the requirements for Alcohol-based hand-rub dispenser installation. Dispensers incorrectly installed may endanger staff, visitors and occupants.. 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: throughout the facility, in resident rooms, Alcohol-based hand-rub dispensers were installed directly over or adjacent to electrical ignition sources. The Maintenance Director acknowledged the facility had installed Alcohol-based hand-rub dispensers directly over or adjacent to electrical ignition sources.	K 211	All other dispensers found directly or adjacent to ignition sources will be taken out and installed away from any ignition source. The Director of Engineering will conduct rounds to ensure compliance.	01/11/2015

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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) 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623. Dispensers shall not be installed over or directly adjacent to an ignition source	K 211		

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	100611	A. BUILDING: 02 - MAIN LIC B. WING	12/11/2014

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HOLLYWOOD HILLS REHABILITATION CENTE	1200 N 35TH AVE HOLLYWOOD, FL 33021

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K 000	Initial Comments	K 000		

State Licensure
K 3 Building: 0101
K 6 Plan Approval: 1964/1973/1979
K 7 Survey Under: 2009 Existing
K 8 SNF/NF

A Relicensure survey was conducted on December 10-11, 2014.
Hollywood Hills Rehabilitation Center had Licensure deficiencies found at the time of the visit.

An unannounced annual fire and Life Safety State Licensure survey was conducted to determine compliance with NFPA Life Safety Code (LSC) 101 (2009) Chapter 2; all NFPA mandatory requirements adopted per NFPA 101, and applicable Florida State Fire Marshal's Rules and Regulations, 69 A-3.012; 69 A-53; FS 633.022, and State of Florida Building Code.

Facility as surveyed was built or licensed in 1964 with a building changes in 1972 and 1989. Building may be of Type II (111) construction. two story, 152 bed nursing home and has (10) smoke compartments. Building features and protection include a complete supervised fire alarm system, a complete automatic fire sprinkler system and a temporary emergency generator. The building is connected to a Psychiatric Hospital and shares all life safety features including fire alarm, sprinkler and generator systems, The facility administrator indicated there are no Fire Safety Evaluation System (FSES) or waivers. Administration 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

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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 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 000		
K 013 SS=F	NFPA 101- LSC 2009 Construction Type (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 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 tour it was noted that there were improper and/or unsealed	K 013	K-013-NFPA 101-LSC 2009 Construction Type 1. Fire stopping materials (3M) will be reapplied in strict accordance with the appropriate tested 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 accordance with the UL tested detail. (Photos are attached. 2. The Director of Engineering/ designee will conduct environmental rounds to assess all smoke barriers for similar concerns. 3. A preventive maintenance schedule will be implemented to ensure that all ceiling and wall penetrations are sealed with fire rated caulking, semi-annually.	01/11/2015

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K 013	Continued From page 2 fire-stop penetrations observed. Examples include but are not limited to the following: (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 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.	K 013	4. All findings will be reported by the Maintenance Director or his designee to the Quality Assurance committee on its monthly meeting and will be monitored by the QA committee for the next three months, and semi-annually thereafter. 5. The Administrator / designee will conduct quarterly and semi-annual.	01/11/2015

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K 013	Continued From page 3 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. Class III Actual NFPA Standards: NFPA 101 LSC (2009) 4.4.6 System design/installation. Any fire protection system, building service equipment, feature of protection, or safeguard provided to achieve the goals of this code shall be designed, installed and approved in accordance with applicable codes and standards referenced in chapter 2. Chapter 2.1 general. The documents or portions thereof listed in this chapter are referenced within this code and shall be considered part of the requirements of this document. Included is ASTM E 814, Standard test method for fire tests of through penetrations fire stops, 2002. NFPA LSC 101 (2009) 4.2.2, which requires structural integrity is maintained, and 4.6.10, which refers to conditions for occupancy. 19.1.6, which covers the minimum facility construction requirements. NFPA 1 (2009) 12.3.2.1 required fire-resistive construction, including fire barriers, fire walls, exterior walls due to location on property, draft stops partitions, and roof coverings, shall be maintained and shall be properly repaired, restored, or replaced where damaged, altered, breached, removed, or improperly installed.	K 013		
K 015 SS=F	NFPA 101- LSC 2009 Interior Finish - Rooms The interior finish for rooms and spaces, not used	K 015	K-015- NFPA 101 Life Safety Standard – flame spread rating of interior finishes (Continued)	01/11/2015

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K 015	Continued From page 4 for corridors and exit ways, shall have a flame spread rating as required; including exposed interior surfaces of buildings, such as, fixed or movable partitions, columns, and ceilings. NFPA 101 (Life Safety Code) (2009) 18.3.3, 19.3.3 This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the flame spread ratings for various interior finishes in the facility. 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 the facility has un-rated plastic folding panel type doors on the resident room closets. The closets were noted in approximately 36 out of 39 rooms on the first floor and 21 out of 30 rooms on the second floor. When requested, written documentation of the flame spread ratings were not produced by the facility. The use of un-rated interior finish's that do not meet the required flame spread ratings could generate excessive toxic smoke, quickly spread fire, and endanger occupants in the event of a fire. An interview was conducted at this time with the Maintenance Director who acknowledged that the facility could not produce documentation of the flame spread rating. The census was verified by the Administrator.	K 015	The closet doors, 36 out of 39 rooms in the first floor and 21 out of 30 rooms in the second floor, will be removed and a self -contained wardrobe will be installed inside the niche.	01/11/2015

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K 015	Continued From page 5 The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observations and at the exit conference on December 11, 2014. Class III Actual NFPA Standards: NFPA LSC 101 (2009) 19.3.3.1 or 21.3.3.1, which requires compliance with the requirements of Section 10.2 Interior Finish.	K 015		
K 016 SS=F	NFPA 101- LSC 2009 Alcohol Based Hand Rub Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3, unless all of the following conditions are met: Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft; The maximum individual dispenser fluid capacity shall be: 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors; 0.53 gal (2.0 L)for dispensers in suites of rooms; The dispensers shall have a minimum horizontal spacing of 4 ft from each other; Not more than an aggregate 10 gal of alcohol-based hand-rub solution shall be in use in a single smoke compartment outside of a storage cabinet; Storage of quantities greater than 5 gal in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code; The dispensers shall not be installed within 1 inch (25mm) above, to the side, or beneath, an ignition source. In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments. NFPA 101 Life Safety Code (2009) 18.3.2.6 &19.3.2.6.	K 016	K-016-NFPA 101- alcohol-based hand-rub dispenser installation. The alcohol-based hand-rub dispensers observed to be installed directly over or adjacent to the electrical switches were all removed. All other dispensers found directly or adjacent to ignition sources will be taken out and installed away from any ignition source. The Director of Engineering will conduct rounds to ensure compliance.	01/11/2015

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K 016	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to properly install dispensers following the requirements for Alcohol-based hand-rub dispenser installation. Dispensers incorrectly installed may endanger staff, visitors and occupants,. 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: throughout the facility, in resident rooms, Alcohol-based hand-rub dispensers were installed directly over or adjacent to electrical ignition sources. The Maintenance Director acknowledged the facility had installed Alcohol-based hand-rub dispensers directly over or adjacent to electrical ignition sources. 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. Class III Actual NFPA Standards: NFPA LSC 101 (2009) 19.3.2.6, and 8.7.3 which determines installation requirements.	K 016		

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K 018	Continued From page 7	K 018		
K 018 SS=F	NFPA 101- LSC 2009 Corridor Doors Corridor doors shall be 1 3/4 inch solid bonded wood core doors or they shall have a 20 minute fire resistive rating (Existing only). If the building or smoke compartment is fully sprinklered, the 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 which keep the door tightly closed in the frame. For NEW doors, roller latches are prohibited. NFPA 101 Life Safety Code (2009), 18.3.6.3 & 19.3.6.3. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the building door opening assemblies. 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 when tested, various corridor doors did not close and latch in the door frame. Doors did not meet the code requirement of providing a means suitable to keep the door closed. The door did not latch closed in the door frame and/or the door to the door frame has an opening which will allow the spread of smoke through the door. Some examples include but are not limited to: (1) Laundry room doors times 3. (2) The first floor East activity room corridor door.	K 018	K-018- NFPA 101- LSC 2009 –Corridor Doors All the doors observed not to latch automatically and not functioning properly had the locks replaced. The other doors, including the laundry room doors, were assessed and were repaired by an outside company (Big Lock and Key). (Please see attached invoice) The Director of Engineering (Maintenance) will regularly assess as part of a preventive maintenance schedule, all fire doors during fire drills. Photos are attached. The Administrator / designee will spot check all doors on a monthly basis, then quarterly thereafter, to ensure compliance.	01/11/2015

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K 018	Continued From page 8 (3) Kitchen to corridor door. (4) First floor smoke compartment doors times 3. An interview was conducted at these times with the Maintenance Director who acknowledged and witnessed that the corridor doors did not meet the code requirement of providing a means suitable to keep the door closed. No additional written documentation to support the testing of the doors for function or providing a smoke barrier was provided at the time of exit. 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. Class III Actual NFPA Standards: NFPA LSC 101 (2009) 19.3.6.3.3, 19-3.6.3.5 installation and maintenance of assemblies and devices used to protect openings in walls, floors, and ceilings against the spread of fire and smoke within, into, or out of buildings. NFPA 80, corridor doors to be provided with a means suitable for keeping the door closed.	K 018		
K 062 SS=F	NFPA 101- LSC 2009 Sprinkler Inspection-Testing All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25 (2008 edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems). NFPA 101 Life Safety Code	K 062	K-062- NFPA 101 Life Safety Standard-automatic fire sprinkler system The closet doors, including the shelf and the rod, will be removed. (Continued)	02/11/2015

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K 062	Continued From page 9 (2009) 18.3.5, 19.3.5 & 9.7.5. This Statute or Rule is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the building automatic fire sprinkler system to code requirements. 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: in 36 out of 39 rooms on the first floor and 21 out of 30 rooms on the second floor, there is no automatic fire sprinkler protection in the resident room closets. An interview was conducted at this time with the Maintenance Director who acknowledged that the fire sprinkler heads were not installed, as per manufacture and code requirements. 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. Class III Actual NFPA Standards: NFPA LSC 101 (2009) 19.3.5, and 9-7. NFPA 1 (2009) 7.3.3.9. NFPA LSC 101 (2009) 19.1., NFPA 1 (2009) 13.3.2.10. NFPA 13 (2007) 8.5	K 062	A self-contained wardrobe will be installed inside the niche. When this work is completed, the wardrobes will not require sprinklering in accordance with CMS S & C letter #5-38. (Please see attached letter and photo). We will be working with the Office of Plans and Construction to request for a desk review or a project number to allow us time to complete this project.	02/11/2015

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	A. BUILDING: 02 - MAIN LIC B. WING	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLYWOOD HILLS REHABILITATION CENTE	1200 N 35TH AVE HOLLYWOOD, FL 33021

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K 062	Continued From page 10 installation of fire sprinkler systems.	K 062		
K 065 SS=F	59A-4.133 FAC, 420.1.4 FBC Addition, Alter & Convert When construction is contemplated for new buildings or for additions, conversions, renovations, or alterations to existing buildings, the plans and specifications for the contemplated construction shall be prepared by Florida-registered architects and engineers. All contemplated additions, conversions, renovations, or alterations shall be submitted to the AHCA Office of Plans and Construction for approval or exemption from the plans review process. Plans and specifications submitted for review shall be subject to a plan review fee. F.A.C. 59A-4.133 & Florida building Code 2010 edition 420.1.4. This Statute or Rule is not met as evidenced by: Based on observation, record review and staff interview the facility failed to notify the Agency of changes to the building made from the original approved plans. 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 the following was noted:	K 065	K-065-59A-4.133 FAC, 420.1.4 FBC Addition, Alter, and Convert 1. This deficient practice has been addressed with the attached review and approval letter showing a project number from the Office of Plans and Construction dated January 7, 2015 (see attached). Therefore, no time waiver is needed to satisfy K-65 as it was written. The nursing home will be working with the Office of Plans and Construction to design, build and install a permanent generator. 2. The metal shed found without the proper paperwork was removed from its current location. 3. An AHCA letter dated September 17, 2012, is attached as evidence that the installations of the exit egress doors have been approved (please see attached letter from AHCA dated Sept. 17, 2012). RECEIVED JAN 15 2015 BY:	06/11/2015

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K 065	Continued From page 11 Examples are noted below of changes that were made from the original approved plans that involve construction changes, where approval and permitting was not done through the office of plans and construction. On the dates of survey the facility was not able to produce any documentation to substantiate that plans were approved by the Agency for Health Care Administration (AHCA) office of plans and construction (OPC) for work done at the facility. (1) The facility has a temporary 100 KW generator on a trailer which is the second temporary generator in at least 3 or more years which did not have any approval blue-prints and no documentation was provided showing this construction change was approved, reviewed or inspected for code compliance on the date of exit. No additional paperwork was provided at the time of exit from the facility. (2) The facility has a metal shed measuring about 10 feet by 10 feet within 4 feet of the window sections of the building. This shed is not installed with hurricane straps and no written documentation was provided when requested showing the installation was approved, reviewed or permitted. No additional paperwork was provided at the time of exit from the facility. (3) The facility has installed special locking arrangements on exit egress doors. The facility is required to obtain approval of revised construction documents or shop drawings which shall be prepared and submitted for review and approved to illustrate corrections or modifications necessitated by field conditions or other provisions to approved plans. During interview with the Maintenance Director he was unable to produce any written documentation to	K 065		

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K 065	Continued From page 12 substantiate the installations had been approved, or that plans were approved for the installation of these changes. No additional paperwork was provided at the time of exit from the facility. The 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. Class III Actual NFPA Standards: NFPA LSC 101 (2009) 4.2.1 Occupant Protection. 4.5.7 System design/installation. NFPA 1 (2009) 1.12 permits and 5-7.1. NFPA LSC 101 (2009) 4.2.1 Occupant Protection. 4.5.7 System design/installation. NFPA 1 (2009) 1.12 permits and 5-7.1. NFPA LSC 101 (2009) 4.5.3.2, 7.1.10.1, 7.3.2.2., 19.1.1.3.2 and 7.2.1.6.2 (1) NFPA 1 (2009) 7.5.1.1 requires exits shall be located and exit egress shall be arranged so that exits are readily accessible at all times. NFPA 1 (2009) 1-14.5 which requires revised construction documents or shop drawings shall be prepared and submitted for review and approved to illustrate corrections or modifications necessitated by field conditions or other provisions to approved plans. NFPA LSC 101 (2009) 7.1.9 any devise or alarm installed to restrict the improper use of a means of egress shall be designed and installed so that it cannot, even in the case of failure, impede or prevent emergency use of such means of egress. NFPA LSC 101 (2009) 7.21.5.2 locks if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 065		

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K 076 SS=F	NFPA 101- LSC 2009 Medical Gas Medical gas storage and administration areas shall be protected in accordance with NFPA 99 (Standard for Health Care Facilities 2005 edition). NFPA 101 Life Safety Code (2009) 18.3.2.4, 19.3.2.4 & NFPA 99 (2005). This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store medical gases. 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: 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.	K 076	K-076- NFPA 101- LSC 2009- Medical gases Plastic covers found covering the E size oxygen cylinders in the oxygen carts were removed. E sized oxygen cylinders found to be loose and freestanding were all taken out from the maintenance shop and stored and secured in the oxygen storage rooms in the first and second floors. There will never be more than 3000 cu. Ft. of oxygen storage in these rooms because an E cylinder only holds 25 cu. Ft. of oxygen and the facility will never store more than 120 E tanks in any storage room at one time. Environmental rounds will include observing for any other oxygen cylinder not properly stored and secured, by the Director of Engineering. Findings of these rounds will be part of a report from the Director of Engineering to the QA committee on a monthly basis, and to be monitored for the next three months by the QA committee members.	01/11/2015

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K 076	Continued From page 14 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. Class III Actual NFPA Standards: NFPA LSC 101 (2009) 19.3.2.4, and NFPA 99 (2005) 5.3.13.1.2 (3) states an oxygen cylinder shall never be draped with any materials such as hospital gowns, masks, or caps. NFPA LSC 101 (2009) 19.3.2.4, and NFPA 99 (2005) requires medical gases to be secured, vented and not stored in closets. NFPA 99 (2005) 5.3.13.2.2 If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. NFPA LSC 101 (2009) 19.3.2.4, and NFPA 99 (2005) 5.3.13.1.2 (3) NFPA 99 (2005) 5.3.3.3.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.	K 076		
K 109 SS=F	NFPA 101- LSC 2009 Emergency Generator Maintained Emergency generator maintenance and testing shall meet the standards in NFPA 101 Life Safety Code (2009) 9.1.3. NFPA 110 (2005) 8.3.8, (A fuel quality test shall be performed at least annually using tests approved by ASTM standards.)	K 109	K-109- NFPA 101- LSC 2009- Emergency generator. An outside company was called in to get the panel working on the remote generator alarm. The company will come out to hook it up to the portable generator.	01/11/2015

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K 109	Continued From page 15 This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the emergency generator to manufacture and code requirements. 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: 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 exit 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. Class III Actual NFPA Standards: NFPA 99 and NFPA 110 (2005) 5.6.6 require a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by	K 109		

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K 109	Continued From page 16 operating personnel at a regular work station.	K 109		

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

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.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
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AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

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
or
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.

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.myflorida.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,

for Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure