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

PRINTED: [redacted]
FORM APPROVED
OMB NO. 0938-0391

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	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER AT HOLLYWOOD HILLS, 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 [redacted] (a)
K 3 Building: 0101
K 6 Plan Approval: [redacted]/1989
K 7 Survey Under: 2000 Existing
K 8 SNF/NF

An unannounced Life Safety Recertification survey was conducted on [redacted] at Rehabilitation Center at Hollywood Hills, LLC, a nursing home located in Hollywood, Florida. Deficiencies were identified as a result of the Life Safety 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).

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 (7) 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 [redacted] Hospital and shares all life safety features including fire alarm, sprinkler and generator systems. Special features of this facility include sharing the building with a [redacted] Hospital and having a temporary emergency generator for a number of years, including last years survey.

RECEIVED
[redacted] 11 2016
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	3/11/16

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

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

PRINTED: [redacted]
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OMB NO. [redacted]

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

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K 000	Continued From page 1 The following deficiencies were cited as K tags as a result of these areas of non-compliance:	K 000		
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building exit egress. This deficient practice affected 4 of 7 smoke compartments and all occupants in these areas. The facility has the capacity for 152 beds and at the time of survey the census was 150. Findings include: On [redacted], 2016 at 8:30 a.m. during the observation tour accompanied by the Maintenance Director, it was noted that the 1st floor stairwell exit door, at the front of the building was blocked by a resident in a wheelchair and a visitor seated in a chair. Any and all occupants trying to exit the stairwell exit egress are obstructed from clear unobstructed access to a point of safety due to the resident and visitor blocking the door. The resident and visitor could also be injured in the event an occupant try to exit the door. Means of egress shall be continuously maintained free of all obstructions or	K 033	K 033 NFPA 101 LIFE SAFETY CODE STANDARD SS=E This plan of correction constitutes our written allegation for compliance for the deficiencies cited. Our submission of the Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal laws All emergency Exit Doors have had a new sign installed with [redacted] Red Bold letters stating FIRE EXIT DO NOT [redacted]. All Staff will be in serviced during fire drills and families will be informed by the front parking attendant. Monitoring and compliance will be reported by Maintenance Director. [redacted]	

ADMINISTRATOR 3/11/16

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 _____	**02/23/2016**

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

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K 033	Continued From page 2 impediments to full instant use in the case of a fire or other emergency. During an interview with the Maintenance Director at the time of observation, he acknowledged that the exit egress access failed to meet code requirements for an unobstructed egress. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on [redacted], 2016. Actual NFPA Standards: NFPA LSC 101 (2000) Ch. 19.2.1., Ch. 7. NFPA 1 (2000) 7.5.1.1 requires exits shall be located and exit egress shall be arranged so that exits are readily accessible at all times.	K 033		

PRINTED: [redacted]
FORM APPROVED

Agency for Health Care Administration

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	100611	A. BUILDING: 03 - MAIN LIC B. WING	02/23/2016

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

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K 000	Initial Comments State Licensure K 3 Building: 0101 K 6 Plan Approval: [redacted]/1979 K 7 Survey Under: 2012 Existing K 8 SNF/NF An unannounced annual Life Safety Relicensure survey was conducted on [redacted] at Rehabilitation Center at Hollywood Hills, LLC. This annual survey was conducted to determine compliance with NFPA Life Safety Code (LSC) 101 (2012) Chapter 2; all NFPA mandatory requirements adopted per NFPA 101, and applicable Florida State Fire Marshal's Rules and Regulations, 69 A-[redacted]; 69 A-53; FS [redacted], and State of Florida Building Code. The facility had deficiencies found at the time of the visit. 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 (7) 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 [redacted] Hospital and shares all life safety features including fire alarm, sprinkler and generator systems, Special features of this facility include sharing the building with [redacted] Hospital and having a temporary emergency generator for a number of years including last years survey. The following deficiencies were cited as K tags as a result of these areas of non-compliance:	K 000	This plan of correction constitutes our written allegation for compliance for the deficiencies cited. Our submission of the Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal laws. RECEIVED [redacted] 11 2016 BY:	
K 029 SS=E	NFPA [redacted] HAZARDOUS AREAS	K 029		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[redacted] ADMINISTRATOR 3/11/16

STATE FORM [redacted] S4XQ21 If continuation sheet 1 of 8

PRINTED: 03/03/2016
FORM APPROVED

Agency for Health Care Administration

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K 029	Continued From page 1 Hazardous areas shall be enclosed with one hour fire rated construction or be protected in accordance with [redacted] 8.7. Doors assemblies shall be 45 minute fire rated without vision panels. In (NEW) occupancies, repair and paint shops, [redacted] storage [redacted] with quantities of combustibles, trash [redacted] exceeding 64 gal. of volume, bulk laundries, soiled linen [redacted] exceeding 64 gal. of volume, and severe hazard labs shall be one hour fire separated and sprinklered. Sprinkler protection of [redacted] hazardous areas with 6 or less sprinkler heads may be supplied by domestic water. NFPA 101 Life Safety Code (2012) 18.3.2.1 & 19.3.2.1 This Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building storage areas with rated assemblies. This deficient practice affected 4 of 7 smoke compartments and all occupants in these areas. The facility has the capacity for 152 beds and at the time of survey the census was 150. Findings include: On [redacted], 2016 at 9 a.m. and 10:15 a.m. accompanied by the Maintenance Director through observation during the tour it was revealed that the [redacted] for medical records	K 029	The facility has hired NAYA Architects, Inc. Architectural drawings are being made. Once the as-built drawings are completed we will proceed to resolution by submitting application for authorization by AHCA office of Plans and Construction. Expected completion: 1. Provide Plans 6 weeks 2. AHCA approval & Permits 90 Days 3. Bidding & Contractor 2 weeks	[redacted]

ADMIN S4XQ21

3/11/16

PRINTED: [redacted]
FORM APPROVED

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
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K 029	Continued From page 2 storage is not rated having sliding glass doors opening into the physical therapy [redacted]. Additionally, the activity [redacted] area is over 50 square [redacted] and is not rated for the current use as storage. An interview was conducted at this time with the Maintenance Director who acknowledged and witnessed that the storage [redacted] did not meet the code requirements for use as storage areas. The Administrator was notified that all work completed requires authorization by the Office of Plans and Construction. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on [redacted], 2016. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.1.5 (7) [redacted] or spaces larger than 50 ft2 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction.	K 029	See attached letter of [redacted], 2016 from Naya Architects.	
K 033 SS=E	NFPA 101- LSC 2012 EXIT ENCLOSURES Exit components (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours (New), (one hour Existing), are arranged to provide a continuous path of escape , and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure as at least one hour.	K 033	K 033 NFPA 101-LSC 2012 EXIT ENCLOSURES All emergency Exit Doors have had a new sign installed with [redacted] Red Bold letters stating FIRE EXIT DO NOT [redacted]. All Staff will be in serviced during fire drills and families will be informed by the front parking attendant. Monitoring and compliance will be reported by Maintenance Director. [redacted]	

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K 033	Continued From page 3 NFPA 101 Life Safety Code (2012) 18.3.1 & 19.3.1, 19.3.1.1, 8.6.5, 7.1.3.2.1. This Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the building exit egress. This deficient practice affected 4 of 7 smoke compartments and all occupants in these areas. The facility has the capacity for 152 beds and at the time of survey the census was 150. Findings include: On [redacted], 2016 at 8:30 a.m. during the observation tour accompanied by the Maintenance Director, it was noted that the 1st floor stairwell exit door, at the front of the building was blocked by a resident in a wheelchair and a visitor seated in a chair. Any and all occupants trying to exit the stairwell exit egress are obstructed from clear unobstructed access to a point of safety due to the resident and visitor blocking the door. The resident and visitor could also be injured in the event an occupant try to exit the door. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of a fire or other emergency. During an Interview with the Maintenance Director at the time of observation, he acknowledged that the exit egress access failed to meet code requirements for an unobstructed egress. The findings were acknowledged by the Administrator and verified by the Maintenance	K 033	Additional daily monitoring will be made by Administrator /designee during observation rounds.	

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K 033	Continued From page 4 Director at the time of observation and at the exit conference on [redacted], 2016. Class III Actual NFPA Standards: NFPA LSC 101 (2012) Ch. 19.1.1.3.2 and 7.2.1.6.2 (1) NFPA 1 (2012) 7.5.1.1 requires exits shall be located and exit egress shall be arranged so that exits are readily accessible at all times.	K 033		
K 144 SS=F	NFPA 101- 2012 LSC, NFPA [redacted] GENERATOR MAINTENANCE & TESTING Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110 (2010), Standard for Emergency and Standby Power Systems. New generator controllers shall be monitored by the fire alarm system, where provided, or at an attended location, for the following conditions: (1) Generator running (2) Generator fault (3) Generator switch in non-automatic position. NFPA 101 Life Safety Code (2012) 18.5.1 & 19.5.1, 9.1.3 thru 9.1.3.2. Emergency generator maintenance and operational testing shall meet the standards in NFPA 101 Life Safety Code (2012) 18.5.1 & 19.5.1, [redacted] 9.1.3.2, NFPA 110 (2010) 8.3 & 8.4 Diesel-powered EPS installations that do not meet the .requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with	K 144		

ADMIN

3/11/16

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K 144	Continued From page 5 [redacted] loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil [redacted] have stabilized. NFPA 101 Life Safety Code (2012) 18.5.1 & 19.5.1, 9.1.3 thru 9.1.3.2, NFPA 110 (2010) 8.4.2.3, 8.4.2.4 Level 1 EPSS shall be tested at least once within every 36 months. Level 1 EPSS shall be tested continuously for the duration of its assigned class (see [redacted] 4.2). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSs, or initiated by opening all switches or breakers supplying normal power to all ATSs that are part of the EPSS being tested. A power interruption to non-EPSS loads shall not be required. The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A [redacted] load bank shall be permitted to be used to meet or exceed the 30 percent requirement. For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust [redacted] temperatures as recommended by the	K 144		

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K 144	Continued From page 6 manufacturer. For spark-ignited EPSs, loading shall be the available EPSS load. The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. NFPA 101 Life Safety Code (2012) 18.5.1 & 19.5.1, 9.1.3 thru 9.1.3.2, NFPA 110 (2010) 8.4.9 thru 8.4.9.7. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain the emergency generator to manufacture and code requirements. This deficient practice affects 7 of 7 smoke compartments and all occupants in these areas. The facility has the capacity for 152 beds and at the time of survey the census was 150. Findings include: On [redacted], 2064 at 1 PM, accompanied by the Maintenance Director during record review, the facility was not able to produce any written documentation to substantiate the emergency generator, which is a temporary generator, had been replaced nor had plans for a permanent generator installation had been submitted as required by the letter from Office of Plans and Construction ([redacted]-1-3) dated [redacted] 7,	K 144	The facility has hired NAYA Architects, Inc. Architectural drawings are being made. Once As-Built drawings are completed we will proceed to resolution by submitting application for authorization by AHCA office of Plans and Construction. [redacted]	

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K 144	Continued From page 7 2015. An interview was conducted at this time with the Maintenance Director who acknowledged that the required documentation was not available for review. No additional written documentation to substantiate compliance was received at the exit conference. The findings were acknowledged by the Administrator and verified by the Maintenance Director the time of observation and at the exit conference on [redacted]. 2016. Class III Actual NFPA Standards: NFPA LSC 101 (2012) Ch. 19, NFPA 110, 4.4.3, " All equipment shall be permanently installed " .	K 144	Expected completion: 1. Provide Plans 6 weeks 2. AHCA approval & Permits 90 Days 3. Bidding & Contractor 2 weeks [redacted]	

ADMINISTRATOR

3/11/16

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

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

RE: Life Safety Code Survey

Dear Administrator:

On [redacted], 2016 through [redacted], 2016, a Life Safety Code survey was conducted in your facility by a representative 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 [redacted], 2016.**

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 [redacted]
Phone:(561) [redacted]; Fax:(561) [redacted]
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
[redacted].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 [redacted], **2016** 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 [redacted], **2016** 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 §[redacted], 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) [redacted]
or
Phone number: (850) [redacted]
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 representative. If you have questions, please contact this office at (561) [redacted].

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

R6WB