15:30 #668 P. / ..

CENTERS FOR MEDICAL TATEMENT OF DEFICIENCIES	RE & MEDICAID SERVICES	· · · · · ·		FORM APPROVE OMB NO. 0938-039
ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105021	B. WING_		02/18/2016
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COL	DE 02/10/2016
	AT HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOLED BE COMPLETION
conducted on Rehabiliation Central facility is not in cot Requirements for F 241 483.75(a) DIGNIT SS=E INDIVIDUALITY The facility must p manner and in an enhances each re-	Recertification survey was to at let at Hollywood Hills. The mpliance with 42 CFR Part 483, Long Term Care Facilities.		This plan of correction consti- written allegation for complia- the deficiencies cited. Our sul- of the Plan of Correction is a damission that the deficiency that one was cited correctly. To of corrections submitted to m	nnce for omission of an exists or This plan leet
by: Based on observareview the facility fireated with dignity freated with dignity individuality and pn sampled residents by failure to include activities, as assess provide activities, as assess provide activities of nall care and shawil (Resident #46), rev failure to address r manner on the sectiding observation.  The findings Include Review of the facility states, (Resident #46), set attending the activities of the section of the sect	y policy titled Quality of Life - idents shall be assisted in les of their choice'		1)Resident #265 was assigned sensory stimulation program group of 5 to 8 residents and i time increments to better met residents need.  Resident #46 was provided wi and was shaved, Staff provided education on ADL including and shaving (see signing shee Staff was provided with educaddressing residents with digrespect. (see attendance shee	in a small in smaller it the s. th nail care d with nail care t attached) attion on nity and

Any deficiency statement anding with an asteries (\*) denotes a deficiency which the institution may be excused from correcting providing a if determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are desclosable 00 days and a sufficient protection to the patient correction is provided. For nursing homes, the shown indigen and plans of correction disclosable 14 days following the state above are disclosable to the state of t

FORM CMS-3557(92-98) Previous Versions Obsoleto Event ID:S4XQ11 Facility ID: 100811

If continuation sheet Page 1 of 49

From:FLORDA AGENCY HEALTH 5614965925

7 15:30 #668 P,

		AND HUMAN SERVICES				FORM	: 03/10/2016 APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILO		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105021	B. WING	3		02	18/2016
	PROVIDER OR SUPPLIER LITATION CENTER AT	HOLLYWOOD HILLS, LLC	-	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021	1 02	18/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	PREF TAG	ix	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE	COMPLETION DATE
	nutrition and hydrail  1. Review of the ini completed documents the curr Resident #265 full documents and/for man explorates the socialization and ini will be escorted to a  On betwee purm unlibigle obsen Resident #265. On Every the curr Resident #265 for Resident #265 for Mitch was not turne turned off and the window drapes close initial record reveal feedings wia feeding concluding at 6 AM day.  Review of the 1st Fit Review of the 1st Fit Resident #265 was  Review of the 1st Fit Resident #265 was  Review of the 1st Fit Resident #265 was  In to Include a stoll Resident #265 was  In the Includent #265 was  I	cess to include and a feeding tube for on.  Itial Activity Assessment dated by an Activity Assistant, ent activity inferests of the Exercise Being Outdoors, and an Activity inferests of the Exercise Being Outdoors, and Music. The includes, Resident will receive digroup programming to michudes, Resident will receive digroup programming to entanction with others, Resident and from activities as needed.  In 11:00 a.m. through 2:00 autons were made of each observation, the ed in her in bed on, facing the overhead TV of on, Twee Service of the Control of the C		241	2) Audit was conducted of all a residents to insure that the active that are being provided are adeq with their cognition and functions status in order to improve their of life. (Audit form attached) 3) To ensure that all residents attending the proper activities their evaluation, staff were insecupdated activity calendar and a lesidents with their assigned activates with their activates with their addressing residents with dignity respect. (see attendance sheet attached)	ities uate nal quality re used on rvice on ist of vities urse tached)	

FORM CMS-2587(02-00) physics version consolor for CMS-2587(02-00) physics version consolor

Event ID: S4XQ11 Facility ID: 100611

If continuation sheet Page 2 of 49 3/18/16

ADHINISTRATON

PRINTED: 03/10/2016

/ 7 15:30 #668 P. 7...

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL ID PLAN OF CORRECTION IDENTIFICATION NUMBER	A. BUILDING	E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
105021	B. WING		02/18/2016
VAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HOLLYWOOD HILLS, LL	_   1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 N 35TH AVE FOLLYWOOD, FL 33021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC
F 241 Continued From page 2	F 241	·	ļ
Review of the Sensory Stimulation Attendar record received from the Activity Director or documents on the resident participated in Group activity, to time was documented), however Resident #255 was observed to be in bed as noted during observations, in the rightgown facing the overhead TV which was not turned on. Rev the Activity Participation record documentes the resident was watching TV.  On at 1000 an. Resident #255 was observed to be up in a wheelchaff in street othese parked between the 2 bads apposit bed. She was observed to be from the 25 bads apposite the company of the participation of the control of the	iew of on on one of one	4) Daily rounds will be conducted by activities director or designee to ensu attendance and any absenteeism will communicated immediately to IDT for further intervention.  If any resident doesn't wish to participate on any day their assigned activities an activity staff member will provide appropriate activities in In adition, DON, designee, Nurse Supevisor and Administrator or designee will observe during daily rounds, all residents remaining in the lengthly periods without receiving stimulation activities. Any findings will be reported to the Activities Director.	re l
however Resident #255 could not see it fro variage point. The overhead TV above Res #265 remained off.  Review of the Sensory Stimulation Altendar record received from the Activity Director or documents on the residen in her on activity Indicated. Review of the Activity Participation record documented on the resident record	n her sident		

CENTERS FOR MEDICARE & MEDICAID SERVICES INTEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	- (50)	(X3) DATE SURVEY COMPLETED	
		105021	B. WING		/18/2016
AE OF F	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, S	TATE, ZIP CODE	
HABI	ITATION CENTER A	T HOLLYWOOD HILLS, LLC	1200 N 35TH AVE HOLLYWOOD, FL 330		
4) ID IBFIX 'AG	JEACH DESICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT TAG CROSS-REFERENCE	AN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	COMPLETION DATE
	read to. Resident in moved from the sy opposite her bed.  On at 10:. Cobserved in her The lights were outlosed.  On 2/17/16 at 11:. Cobserved in her The observed in her The overhead TV. and the window of the cobserved remains the TV not on. The window cutarians wonder the total cobserved remains the TV not on. The window cutarians wonder the cobserved remains the TV not on. The the first floor half in an interactive si outside patio.  On at 3:00 observed remains the TV not on. The the singing activity.  Review of the Ser encord received for encord received for at 3:20 p. Interaction. Review of the Ser encord rece	n, listened to music, and was 1265 was not observed to have bot between the 2 beds 100 a.m. Resident #265 was bed in her nightgown. I and the window curtains were 100 a.m. Resident #265 was bed in her nightgown. was not on. The lights were out trains were old in 1615 was 1615 was 16 p.m. Resident #265 was gir hed, in her nightgown with e lights were out and the ere closed. 5 p.m. Resident #265 was gir hed with the rightgown with lights were out and the eres closed.	F 241		
	Review of the 1st the days activities	Floor Activity Calendar revealed on which Resident	1		,

To:15614965924 ;9549817229 # \_ 7 . .

		AND HUMAN SERVICES  & MEDICAID SERVICES				APPROVEI . 0938-039
TEMENT PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDE	TIPLE CONSTRUCTION NG	(X3) DA	E SURVEY APLETED
		105021	B. WING		02	18/2016
	PROVIDER OR SUPPLIER LITATION CENTER AT	HOLLYWOOD HILLS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021		
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES FMUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE
	Include, 10:45 a.m.  On at 10:0 observed in bed in not on and the light curtains closed.  On at 10:0 observed in bed in not on and the light curtains closed.  On at 10:0 observed in her her bed. The TV war and the window our On at 12:2 observed in her her bed. The TV way, the lights were drawn. A nurse am way, the lights were drawn. A nurse and the window out of the test of test of the t	as having interest in, to Morning Stretch, at 2:30 p.m. 14:00 p.m. a group watching of 100 p.m. a group watching of 100 p.m. Resident #265 was her rightgown. The TV was swere off and window is a.m. Resident #265 was in a wheelchair next to so not on, the lights were out tains drawn.  p.m. Resident #265 was in a wheelchair next to so not on, the lights were out tains drawn.  p.m. Resident #265 was in a wheelchair next to so ff and facility and the window curtains it an alide were observed in the resident of the door bed back urse stated they are getting bed so she can start the	F2:			

#688 P.

From:FLORDA AGENCY HEALTH

5614966925

16:31

PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING 105021 B. WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX YAG COMPLETION F 241 Continued From page 5 F 241 entertainment, take them outside and do word games with them. She stated residents with tubes are not eliminated from group activities. She stated Resident #265 has "something" done every day however, Resident #265 was not observed from through to be out of her , participating in any group exercise or music activities that were observed to be attended by other that did not have feeding tubes and who did not have the | tube feedings commencing at 2 PM in the aftermoon. 2) On at 11:30 a.m. Resident #46 was observed in his bed. His fingemalls on both of his hands were observed to be long with the right hand worse, with long jagged sharp edges and a black unknown substance observed under the nails of his right hand and a thick yellowish spongy substance under the left hand fingernalls. Additionally, the resident looked like he had not been shaven for a few days. The skin on his arms was noted to be very fragile with multiple and scretches on both arms. An inquiry was made if he had accidentally scratched himself with his long fingernalls and he stated his skin scratches easily however, as far he is aware he has not scratched himself as of yet. The resident stated he thinks he is going to get shaved "today" and maybe in a day or two they will cut his fingernalis. Review of the clinical record revealed Resident #46 was initially admitted to the facility on with hospital admissions on through

On at 9:51 a.m. the resident 's fingernalis on foth hands remained long and forgiverall FORM CMS-2867(02-09) Previous Versions Object

On

with a readmission back to the facility on

Event ID: S4XQ11

, Facility ID: 100811

ADMIL

sheet Page 6 of 49

FORM CMS-2587(02-89) Pri

From:FLORDA AGENCY HEALTH 5614985925 / / 15:31 #668 P. /

		AND HUMAN SERVICES					FORM.	03/10/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE BURVEY COMPLETED		
		105021	8. WING	·			02/1	8/2016
	PROVIDER OR SUPPLIER LITATION CENTER A	FHOLLYWOOD HILLS, LLC		12001	ET ADDRESS, CITY, STATE, 21 N 35TH AVE LYWOOD, FL 33021	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	KTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF O (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD HE APPROPE	86 1	COMPLETION DATE
:	the right hand finge spongy substance. He remained unshis conserved in his time he had a shaw he hospital and he (name of alde) to that she will shave nails were observed his block has the blackth substa fingernals and his hubble shown halls were observed. We have not shall be the conserved his substa fingernals and his thick spongy substresident stated (nat tomorrow.  Review of the Certi Tracking Form for Tracking Form for assistance with ADI include shaving even hail Care there was resident's long finge On at 11:1:	ck substance remaining under mails and the finitely vellowish under the left hand fingernalis. Wen. I have been to be the stated the last bed. He stated the last was last Thursday while his swatting for a least Thursday while his swatting for a least the last the was last Thursday while his swatting for a least the last the was last Thursday while his to still be long, jagged with neon under the right hand off hand fingernalis with the ince under his nalis. The ne of alde) will help him fled Nursing Assistant 2016 and "Personal Hyglene" resident was recolving a (activities of daily hiving) to rys shift. Additionally under no documentation the rais modern server being addressed. 5 als wet being addressed.	F:	241				
	his face had been s aide cut his fingerna yesterday as he hel 'They look pretty go	id now been manicured and haven. The resident stated an sills and gave him a shave dout his right hand stating od don't they?" swattons in the 2E dining					;	
	delivery, it was note referred to by the st according to their re	t 12:38 PM during tray d that residents were being aff as "feeders" and identified om number, not their name.		İ				
RM CMS-26	87(02-80) Providus Versions	phospila Eveni ID: S4XQ11  Wall Eveni ID: S4XQ11	mi	Facility ID	: 100811	3/18	on sheet	Page 7 of 49

# ../ ..!

From:FLORDA AGENCY HEALTH V ... 15:31 #668 P. / PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 105021 02/18/2016 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIES 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (XS) COMPLETION DATE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION F 241 Continued From page 7 F 241 For example, Staff J was heard announcing out Staff K, loud from Inside the 2E dining who was out in the hallway next to the tray cart "she is " as she pointed to a resident. In return, Staff K stated loudly back at Staff J, three resident names to include Resident #270 and stated "they are feeders". Staff K then asked from the hallway dining cart into the dining those who were listening, "who are the other feeders?" at 1:18 PM, Staff K was observed delivering a tray into delivering a tray into tray. As she exited, she was heard asking loudly, "is 201A is a feeder?, as the Certified Nursing Assistant (CNA) her, At 1:22 PM she was entered the heard in the hallway saying, "202B is a feeder". In an interview on at 12:62 PM, Staff K stated that a feeder is someone who need assistance by the CNA to eat. During further interview Staff K revealed that she did not find anything offensive in calling residents' feeders because "that is what they need." F 250 483.15(g)(1) PROVISION OF MEDICALLY SS=D RELATED SOCIAL SERVICE F 250; A grievance was done for Resident #118 , Glasses and regarding The facility must provide medically-related sociel Hearing Aid unanswered requests. services to attain or maintain the highest Resident #118 was seen by mobile eye practicable physical, mental, and psychosocial care on ... Examination well-being of each resident. revealed that glasses would not improve

FORM CMS-2567 bos de Cartallo

This REQUIREMENT is not met as evidenced

Based on interview and record review, it was

determined that the facility failed to provide

Event ID: S4XQ11

ADHU

(See attached Forms) Facility ID: 100811

resident vision due to eyes. (See attached consult)

Dentist on

delivered on

Resident was seen and evaluated by

if continuation sheet Page 8 of 49

3/18/16

will be

To:15614965924 ;9549817229

From:FLORDA AGENCY HEALTH

5614965926

15:32

#668 P. DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/10/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 105021 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID F PREFIX -PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION CATE PREFIX TAG F 250 Continued From page 8 F 250 medically-related social services that included dental services, hearing, and vision for 1 Resident was seen by Hearing USA on (Resident #118) of 1 sampled residents reviewed for social services. . Consult recommended for wax removal. (See Attached) The findings included: Resident was seen by evaluation of poor hearing. Cerumen During an Interview conducted with Resident #118's designated health care surrogate (HCS) dissipation was done. at 3:31 PM, it was revealed that on Grievance was resolved to family she has been requesting , glasses, and satisfaction. hearing , from social services multiple times on previous occassions, but does not recall a specific staff members name. She stated that she spoke with Staff I, in the business office "today" She also stated because of the facility's change in ownership, resident services are delayed. The HCS also stated the facility called approximately one month ago and stated they cleaned the resident's , but that is not what the HCA wanted. Resident #118 has , but they no longer fit due to the residents ongoing weight loss. The HCS stated that she initially requested a dental evaluation, hearing and glasses about 3-4 months ago. During an interview conducted with the Director of Social Services on at 2:17 PM . she stated that she has been employed at the facility for only four months. She further stated that the facility had recently changed dental contractors. During the Interview, the Director Initially, had no recollection of Resident #118's needs for , hearing aid, or glasses. When questioned if the HCS for Resident #118 had

Spoke to Alaff I.

FORM CMS-2687(02-08) Privatus Version Obsolete

for if Consulta

spoken to anyone the previous day, she was unaware. The surveyor informed the Director of Social Services that Resident #118's relative

Event 10: S4XQ11

Fecility (0: 100811

ADHU

Page 9 of 49

To:15614965924 ;9549817229 # .\_/ ...

From:FLORDA AGENCY HEALTH 5614965926 / 18:32 #668 P. /

PRINTED: 03/10/2016

CENTERS FOR MEDICARE &	MEDICAID SERVICES			APPROVE( . 0938-039
	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION (X3) DAT	E SURVEY PLETED
	105021	B. WING		18/2016
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HE	DLLYWOOD HILLS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021	
PRESIX (EACH DEFICIENCY ML	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
did come to the busine about hearin stated she told Reside Social Services Direct were in the middle of a During an Interview with Services and Director at 2:35 (in the Director at 2:36 (in the 2:36 (in the Director at 2:36 (in the 2:36	th Staff I on at hat Resident #118's NCS sessident #118's NCS ses office to inquire again general ground gr		An audit of all active Residents was conducted by Social Service Director to ensure that no other Resident was identified with hearing, vision or dental without proper follow up.  To ensure compliance, QA Committee will audit sample charts of residents identified with having vision hearing and dental related concerns. Facility will assess the need for hearing dental services, and eye care upon admission, and as needed during ADL's. Staff provided with in-Service related to communicating any noted by IDT to Social Services immediately for proper follow-up.	

To:15614965924 ;9549817229 # .3/ .4

From:FLORDA AC	ENCY HEALTH
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5614965925 / 15:32 #668 P. /

ATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		105021	B WING		02	/18/2016
AME OF F	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE,	ZIP CODE	
		HOLLYWOOD HILLS, LLC		1200 N 36TH AVE HOLLYWOOD, FL 33021		
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES	io I	PROVIDER'S PLAN O	CORRECTION	(165)
PREFIX	(EACH DEDICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE CY)	COMPLETION
E 250	Continued From pa	nna 10	F 250			Ì
. 200	examination dated			ì		i
		or surgery. Glasses				1
	will not improve vis			i		
		to Resident #118's HCA, the	i	i		i
		ervices did not know.		1		
	Documentation was	s also shown for orders for a	!	i		1
	hearing consult dal			}		1
	second opinion dat			1		
	hearing appointme	nt, on at 11:00 AM,		1		1
	dated	and a resident		l control of the cont		
	grievance/complair	nt for , glasses, and				1
	hearing dated	. When questioned		1		i
	about follow up with			!		1
		, the Director of Social		1		1
		re was no follow up and no		i		
		at this time. She stated the		:		į
	dental services usu	ally call them, but she would		1		1
	give them a cell an	d make the vision		i		
	appointment.			!		1
				F		
		with the Director of Social		ł		1
	Services on	at 3:30 PM, the Director		1		i
		ation of "eyecare examination"		!		1
		he stated that when she called		1		1
		ment they informed her that		!		i
		seen on that date. They faxed in nentation of evecare		ì		1
	examination, dated					1
	patient was seen or			į.		!
		es would not improve patients		1		1
	vision due to the pr					1
		ion also provided with dental		1		
		a Dental Services company		ì		
	with appointment d					
	at 11:00			!		
		f Social Services stated she				!
		t #118 HCA a call to inform		1		*
	her.					
M CMS-25	67(02-88) Previous Versions	Official ID. S4XQ11	Fa	: ::::::::::::::::::::::::::::::::::::	If continuation shee	Page 11 of
	77	Cartallo		prin	3/1011	-
	//	N A 1/12	v	TIMUL	2114116	

From:FLORDA AGENCY HEALTH 5814966925

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 03/10 FORM APPRO	OVE
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	EY
		105021	B. WNG		02/18/201	c
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/16/201	•
		HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 35021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROVIDENCY)	UBE COMBI	ETION
F 250	Continued From page	ne 11	F 250			
		e clinical record or Resident	. 1 200	2	1	
	#118 on	it was noted an admission				
		at included diagnosis of			i	
		and Anorexia			1	
	Record further reve				Ī	
	and a total	assist for Activities of Dally		!		
F 253	483,15(h)(2) HOUS	EKEEDING #	F 253	•	i	
SSEE	MAINTENANCE SE	RVICES	F 253			
	210 1102 02			RCHH will make every effort to e	neura	
	The facility must pro	vide housekeeping and		Housekeeping and Maintenance		
	maintenance service	es necessary to maintain a		Services are provided to maintain	_	
	sanitary, orderly, and	d comfortable interior.		sanitary, orderly and conformable		
		i		environment.		
	by:	T is not met as evidenced		environment.	<b>!</b>	
:		on and interview conducted			1	-
	on It was	determined that the facility	- 7		ļ	
	raneo to provide nou	sekeeping and maintenance o maintain a sanitary,				
	orderly, and comforts	able interior in 4 (1 East, 1			i	
	West, 2 East, and 2	West) of 4 Resident Units.	!		ŀ	
•	The findings includes		i			
	During an environme	ntal tour conducted on			ĺ	
	at 10:05 A	M and 1:00 PM	)		1	- 1
,	accompanied with th	e Administrator, Engineer	į		1	- 1
	Director, the following	Nursing and Environmental g concerns were noted:	- 1			
•	1.) 1 East Wing:	\$ :	i	1. (a) entrance	has	
	a The w	ooden was	1	been fixed.	1	
	scratched and chippe					- 1
			1	(b) sink has been repai	red	
	b The a	rea on the floor around the		and cracked tile replaced.		

FORM CMS-2587(02-88) Provious Very Congress Event 10. SAXOTI FECILIA DO: 100811

AD HINIS FRATE-

H continuation sheet Page 12 of 49

From:FLORDA AGENCY MEALTH 5614965925 / 15:93 #668 P. /

	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	105021	B. WING		62/18/2016
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER A			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 36TH AVE HOLLYWOOD, FL 33021	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
hole in the floor in the floor in the floor in the same peeling. There is stand was peeling. There is stand was scratch d. It is stand was scratch desilvering. The desilvering help in the bottom of the rusted.  e.   The we was in disrepair with the wooden door, sink was desilvering was the site on the floor.	and cracked tile. There was a as the sink.  paint on the was not a trash can in the cond bed's dresser/night ed and worn.  mirror above the sink was spots. The wall under the toesing and was scratched, melt was the cracked. The his cracked she his cracked. The his cracked she is cracked. The his cracked she is cracked she is cracked. The his cracked she is cracked she is cracked. The his cracked she is cracked she is cracked. The his cracked she is cracked she i	F 25	(c) has been painted an trash can has been placed in the be. The bed dresser has been replaced. (d) mirror above the sin been replaced. Wall area under the television has been fixed and paint been replaced, bath has been fixed. The mit by the sink has been replaced.	k has ed.
throughout the 1 E deep scratches an  g. Storage if the hallway contribution of the sedings ( as tube feeding su  h. Solled utility	f - An unlocked supply ained 10 cases of tube and fibersource), as well opties.		(f) Corridor hand rails in 1 East Wir have been painted. (g) Storage # has been lockee and appropriate staff given a key. (h)Building Service Staff and Clinice Staff have been inserviced in proper trash disposal in Soiled Utility. (see attached)	i
trash in bins and to	ash on the floor.		(i) All pull have been loosened and Housekeeping Department Director has in- serviced staff on keeping free	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

FORM CMS\_2007(07-07-07-00-04-07-00-0

H continuation shept Page 13 of 49

To:15614965924 :9549817229

#668 P.019/096

From:FLORDA AGENCY HEALTH

5614965926

15:33

PRINTED: 03/10/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER: A RISH DING 105021 A WANG 02/18/2016 STREET ADDRESS, CITY, STATE, 2IP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE F 253; Continued From page 13 F 253 (i) Wet floor signs have been removed were stored on the floor next to the countertop from Pantry. House Keeping staff The retrigerator and freezer gaskets were full of inserviced. Signs moved to Janitors dirt and debris. closet, (Staff in-serviced) (k) 1 East Activity k. 1East Activity -The wooden entry doors have were in disrepair with deep scrapes and scuffs. been repaired. The back walls had peeling paint. (1) Lock has been replaced and floor # - had a loose door knob and I. Storage cleaned. dirty floor. 2.) 1 West 1 West Wing:
 a. \_\_\_\_ The door jam 's paint was chipped, and the floor at the door was chipped. The (a) door jam's was filled and painted. The rail bumper guard has been fixed. ralling/bumper guard displayed the metal outside (b)Open shampoo bottles removed, mouthwash removed, wet paper towels b. Shower - contained open bottles of removed staff in-serviced to discard all shampoo (2), mouthwash, lotion and wet paper used items after residents shower. entry door has been (c) - The entry door was scraped. The fixed, the wall of the bed has been wall of bed 2 displayed 2 metal picture hangers and scrapped walls. There was a chair with tom repaired and painted, metal picture hangers removed and wall fixed, cushions. The air conditioner vent was rusty. cusheons discarded and A/C vent rust fixed d. Medication carts- 3 of 3 trash cans were observed full of waste products with no cover, (d) Medication waste covers purchased and installed. Staff inserviced on waste 3.) 2 East: level and disposal. Hallway corridors have been fixed and Hallway Corridors- The corridor handrails painted.

throughoutwere worn.

- The wooden head board and foot board of beds B and C were in disrepair with scratches and scrapes. A hole was noted in the wall in the . The night table of bed 1 is in disrepair.

(a)

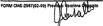
ion sheet Page 14 of 49 3/18/16

Wooden Head boards B

been fixed. The

and C have been replaced. The hole in

night table of bed 1 has been replaced.



Event ID: S4XQ11 Facility ID: 100811 , Min

# . 7

From:FLORDA AGENCY HEALTH

6614965925

15:33 #668 P. /

PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (XS) DATE SURVEY A. BUILDING\_ 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC 1200 N 35TH AVE HOLLYWOOD, FL 33021 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) co F 253 Continued From page 14 F 263 b. - The entry door was scrapped. The baseboard behind bed B was dirty and chipped. door has been fixed. The baseboard behind bed B cleaned and The night table for bed C was dirty. painted. Night table for bed C has been c. - There were staples and nails in the walls. The baseboard under the window had cleaned. (c) staples and nails removed black stains. There were numerous small holes in the floor tile in the the wall was painted. Floor tiles in the been replaced. Entry door fixed wall door is chipped and the wall behind bed B is scratched. behind bed B was fixed and corner The corner guard is guard fixed. Walls fixed and painted, (e) - The walls had paint peeling. The night table bed A has been replaced. night table of bed A was in disrepair. - The overbed table 's legs were (f) The overbed table was peeling paint. replaced. (g) frame was -The i's door frame was fixed and painted. The bath tub was rusted. The tub was soiled. - The wall behind bed A had paint (h) behind bed A was peeling fixed and painted. (i) Clean Linen doors handle fixed doors I. Clean Linen Doors- were in disrepair and the fixed. handle was falling off. j. 2 East Dining //Activity -The entr to the chipped The air vents were dusty, and the walls paint was peeling. -The entry (j) 2 East Dining door entry fixed and painted, air vents cleaned and walls paitned. 4.) 4.) 2 West Wing: (a) tiles fixed. а - The has missing tile (b) fixed, tiles replaced. 1- The Soiled wheelchair removed and cleaned. h has FORM CMS-2567(02-09) Prov Event ID: S4XO11 Facility (0: 100811 ion sheet Page 15 of 49 ADMIN

From:FLORDA AGENCY HEALTH 5614965025

From:FLORDA AGENCY HEALTH 66	14965025	75:34	#668 P. /
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			PRINTED: 03/10/201
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	(X2) MULTI A. BURLDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
105021	B. WNG_		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	02/18/2016
REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC	- 1	1200 N 35TH AVE HOLLYWOOD, FL 33021	
(AS) D SUMMARY STATEMENT OF DEFICIENCIES PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (XS) LD BE COMPLETION PRIATE DAYE
F 253 : Continued From page 15 missing/broken tile. The uneven with the was observed in the . A solled wheelchair was observed in the . The baseboard was	F 253		
c baseboard outside of j metal exposed.		(c)Room 225 baseboard outside was repaired.	
d. Shower — tollet seat was loose. The shower — call light was too short.  e. Pantry — had personal belongings, a jacket, and more than 4 purses.  f. 2 West Activity — wall paper was bubbled. The window sills were stained.  During an interview directly following the emvironmental tour on the Administrator. Engineer Directive were stained in the Administrator. Engineer Directive revealed that the procedure was for staff reporting broken items or items that need to be repaired, the Director of Engineering responded that each nursing station has a box in which work orders are placed, then he retrieves them daily. The Director of Engineering stated that the staff needs a refresher courseln service on how to report housekeeping/maintenance. The Administrator stated that only recently was a quality assurance tool developed an implemented for housekeeping/maintenance.  F 314 482.25(c) TREATMENT/SVCS TO	F 314	(d)Shower seat was fe call light cord was replaced. (e)Facility staff in-serviced not to personal belongings in Pantry (f)2 West Activity parboen fixed window sills replaced. All other facility in comma areas have been assessed and all nescssary repairs have been comptone of Maintenance will maintain preventative maintenan manual with a log for daily round. In addition the Administrator wi make weekly rounds to observe Maintenance and Housekeeping provided by facility.	p place per has  on  the control of
M CMS-2597(92-99) Profloys Versions Obsolote Event ID: SAYON		r iD: 100811 If continue to	
Greekall		LMSTAC 3	sheet Page 16 of 49

From:FLORDA AGENCY HEALTH 5614966928

/ / 15:34 #668 P. W

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		P		: 03/10/201   APPROVE
		& MEDICAID SERVICES				. 0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
		105021	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	18/2016
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		1205 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE BIATE	COMPLETION DATE
F 314	Continued From page	ne 16	F 314			
		ty without pressure sores	17 314	1. Resident # 46 was not affected by		
	does not develop or	essure sores unless the		1. Resident # 46 was not affected b	cited	
	individual's clinical o	ondition demonstrates that		care procedure as evidence	d by	
	they were unavoidal	ble; and a resident having		left heal resolved, left		
	Dressure sores rece	ives necessary treatment and		improved and right heal	1	
	services to promote	healing, prevent and		improved.	Į.	
	prevent new sores for	rom developing.		improved.	1	
					1	
	This REQUIREMEN	T is not met as evidenced		<ol> <li>care nurse was provided</li> </ol>	with	
	by:	,		1:1 education on proper car		
i	Based on observation	on, interview and record		procedure to prevent		
i	review, the facility fa	led to ensure the appropriate	į		and	
	provision of	are was provided for 1 of 1		avoid cross contamination to inclu	de	
	Residents reviewed:	for		proper handwashing with return	- 1	
1	(Residents #46), as a	evidenced by falling to	- 1	demonstration. (see attendance she	et i	
	potential for contami	in a manner to prevent the nation of the wounds for	ì	attached)		
1	Resident #46.	i	- 1	3 Campana	- 1	- 1
	The Control 1 1 1		- 1	3-Competency validation of dressit	)g	- 1
	The findings included	i: !	i	changes was performed on both	1	- 1
- 1	Davidson - Cabo - Co. 100	i	!	care nurses to ensure compliance. (	sce !	1
1	Review of the facility	policy for		competencies attached)	i	1
	rrandwasning/Hand F	lygione states in part.	1		- 1	1
1	Employees must was	sh their hands for at least	- 1	4.3471-1	!	- 1
	fifteen (15) seconds u		- 1	4-Weekly observations to b		- 1
	followine sensitive ::	p and water under the	1	done by DON or designee for the r	ext i	- 1
- 1	dresning conditions; I	Before and after changing a	- 1	three months to ensure proper		- 1
	orosonig. The Proce	dure states: 'Vigorously		care procedure is being followed, re	norts	- 1
	creating friction to all	p and rub them together, surfaces, for at least fifteen		will be taken to QA monthly. (see	F	- 1
- 17	(15) seconds under a	moderate stream of running	i	sample observation attached)	i	- 1
- 1	vater, at a comfortable	e temperature'.		sample ooservation attached)		
f	Review of the facility p	policy for Care	1			- 1
; 0	ocuments the Steps	in the Procedure for	1			
' E	ion-disposable suppli	es to include; Wipe	i			1
r	eusable supplies with	as indicated () e				i
٠ و	outsides of containers	that were touched by				
M CMS-2887	rayland Demolous Markons 20		Fr	y ID: 100911		
	yord Carl	all and		y ID: 100911 If continugation :	heet Pag	e 17 of 49
	Cho The Caron	TAD!	4	3/10	1,	
	Ø.			-//8	114	
					, ,	

From:FLORDA AGENCY HEA	LTH 5614	965926	,	15:34	#668 P. /
DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME	HUMAN SERVICES				PRINTED: 03/10/2016 FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PLAN OF CORRECTION (X1)	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MUI A. BUILO	TIPLE CONSTRUCTION	<u>-</u>	(X3) DATE SURVEY COMPLETED
	106021	B. WING			02/18/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	02010/2010
REHABILITATION CENTER AT HOLL			1200 N 35TH AVE HOLLYWOOD, FL 33	021	
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST I	OF DEFICIENCIES	ID.	PROVIDER'S F	PLAN OF CORRECTION	N (x6)
TAG REGULATORY OR LSC IDEN	TIFYING INFORMATION)	TAG	X (EACH CORRECT CROSS-REFERENCE	TIVE ACTION SHOULD CED TO THE APPROPE EFICIENCY)	OF COUNTRAL
F 314 Continued From page 17					
unclean hands, scissor bla	edes etc.)	F3	14		
Resident #46 was admitte	d to the facility on				
with hospital adm	no anolezir a diw		1		1 1
readmission back to the fa	cility on		1		
Review of the clinical recor	rd revealed Resident		1		
#46 was admitted with a to the sacral area, an unsta	أأحد ومريانية		1		1 1
and a susne	ected deep tissue injury				
to the right neel.	sold deep assue injury				
On at 10:30 a.m.,	with the consent of		}		!!
the resident, observation of commenced with					1
Staff A. With the assistance	are Registered Nurse,				
resident was repositioned to	o his left side and the		1		1
adult brief was removed, it:	was observed there				
was no dressing on the sac was noted to be the size of	rai The				
, by side with a smaller	the sonrovimate				
size of a dime below and to	the right of the larger		1		
. The wounds were o	bserved to be draining		1		i 1
a small amount of A removed her gloves, wash	drainage. Staff		!		
seconds and donned new g	loves. She then		;		
poured sterile normal	on a war of nauro		4		1 1
and proceeded to cleanse th	ne wounds with				!!!
initially a dabbing motion and motion over the entire wound	d then a swiping		1		
Wounds with dry gauze. She	then removed her				- :
gloves, washed her hands for	or 4 seconds and		1		
i donned new gloves. She sat	IARZANI		1		- 1
care ointment in a medication tongue depressor placed the	n cup and with a		1		
, wounds in a swiping motion.	She then picked up		1		
another wad of gauze and w	ith her aloved figures		1		1
touching the side of the gauz	e that was going to		;		1
	she placed the		i		. 1
M CMS-2587(92-89) Previous Varaione Observato	Evert ID:SAXO11	Fe	cilly ID: 100521	if continuation s	sheet Page 18 of 49
/ has	de sall		ADMan		10/1

CTATCLAR		& MEDICAID SERVICES				M APPROVE D. 0938-039
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY
		105021	B. WING		0.	2/18/2016
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP C		7 10/2010
REHABIL		HOLLYWOOD HILLS, LLC		DLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	RHOURD BE	COMPLETION DATE
t to the control of t	Omili fix dressing. She the did not wash he had desising. She the without washing her resident's left leg on the left heel. She raise he left heel. The left heel may be an unstaged on the left heel. The left heel may be an unstaged with sold she with sold she with sold she with sold she left heel. The left heel made heel with set of the left heel. The left heel made heel with set of the left heel. The left heel made heel with set of the left heel. The left heel heel heel heel heel heel heel hee	nds and secured with an observed her gloves, nds, and dated the outside of en donned new gloves hands and repositioned the a pillow to have access to moved her gloves, washed onds, donned new gloves and the Kling wrap dressing over there! "was observed to there!" was observed to there! "was observed to there! "was observed to there! "was observed to there! "have observed to there!" was observed to there! "have observed to go on the filling of the dry go containing e clean field. In the floor, it is the plastic bac off the ck on the clean care took a box of gloves stilling upply field and placed the bad next to the laft leg. She ves, washel her hands for 4 new gloves. She placed the in medication cup and then is she used to the first general the second of the country of the second of the	F 314			

From:FLORDA AGENCY HEALTH 5614965925 / 15:36 #668 P.024/098

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	IYO MUUTON D	CONSTRUCTION		0. 0938-0
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING_	CONSTRUCTION		TE SURVEY
		105021	8 WING		-	1/18/2016
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DE UZ	/ 10/2016
REHABI	LITATION CENTER A	HOLLYWOOD HILLS, LLC		DLLYWOOD, FL 33021	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR [EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLET DATE
F 314	Continued From pa	oe 19	F 314			
		ne left heel, cut off the				1
	dressing on the rigi	it heel and placed the scissors				1
	back on the clean f	eld next to a clean wad of	- 1			1
	gauze. She then pla					1
	the right heel	with a tongue depressor				1
	however did not cle	anse the first. She	!			1
	removed her gloves	, washed her hands for 3	- 1			1
,	seconds, danned n	ew gloves and picking up the				i
	wad of gauze sitting	next to the used scissors on				i
1	the clean field, plac	ed the gauze over the right				
	heel and sec	cured with Kling wrap. Using	!			1
3	the same scissors s	he cut a piece of the Omni fix	ì			;
	previously used sele	ed the Kling, placed the sors back on the clean field,	i			1
3	placed the Omni fly	dressing over the Kling wrap	1			ļ
	and dated the dress	ing. She closed up the red	1			
,	biohazard garbage	ong, took her gloves off and				1
	washed her hands (	or 6 seconds. She took the	i			1
		came back in, washed her	1			!
i i		and proceeded to pick up	i			ì
	the paper package of	of clean gauze and box of	1			
- 1	Omni fix tape holdin	g them to her body then put	1			
	them back on the cli	ean field. She then went out	- 1			1
- 1	of the retu	rned with another red	}			
- :	biohazard bag and p	laced some of the used	1			}
	supplies in the bag t	hen picked up the paper	į.			
	package of gauze, C	mni fix tape, and cintments,	;			i
	placed them on a wi	ite foam tray and placed the	į.			
- ;	box of gloves that ha	d been sitting on the				
- 1	resident's bed, on to	p of the supplies and took the	ì		:	
	biohazard bag out of back to the re		- 1			
		moved her gloves and	i			
		or 5 seconds. She then took	1			
	use oox or groves he	w sitting on top of the the rack above the sink.	-			
- 1	nicked up the pistms	ints, paper package of gauze	ì			
	and Omni fix tape, w	ent to the care	ļ		i	
- 1	treatment cart, and o	laced the supplies back into				
- 1	the cars. Returning b	ack to the went to				
	71 CO Contain Variation of	Senteto Francisco Company	Farfilly	ID: 100811 If sonti		
	Harall		MOHIL		nuation sheet F	age 20 of

	RS FOR MEDICARE T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7		OMB	NO. 0938-03
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		105021	B. WING_			02/18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	IP CODE	02/10/2015
		HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	YEAGH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLETIO DATE
F 314	: Continued From page		F 314			
:	towel, returned to the opened the top draw still in a paper towel the cart. She then di	er and placed the scissors,				
F 315;	On at appr Director of Nurses w care observation of s which she responder Staff A did as poorly	oximately 4:00 nm the	F 315			
	resident who enters to is resident's clinical con was n who is of treatment and service	ity must ensure that a he facility without an not unless the dition demonstrates that eccessary; and a resident		back with orders to remo	and came ve as (see order	
t r	ry: Based on observation	s reviewed for				

From#LORDA AGENCY HEALTH

/ 15:35 #668 P.

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				ED: 03/10/2016 RM APPROVED
	T OF DEFICIENCIES	& MEDICAID SERVICES			OMB N	IO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		105021	8. WING		1.	02/18/2016
NAME OF	PROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, SYAT	E. ZIP CODE	2211072016
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC	- 1	1200 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN	OF CORRECTION	<del></del>
PRÉFIX TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION DATE
F 315	Continued From pa		F 31			
	The impings include	:	1	2- Staff was educated		
	Record review rever	aled Resident #269 was	í	residents who enter		ıt
:	admitted to the facili	ty on with an	!	an	are not	1 1
	Indwelling	, with the indication of		catherized unless the		
	retention" n	oted in the Physician Orders.		condition demonstra		
	address the resident	n's progress note does not		catherization is nece		1 1
	diagnosis/plan nor if	the resident has on	1	attendance signing s	heet attached)	
	indwelling	present. The Nursino	ì	3- Restorative assess		!!!
	note entry's only me	ntion the indwelling		updated to reflect re-	sidents that are	i l
	twice; once	in the admission note and	:	admitted with	and the	1 1
	the second time in a	norsing entry dated now that the physician was		diagnosis with prope		1 1
	contacted to discuss	the follow up care or plan		Restorative Nurse ed	ucated on the nee	d!
	related to the resider	it's indwelling		for assessment of all		1
	No consults	had been made to address		admitted to the facili	ty with an	! !
	the resident 's urolo	gical status		indwelling	for proper	
4.	The Minimum Data S	let (MDS) reveals that the		follow up and care pl	an.	! [
1	resident has a	et (MUS) reveals that the		4- An audit was cond	lucted of all	1
- 1	(BIMS) summary soo	re of 15, which indicates		current residents in t	he facility to	1
:1	Resident #269 as abi	e to be interviewed and		ensure proper follow		1
	Intact, In	addition, the bowel and		have been scheduled		1 1
	is present.	s an indwelling		without a diagnosis t	o support an	1 1
i	.,			indwelling	. (Sec	1 1
, ,	Record review reveal	ed two care plans		attached)	. (	!
1 2	addressing st	atus were initiated, however		5-A weekly audit will	be conducted by	1
į e	plan, other than to b	eep drainage bag below		DON or designee of	all residents with	i l
	level, is not in	dicated.			are the proper	
: 0	On - at 1:43	PM, the ADON (Assistant		diagnosis are in place	for the use of	: 1
E	Director of Nursing) si	tated that the reason for			rders for attempts	
- 1	is Reten	tion and that this is an		of removal from MD	are in place for	
a	cceptable diagnosis,	She stated that there		those that are not nec	essarv.	
s	hould be follow-up re hart but was unable t	garding the in the		mar are not nec		
re	gapting the plan to	assist the resident in the				
	102,000 Provious Parsions Co.					
	LIGATOR PAGE 1900 CP	gleje Event ID: S4XQ11	Fee	SRy ID: 100611	If continuation sheat	Page 22 of 40

FORM CMS.2587(02/00 Provious presions Obsoles

ADHINISTEASON

If continuation sheet Page 22 of 49

From:FLORDA AGENCY HEALTH

- 15:35 #668 P. /

ATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	DV21 MILITIDI	E CONSTRUCTION		O. 0938-03
D PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A CONSTRUCTION	(xa) D	ATE SURVEY OMPLETED
		105021	B, WING			2/18/2016
IAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	271012070
EHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		200 N 36TH AVE OLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIPYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD RE	COMPLEYS DATE
F 315	Continued From pa	ne 22	F 315			
	restoration of her	function. She stated	F 313			3
	that they have morr	ing meetings and clinical				1
	meetings regarding	residents to discuss care and :				1
	concerns; however,	this was not identified. The				1
	and make a follow to	ey need to contact the doctor	1			1
	indicated, attempt to					
	ADON acknowledge	ed the lack of documentation	i			!
- 1	throughout the chan	and that she too could not				1
1	see a clear picture of	of the plan of care.	j			i
	On   at 2:5		1			
		3 PM in an interview with the stated that the resident has	- 1			1
		retention and thinks the	i			1
	resident may have a	doctors appointment but is	- 1			1
į	not sure and could n	ot locate any additional	;			!
	information. She sta	nted that she was not sure as	i			
,	to what the Physicia	n's plan is for the resident.				!
	In an interview on	at 2:47 PM with Staff	1			!
		not sure why the resident	1			i
	has an Indwelling	and does not	1			!
	know what the plan i	s, if any.	!			1
1	On the Re	sident #269 was observed :	1			
	several times during	the day at Physical	1			
	and in her	the indwelling	1			İ
	At 2:58 PM the resid	ent stated she had a good	j			i
	day and upon survey	or inquiry regarding the	1			ļ
	indwelling	she stated they put it in	- 1			ļ
31		se she was having difficulty she is not sure what they are	į			
. 1	doing about it now ar	id has not seen the doctor or	i			
	a regarding	it since she has been	ì			
į.	discharged from the	hospital.				
٠,	On at 4:18	PM, the ADON confirmed	ł			
		ntment had been made	1			
- 4	which was confirmed	by the surveyor in calling	1			
			Ea-m-	(D): 100811 (f con		
	, , , , , , , , , , , , , , , , , , , ,	Cartall Event 10: S4X011	ADMIL		ilinyation sheat f	2000 23 of 4

To:15614965924 :9549817229 # 1/ 1 .:- :- :;09:28PM;From:

From:FLORDA AGENCY HEALTH 5614965925 / 15:36 #698 P.028/095

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: FORM A	PPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION  G	(X3) DATE COMP	
		105021	D. WING_		02/11	3/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP GODE	1 421	2/2010
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE I	(XS) COMPLETION DATE
F 315	Continued From pa	ge 23	F 31	5		
	been scheduled on stated upon surveys would be seen on willing to pay for the contact them back a DON was notified. On at 10: DON, Administrator they acknowledged have had the indwel and its necessity extent that they wer appointment and pate 17the DON acknowles have been to follow if indicated or set up.	aluated. The Administrator is beeping the seeping the steeping the steeping the gradient of the seep seep seep seep seep seep seep se				
F 332 SS≈D	in place. 483.25(m)(1) FREE RATES OF 5% OR I	OF MEDICATION ERROR MORE	F 332	1-LPN Staff B was provided with 1		
	The facility must ens medication error rate	sure that it is free of es of five percent or greater.		education on med pass. ( see attack	hed)	
; ;	by: Based on observation review, it was determed error rate was 25.9 p were identified white	T is not met as evidenced on, interview and record fined that the medication ercont. 7 medication errors observing a total of 27 ng Resident #268 and		2-Staff C was provided with 1:1 education on med pass to include administration of different types inhalant medications. (see attache	of	

Event ID: SAXQ11 Facility ID: 100B11
ADMINGSTEAL

/ 15:36 #G68 P.

STATEMENT OF DEFICIENCIES (I	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		O. 0938-03
FOR OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	(X3) D	ATE SURVEY
	105021	B. WING_		1	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02	2/18/2016
REHABILITATION CENTER AT N  (X4) 10 SUMMARY STATE			1200 N 36TH AVE HOLLYWOOD, FL 33021		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
F 332 Continued From page	24	F 332			T
The findings include:		1 004	i		
1) On as condi- observation was condi- practical Nurse (LPN) Resident #268 was ch was noted she had ey- reviewing the Medicati (MAR) for Resident #258 medications and place- glill into sustant it rooks like this right now, she only has observe the medication advised this medication included in the number to be observed. Staff B Resident #266's she had the Aspirin pill a take.	Staff B for Resident #268. seen for observation as it drops ordered. After an Administration Record may be a seen for observation as the medication cup and the medication cup and the medication cup and the medication subsection will be a seen for the medication will be a seen for the medication of the medication subsection will be pass? Staff B was pass observation will be of opportunities required then proceeded into stated to the resident and iron pill for her to		3-All nurses were provided with education on med pass.  4 - Observations on med pass beit conducted three times a week by or designee to ensure compliance med pass policy and procedure for next three months. Summary of observations to be reviewed with committee monthly.  5 - Resident # 264 and #268 suffer adverse reactions from cited incorn administration of medication.	DON of r the QA	
conducted by reviewing MARS. The physician on mg due at 8:30 a.m., at 8:30 a.m., 8:30 a.m., at 8:30 a.m. at 8	ares included 325 groups and 325 mg due at 10 ml fiquid daily due at 10 ml fiquid daily due at 1 ars one drop to right eye included a 1 ars one drop to right eye included a 1 ars one drop to right eye included a 1 ars one drop to right eye included a 1 ars one drop to right eye included a 1 ars one drop to right eye included a 1 ars one of the C. Further included a 1 are includ				

#668 P.

From:FLORDA AGENCY HEALTH

5014965925

15:36

PRINTED: 03/10/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING\_ 105021 B. WING 02/18/2016 STREET ADDRESS. CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX COMPLETION DATE F 332 . Continued From page 25 F 332 Lati at 3:40 p.m. and when asked how many pills she received during the medication she confirmed she pass observation on only received 2 pills, the and the Iron pill. On 02/1 at approximately 4:00 p.m. an interview was conducted with the pharmacy consultant who was apprised of the medication pass observation conducted on and Staff B failing to administer the 3 medications. due at that time. After checking his electronic medication record he confirmed those medications were not discontinued and should have been administered. He stated he could not understand why the nurse would omit those medications and they will speak with Staff B about this incident During a medication administration pass observation on at 3:04 AM, Staff C prepared Resident #264's medication as prescribed. The medication included: 0.4mg/24 hour 1 patch QC Staff C stated as she was getting ready to apply OD patch, that the the newly opened previous patch had been removed at 7:55 AM for morning care. She then proceeded to apply the new patch to the resident's right shoulder at 9:17AM and then dated and initialed the patch.

was getting ready to give the resident 's mediations, but that it took much longer than Providus Version Pasciele

Upon interview with Staff C at 10:00 AM she stated that she had not waited to remove the patch until the new one was being placed because she misjudged the time and figured she

Event ID:S4XQ11

Facility ID: 100811 ADMIN

If continuation sheet Page 26 of 49

3/18/12

PRINTED: 03/10/2016

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FOR	D: 03/10/2016 M APPROVED D: 0938-0391
TATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) D/	TE SURVEY
		105021	B. WING			2/18/2016
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP C		
REHABI	ITATION CENTER A	T HOLLYWOOD HILLS, LLC		00 N 35TH AVE DLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 332	Continued From pa	age 26	F 332			İ
	expected and that medication during t	the resident did go without the that time.				
ļ	11:12 AM he states order,	h the Pharmacist, on at is that based on the current the old patch should have prior to the new patch being				
	observation on Resident #264, Sta administer three back, in the followir seconds between e Handheld 18mcg ci Diskus Aer 1 puff in					
i	inhalants should be they are in suspens must be uniform the administering. This	that all of the medication shaken before used because ion form and the ingredients	man a ta e problement			
i	Medication Record, on three types of int should be delivered that the first type to the ; the administered is the and third medication	view of Resident #264's he stated that the resident is haler medications which in a specific order. He stated be given is the Agonist, second inhaiant to Spiriva n to be administered is the He also stated that		·		

FORM CMS-3857(22-39) Previous Virtualis Obsoling Even ID. Sex (21) Focally ID: 100511

AD M W

If continuation sheet Page 27 of 49 3/18/16

From:FLORDA AGENCY HEALTH 5614965925 / 18:37 #668 P. /

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/10/2016 APPROVED : 0938-0391	
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	s	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		LÉ CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105021	B. WING	·		02/	18/2016	
NAME OF PROVIDER OR SU					TREET ADDRESS, CITY, STATE, ZIP CODE		10/2010	
		HOLLYWOOD HILLS, LLC			200 N 36TH AVE IOLLYWOOD, FL 33021			
PREFIX (EACH DEF	ICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	iE ATE	COMPLETION DATE	
the the 2-5 minute par medication Lastly, in the form provided and inservice interview with canister six fill MDI's in the steroids last; wait one minumedication as medication . The facility medications on the dietary service of the dietary service who facility is serviced on the provided time!	Inhibite the state of the state	aler the nurse should have eir mouth and spit it out after d that there needs to be a tween each inhalant d Dose Inhaler's (MDI'S) surveyor by the Pharmacist staff after the surveyor's armacists states to shake fore each inhalation; give	F3		The Meal Schedule was reviewed ar revised based on resident needs. The Dictary staff was in-serviced or importance of following the meal schedule.  Dictary staffing was reviewed and jusks were revised as needed to ensith at the current meal schedule/time will be followed.	ob ure		
	additio	nal unsampled resident.				-		
1) During dinin noted that the	ig obse tray sci	rvations on it was hedule provided for 2 East				i		
gor S	Carl	acide Event ID: 54X011	Hin	Fecili	y 10: 100011 If continuation:	sheet Pr	age 28 of 49	

FromSFLORDA AGENCY HEALTH 5614965925 / 16:37 #668 P. /

CENTERS FOR MEDICARE & MEDICAID SERVICE			FOR	D: 03/10/201 MAPPROVE D: 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	R. A. BUILDING	PLE CONSTRUCTION		MPLETED
105021	8. WING		1	
NAME OF PROVIDER OR SUPPLIER	——————————————————————————————————————	STREET ADDRESS, CITY, STATE, ZIP CODE	02	2/18/2016
REHABILITATION CENTER AT HOLLYWOOD HILLS, LL	.	1200 N 35TH AVE HOLLYWOOD, FL 33021		
OK4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX YAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D DC	COMPLETION DATE
F 362 Continued From page 28 read 11:40 AM for first tray deliver and 11:50 for the second lunch tray delivery. On at 12:38 PM, the first of two food carts arrive the 2 East dining Inalway. Food service the 2 East dining Inalway. Food service delivery was being conducted by Staft J. K. a various certified nursing assistants. At this til when Resident 44% was observed being mov out the of dining second time since of AM and placed in the hallway just outside the dining as her tray did not arrive per Sts A1 12:53 PM the Administrator walked by and the resident sitting outside the dining hall. He inquired if the resident had eaten an the food was good. The resident shock her h and stated no and continued speaking in Spanish. Staff K then informed the Administra- that they were going to get her a tray, however was never asked of or assigned to obtain the during this dining. Al. 122 PM the resident received her lunch tray and was taken back in the dining eat.  On at 1:40 PM, Resident #60 was observed in the 2 East hallway screaming she wants lunch as she strolled back and forth with her virient/bard dressed in a patient gown.  On at 0:40 PM, Resident #60 was observed and of the was hungry. At 1.49 PM see the condition of the second ocar arrived to the 2 East All food was distributed to the residents' 1.41 PM for the condition of the	d to be end of the common of t	A daily check will be conducted food Service Director or designant conjunction with ongoing monithe Consultant Dietitian on rout visits to ensure the meal schedule followed.  A consultant Dietitian and new Cower hired to assist with plan of correction and implement system issues to ensure compliance.	e in or by ine e is	

To:15614965924 ;9549817229 # . / \_ /

		AND HUMAN SERVICES				RINTED: 03/10/2016 FORM APPROVED MB NO. 0038-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		105021	B. WING_			00/40/000
NAME OF	PROVIDER OR SUPPLIER		۳	STREET ADDRESS, CITY, STAT	E, ZIP CODE	02/18/2016
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REPERENCED DEFICI	ACTION SHOULD TO THE APPROPR	BE COMPLETION
	was observed calling was observed calling come. I want food, inquiry Staff L close (inquiry	2 West Wing, Resident #186 g out for food, 'come, food, food' Upon surveyor of the dining one view. She stated that the near the elevator are waiting said that they had moved the dining table a few use it is not fair for her to see ted that this is not fair for her to see ted that this is normally how the the see and that she She then entered the nurse downstairs to self the downstairs to self the downstairs to self the downstairs to self the downstairs to self the downstairs to self the downstairs are and that she could see how the wind they are the self-than than the self-than t	F36			
ORM CMS-250	7(02-99) Previous Versions O	bscioje Eveni ID: S4XQ11		100 10: 10:00:11 H L	If continuation	sheet Page 30 of 49

From:FLORDA AGENCY HEALTH 6614966925 / 16:37 #666 P.036/095

		AND HUMAN SERVICES			FORM A	03/10/2016 PPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	0938-0391 SURVEY LETED
		105021	B. WING _		02/41	8/2016
l		HOLLYWOOD HILLS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 36TH AVE HOLLYWOOD, FL 33021	<u> </u>	22010
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	AC :	(XS) COMPLETION DATE
F 362	Continued From page	ge 30	F 36	2		
F 363 SS=E /	by the facility, docur who eat in their delivery on the One 12:05 p.m. with a se 12:30 p.m. with a se 12:30 p.m. On 027:10 p.m. On 027:10 p.m. On 027:10 p.m. On 027:10 p.m. On 027:10 p.m. On 027:10 p.m. On 027:10 p.m. Deth lunch cart tray deliver of the lunch cart tray deliver of the lunch cart tray of the lunch cart tray of the lunch cart tray of the lunch cart tray of the lunch cart tray of the lunch of the lunch cart tray of the lunch of the lunch cart tray of the lunch of the lunch of the lunch of the lunch of the lunch of the lunch of the lunch of the lunch of the lunch of the lunch of the lunch of lunc	er the funch trays did not observation of the second pry was commenced however lid not arrive. On at he cart trays had not been East unit.  p.m. while surveyor was East Nursing Station a mber was overheard stating then are the funch trays is nursyn? Can I take her to it too late? Have they closed of the desk nurse was citizen to see if they were at in the dining immed they were. The desk her family member. "If you they control to the dining immed they were. The desk her family member." They only the control to the dining immed they were. The desk her family member. "If you have to the dining immed they were. The desk her family member." If you have to the dining immed they were. The desk her family member. "If you have to the dining immed they were. The status and the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the control that the status of the status of the control that the status of the control that the status of the control that the status of		The dinner menu was adjusted for /16 to ensure the residents rece adequate protein for the day.		3 31 01 49
	forge (aba	No	ADNO	ustate 3/18	115	, 010145

5614965925

/ / 15:38 #668 P.

# \_ / \_ ...

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION	(X3) DAT	ESURVEY
AND PLAN OF CORRECTION DENTIFICATION NUMBER:		A BUILDING			PLETED	
		105021	B. WING		02/	18/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REHABI	ITATION CENTER AT	HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LOBE	COMPLETION DATE
E 363	Continued From pa	na 31	F 363			
. 505		nal Research Council, National		The current 4- week menu cycle	was	į
		es; be prepared in advance;	!	reviewed by the Consultant Die		
	and be followed.		1	menus have been adjusted to m	et	
				minimum standards. All therap	eutic and	
	This RECUIREME	NT is not met as evidenced		mechanically altered diet extens		Í
	by:			have been reviewed and revised		
		tion, interview, and record		needed to ensure all residents re	ceive the	
		mined that the resident		correct diet as ordered.		
	approved menu wa	s not being followed.		The Dietary staff was in-service		
	The findings includ	e:		following the menu with prope		
			:	portions and menu extensions.		
		tion of the lunch meal service	:	Daily monitor by the Food Serv		
	In the main kitchen	on at 11:30 AM the Administrator it was		Director or designee will be con		i
		pproved menu was not being		to ensure the approved menus	re	1
	as evidenced by the			followed each day.		
	1) Observation of the	he Chicken Enchilada revealed be an egg roll appetizer (2 rolls		A consultant Dietitian and new	CDM	
		oe an egg roll appetizer (2 rolls or review revealed that the	i	were hired to assist with plan of		
		labeled "Chicken Egg Rolls".	1	correction and implement system	ns	
	Further Investigation	n of the box revealed		issues to ensure compliance.		
		on Facts that 1 egg roll		issues to enoure compliance.		
		ams of protein which ams of protein per resident	i			
		with the Food Service Manager	:	1		
		bservation revealed that he		1		
		he approved menu entree				
		ne residents did not meet the 4		:		
		ortion and only 16 grams (2 otein was being served,		i		
		dministrator at the time of the	:	1		
	observation revealed	ed that the entree being served				
	was not a chicken	enchilada.	,	1		,
	2) Observation of 4	ne lunch tray line revealed that		1		
		d was not prepared for all		ŧ.		į.
DOM CHE 3	67(02-69) Previous Varsions		, ,	ncliny ID: 100811 If continu	ation sheet	Page 32 of 4
Unin UMS-2				minestrati	2/11	111
	borgel	0 1.0 1/10	$\pi$	// (Upaco de la la	J 18	1 1 k

To:15614965924 ;9549817229

# .3/ .3

15:38 #668 P. PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING\_ 105021 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 M 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION F 363 F 363 Continued From page 32 regular, therapeutic and mechanically altered diets. The Food Service Manager stated that the salad was not prepared by dietary staff and that there was an error as to which lunch menu was to be followed by the dietary staff for lunch meal preparation. 3) Observation of the lunch tray line revealed that the 4 ounce serving portion of portion of canned pineapple was not prepared for all regular, and therapeutic diets. The Food Service Manager stated that the salad was not prepared by dietary staff and that there was an error as to which lunch menu was to followed by the dietary staff for the lunch preparation 4) Observation of the lunch tray line revealed that the dinner rolls were not purchased or available for all regular, therapeutic and mechanically altered diets. The Food Service Manager stated that the issue with the dinner rolls was an error as to which lunch menu was to be followed by the dietary staff for lunch meal preparation. 5) During an interview conducted with the Food Service Manager at the time of the observation of the lunch meal service it was revealed that he was unaware the puree diets to be served is for all food menu items in a pureed form. The manager was unaware the the rice was to be pureed and that a vegetable juice and cooked vegetable should have been prepared in place of the salad menu items.

5614965925

Each resident receives and the facility provides food prepared by methods that conserve nutritive

FORM CMS-2567(02-99) Pro

F 364 | 483,35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=E PALATABLE/PREFER TEMP

fictis version Codeciese

Event IO: S4XQ11 Facility ID: 100611 APMINISTRATO

F 384

18/16

From:FLORDA AGENCY HEALTH

5614965925

16:38

#668 P.038/095 PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUSI DING 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG F 364 Continued From page 33 F 364 The facility will prepare cooked value, flavor, and appearance; and food that is vegetables by methods that will conserve palatable, attractive, and at the proper nutritive value, flavor, appearance and temperature palatability. This REQUIREMENT is not met as evidenced The Dietary staff who prepares by: Based on observation and interview, it was vegetables was in serviced on proper cooking methods to conserve nutritive determined that the facility failed to prepare value, appearance and palatability. cooked vegetables by methods that conserve nutritive value, flavor, appearance; and that food is palatable Ongoing monitoring by the Food The findings include: Service Director or designee will be conducted to ensure that vegetables are cooked by methods that conserve During the kitchen sanitation tour on nutritive value, flavor, appearance and 8:50 AM, accompanied with the facility's Food Service Manager, it was noted that three large palatability. pans of carrots were observed bolling on top of Ongoing monitor by the Consultant the stove. The surveyor questioned why the Dietitian on routine visits will be carrots were being cooked approximately 3 hours conducted as well. prior to the beginning of the resident's lunch meal service. The Food Service Manager stated that vegetables are cooked early and some of them A consultant Dietitian and new CDM pureed and then reheated for meal service. The manager then stated that the vegetables are then were hired to assist with plan of cooled down and are reheated/re-cooked just prior to the beginning of the meal service. The correction and implement systems issues to ensure compliance. surveyor again questioned the Food Service Manager and it was discussed by the surveyor that continued cooking and heating of the carrots would result in loss of nutritive value, appearance,

also pated that the majority of the lunch meals previous farione phoenie FORM CMS-2587(02-0

and palatability. The Food Service Manager disagreed and continued cooking and reheating the carrots for the lunch meal service. Observation of the lunch meal by the survey team at 12:15 PM revealed that the carrots appeared overcooked and mushy in appearance. It was

> Facility ID: 100011 ADHenestan

Page 34 of 49

# . 7 . .

From:FLORDA AGENCY HEALTH

5614966926

16:38 #668 F

PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA A BUILDING\_ B. WING 105021 02/18/2016 STREET ADDRESS, CITY, STATE, 2IP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) (XS) WPLETION SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) F 364 Continued From page 34 F 364 observed by the surveyors revealed that there was poor consumption of the carrots by the residents. F 369 : 483.35(g) ASSISTIVE DEVICES - EATING SS=D : EQUIPMENT/UTENSILS F 369 The facility must provide special eating equipment and utensils for residents who need them. The facility will provide adaptive eating This REQUIREMENT is not met as evidenced equipment/utensils as ordered. by: Based on observation, interview, and record The Occupational along with review, it was determined that the facility failed to the facility's full-time Registered provide physician ordered adaptive eating utensils (Rocker Knife) for 1 (Resident #87), of 1 Dietitian have reviewed all residents with current orders for adaptive eating sampled residents who require adaptive eating utensils. An audit was conducted of the utensils. tray tickets to ensure all residents with a The findings include: current order for adaptive eating utensil(s) are on the tray ticket to During the observation of funch meal in the main dining at 12:15 PM, it was indicate to the kitchen staff which adaptive utensil(s) are to be provided to noted the the lunch meal card for Resident #87 documented adaptive equipment to include: each resident. Built-up Fork, Built-up Spoon, and Rocker Knife. An observation of the residents lunch meal revealed that she was given the built-up spoon fork, however the Rocker Knife was not included. The resident was observed having difficulty cutting foods with the use of the fork and stated to the surveyor that she is never given the Rocker Knife with meals. The Assistant Director of Nursing (ADON) was notified at the time of the

FORM CMS-2567 (05-04) Previous Vigrations Observing

observation and it took approximately 5 minutes to locate a Rocker Knife in the kitchen. The ADON stated to the surveyor the the facility does not have a sufficient supply of the Rocker Knife.

Event ID: S4XQ11 Facility ID: 109611

If continuation sheet Page 35 of 49

3/18/16

From:FLORDA AGENCY HEALTH 5614905925 \_\_\_/ 15:39 #668 P. /

PRINTED: 03/10/2016

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A BUILDING		COMP	COMPLETED	
		105021	B. WING		02/18	/2016	
AND OF D	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				1200 N 35TH AVE			
EHABIL	ITATION CENTER A	HOLLYWOOD HILLS, LLC		HOLLYWOOD, FL 33021	101	mt)	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (BACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		COMPLETE DATE	
<del></del>			F 36	,			
F 369	Continued From pa	age 35	F 50.				
1	During an observa	tion of Resident #87 on M it was noted that the resident		An inventory was taken of all ac	aptive		
i	manium har break	fast meal in the once		cating utensils to ensure that an	y utensil		
	again the Rocker I	(nife was not included on the		that is currently ordered is avail	able for		
į	brookfast tray The	resident again was observed		use.	1		
	having difficulty cu	tting breakfast foods with the oriented resident again stated			1		
	that the Backer Kr	life is not being included with		The Dictary staff was in serviced	lon i		
	meals "all of the til	ne" and "needs the Rocker		reading the trays tickets properl			
	Knife with meal to	be able to cut foods." The		emphasis on adaptive cating uto	nsils.		
	resident also state	d that she keeps informing the t receiving the Rocker Knife		Daily monitor by the FSD or de			
	with meals. The A	dministrator was summoned to	i	will be conducted to ensure all r			
	the residents	confirmed that the	!	with an order for adaptive eatin			
	resident's Rocker	Knife was not included on the	1	are provided to them as ordered			
	breakfast tray. Th	e resident also stated to the the Rocker Knife is not	i	A consultant Dietitian and new			
	included with mos	t of the meals and keeps					
	informing staff tha	t she is not receiving the		were hired to assist with plan o			
	Rocker Knife.			correction and implement systematics issues to ensure compliance.	inis		
	On an in	terview was conducted with the and it was revealed		issues to ensure compliance.			
	through documen	tation provided that the resident	1			. "	
	had a current orde	er for a Built-up Fork & Spoon	1	1			
	and Rocker Knife	with meals and was ordered by		•			
	the physician on	OSE GARBAGE & REFUSE	F 37	2			
F 372 SS=F	PROPERLY	USE GARDAGE GIVEN GOL	1				
				Facility disposes of garbage and	reruse		
	The facility must	dispose of garbage and refuse	1	properly.			
	property.			Dumpster area and surroundir	a mound		
			1	area leading to the dumpster w			
	This REQUIREM	ENT is not met as evidenced	1	cleaned. An ongoing cleaning			
	: hv			was developed to maintain con			
	determined that t	ration and interview, it was he facility failed to dispose of			-p		
	garbage and refu	se properly.				1	
- //				Facility IO: 100911 If cont	nuation sheet		

To:15614965924 :9549817229

15:39

#668 P.041/095

From:FLORDA AGENCY HEALTH 5614965925 PRINTED: FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 02/18/2016 105021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG F 372 2. All the ground areas leading to the F 372 Continued From page 36 dumpsters and around the dumpsters were cleaned. The findings include: Curing the kitchen sanitation tour conducted on 3. The ground area around the accompanied with the Food Service dumpsters was cleaned. Manager the following concerns were noted 4. The Company that provides garbage 1) The ground area leading to the dumpster and around the dumpster was noted to have pick up was contacted to review numerous large areas of foul smelling standing agreement of daily garbage schedule to make sure garbage is picked up daily 2) Other ground areas leading to the dumpster and ensure that the dumpsters do not and around the dumpster were noted to have a build-up of green algae type substance and black overflow. Larger dumpsters were ordered to mold type substance. avoid overflow. Ongoing evaluation by the The ground area around the dumpster was noted to be littered with garbage and trash. housekeeping, maintenance and Food Services Director will be conducted for 4) The dumpster was noted to be so full that the compliance to maintain proper disposal containers of trash were hanging out over the sides, in the front of the dumpster and the 2 large of garbage and refuse properly.

time of the observation revealed that the ground area around the dumpster is always in this condition and that the dumpster capacity is too small to handle the amount of trash/garbage that the facility generates per day. F 431 483.60(b), (d), (e) DRUG RECORDS, SSEE LABEUSTORE DRUGS & BIOLOGICALS

5) Interview with the Food Service Manager at the

lids were not able to be closed.

The facility must employ or obtain the services of a ilcensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an

storage drugs and biologicals to include tube feeding and medications.

The Administrator will also conduct

1-Staff was in serviced on proper

random rounds to ensure compliance.

3/18/16

3/18/16

Lors Catallo

Facility ID: 100611 ADMINISTRATO

F 431

nest Page 37 of 49 If continuation s

To:15614965924 ;9549817229

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T OF HEALTH	AND HUMAN SERVICES				FORM /	APPROVED 0938-0391
FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COME	SURVEY
	195021	8. WNG				
	HOLLYWOOD HILLS, LLC		12	100 N 36TH AVE OLLYWOOD, FL 33021		
MACH OFFICIENCS	Y MUST RE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE E	DATE COMPLETION (AG)
unde reconciliained are in order are in orde	tion: and determines that drug rand that an account of all maintained and periodically also used in the facility must be now with currently accepted oles, and include the topy and cautionary experience of the cautionary	A CAMPAN THE MANAGEMENT AND A CAMPAN AND A C	431	feedings were locked and secured proper storage.  3-Daily rounds made by DON or designee to ensure all doors are le and all supplies are kept in safe storage.  4-Storage # (1 East) has locked and appropriate staff give key.  (b) Storage # (2 West) 1	for	2.773
	DR MEDICARE PROFICIANTS  PROFICIANTS  SUMMARY STI  GAUN DEPTIER  SUMMARY STI  GAUN DEPTIER  IN THE TOTAL THE TOTAL  SUMMARY STI  GAUN DEPTIER  SUMMARY STI  GAUN DEPTIER  SUMMARY STI  GAUN DEPTIER  SUMMARY STI  GAUN DEPTIER  SUMMARY STI  SU	INDECTION  IDENTIFICATION NUMBER:  195021  DER OR SUPPLER  ION CENTER AT HOLLYWOOD HILLS, LLC  SUMMARY STATEMENT OF DEPICIENCIES  (BACH DEPICIENCY MUST BE PRECEDED BY PULL  REGOUNTON OR LSC IDENTIFIANCE NECESSION BY  Interest percentilation; and determines that drug  prids are in order and that an account of all  trolled drugs is maintained and periodically  onciled.  gs and biologicals used in the facility must be  ded in accordance with currently accepted  resistional principles, and include the  repriate accessory and caultonary  nuctions, and the expiration date when  likeble.  Light must store all drugs and biologicals in  ced compartments under proper temperature  trols, and permit only authorized personnel to  e access to the keys.  I facility must provide separately locked,  manently affixed compartments for storage of  trolled drugs lated in Scheduler lof the  myrehensive Drug Prevention and  trol Act of 1976 and other drugs subject to  except when the facility wills which the  acces and additabliout on systems in which the	OR MEDICARE & MEDICAID SERVICES PECICINES  (XT) PROVIDENZIA (A)  (A) MULL  105021  BERGETION  105021  BERGETION  105021  BERGETION  105021  BERGETION  105021  BERGETION  INDICATE AT HOLLYWOOD HILLS, LLC  SUMMARY STATEMENT OF DEFICIENCIES (SCAL) DEFICIENCIES (SCAL) DEFICIENCY MUST BE PRECEDED BY JULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Altinued From page 37  Urate reconcilitation; and determines that drug prids are in order and that an account of all tobled drugs is maintained and periodically snocled.  Sa and biologicals used in the facility must be beled in accordance with currently accepted fessional principles, and include the reprinte accessory and caulionary ructions, and the expiration date when licable.  Incordance with State and Federal laws, the lity must store all drugs and biologicals in recordance with State and Federal laws, the lity must store all drugs and biologicals in recordance with state and Federal laws, the lity must store all drugs and biologicals in recordance with State and Federal laws, the lity must store all drugs and biologicals in recording listed in Schree II of the prehensive in the keys.  Incline in the superior temperature trois, and permit only authorized personnel to e access to the keys.  Incline in the superior temperature trois, and permit only authorized personnel to e access to the keys.  Incline in the superior temperature trois, and permit only authorized personnel to expect when the facility uses elingia unit keeps drug distribution systems in which the interest of the superior of the sup	DR. MEDICARE & MEDICAID SERVICES PROTECTION  TO PROVIDERS AND PRICE AND PROVIDERS AND	IT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICARE & MEDICARE SERVICES (XT) PROVIDERSUPPLENCIA DESCRIPTION NAMERS*  195021	IT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICARE

The findings include:

ADMINISTRATO

# .17 .3

#868 P.

. 1 15:39 6614966926 From:FLORDA AGENCY HEALTH PRINTED: FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DAYE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 105021 NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX (X4) ID PREFIX E 431 F 431 Continued From page 38 at 8:23 AM, Staff C was observation on noted to be standing at the medication cart patch packaging when reviewing a she was interrupted by the DON (Director of Nursing) and 1 East Desk Manager. They Resident instructed her to enter the #264. At 8:27 AM, Staff C was observed placing the Ziploc plastic bag with the pharmacy label to include: the resident's name, medication and other pertinent information, along with greater patch packages for than 10 Resident #264 in her medication book on top of the medication cart and closing it. She then the medication in walked into the the medication book on top of the medication cart. Upon surveyor intervention at 8:31 AM, she returned to the cart and retrieved the medication to begin the medication pass observation. Upon interview with Staff C at 10:00 AM she stated that she had not realized it but understood it needed to be placed in the locked cart and not accessible to others Upon interview with the DON during the morning of she stated that she acknowledged she had interrupted Staff C's process by asking her to step into the resident 's by doing so, Staff C did not follow the policy and procedure for securing medications. 2) During the environmental observation tours at 10 AM conducted of the facility on and 1 PM, accompanied with the Administrator, Director of Nursing, Director of Housekeeping, and Director of Maintenance, the following concerns were noted: .# . (1 East) - An

unlocked/non-secured supply FORM CMS-2507(0266) Province Openione Openione Openione Openione

a Storage

In the Event ID: S4XQ11 Pecility 10: 100011 ADMU

If continuation shoot Page 39 of 49 3/18/16

From:FLORDA AGENCY HEALTH 6614965926 ... 15:40 #666 P.

EET ADDRESS, CITY, STATE, 2IP CODE  N 36TH AVE LIVWOOD, FL 33021  PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  OBTICIENCY)
N 35TH AVE LLYWOOD, FL 33021  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CAGOS-REFERENCED TO THE APPROPRIATE CANSS-REFERENCED TO THE APPROPRIATE  CANSS-REFERENCED TO THE APPROPRIATE
PROVIDER'S PLAN OF CORRECTION  [EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE CAT
(EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE
Facility has established and maintains an effective Control program.  (a) Two utility hooks were installed one on dirty side of wash area and one on clean side of wash area to hang keep them off of the floor.
efi (a or

Fram:FLORD	A AGEN	JCY HE	ALTH

5614965926 / 15:40 #668 P.

EMENT LAN O	OF DEFICIÊNCIES CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		105021	B. WING	
	ROVIDER OR SUPPLIER	T HOLLYWOOD HILLS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021
I) ID EFIX AG		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECTION (MS)  K (EACH CORRECTIVE ACTION SHOULD BE COMPLETED (CONTINUED BE)  CROSS-REFERENCES TO THE APPROPRIATE DATE  DEFICIENCY)
441	(3) Maintains a reactions related to (b) Preventing SP (1) When the determines that a prevent the spreach the reside (2) The facility me communicable from direct contact will (3) The facility me hands after each hand washing by professional practice. It was the contact will be contacted the contact will be contacted that the contact will be contacted the contact will be contacted to the contacted to the	to an individual resident; and corrective read of Control Program resident needs isolation to d of , the facility must nt. the problem of the properties of the problem of	F. F. T. T. T. T. T. T. T. T. T. T. T. T. T.	(b)The ceiling area of the clean wash dryer been fixed and painted.  (c) Laundry staff was in- serviced on the proper cleaning of Laundry carts, Laundry carts are being cleaned after every use and logged. (see inservice sheet)  (d)Laundry staff was in- serviced on proper cleaning of lint compartment, lint compartment is being checked AM/PN by supervisor to assure proper cleaning and logging. Administrator randomly is checking the dryers for lint buildup.
	by: Based on obser determined that incontrol area and failed to was properly sar The findings Incl 1) During observing facility laund.	ration of the environmental tour or ry service area on at npanied by the Environmental	1	Facility () 190911 If continually sheet Page 4

DEPARTMENT OF HE	MITH AND HUM	AN SERVICES			PF		03/10/2016 APPROVED
CENTERS FOR MEDIC					O		0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDE	ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MUI A BUILD		ECONSTRUCTION	(X3) DATE	
		105021	e, WING			02/1	18/2016
NAME OF PROVIDER OR SUP	LIER			ST	FREET ADDRESS, GITY, STATE, ZIP CODE		
REHABILITATION CENT		OD HILLS, LLC			200 N 35TH AYE OLLYWOOD, FL 33021		
PRIERY (EACH DEF)	RY STATEMENT OF D CIENCY MUST BE PRI Y OR LSC IDENTIFYIN	ECEDED BY FULL	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE i	COMPLETION CATE
F 441 Continued From were noted:	m page 41		F	441			
be peeling fro wash that the peelin linen. (c) Three of the clean linens we of trash on the	h large areas of p m the ceiling sur- dryer The g paint could a large laundry carts are laundry carts are noted to have bottom of each	ted to be stored in aint was noted to face of the clean here was a potential on resident clean s used to transport e a heavy build up cart, Upon	and a second sec	1	(e) All trash cans have been replaced new trash can step- on type with clot iid. (f) Vent sorrounding clean linen ar cleaned and condensation was corr	osing ea was	
interview duffith that they are ruse. (d) Observable five commercial five commercial excossive bull states that the provided docurentation was initialed from the initial (e) Observable revealed that overflowing. It overflowing it of stored clean (f) Observable (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of stored clean (f) Observable for the initial exception of the initial excep	ing the tour, the is tot cleaning the count of the lint come at dryers was no dup of lint/trast to interest and the come that the come that the come that the count of the count of the count of the clean lint the trash contain the trash contain the trash contain the trash comment of the clean lint the trash contain the trash contain the trash contain the trash contain to the comment of the clean lint the trash contain the trash contain the trash contain the trash contain to no comment of the ceiling in linen.	undry staff stated carts after each partment of five of ted to have an . The Director be cleaned and aning a minimum f the dryer cleaning the last cleaning . During the sonnel confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed inguited the confirmed the			(g) No personal items are allowed ilinen area all personal items must to stored in lockers. Staff informed ar Housekeeping Supervisor will enfo	oe nd	
and surround black mold lik condensation contaminate underneath. (g) Observation revealed a pe	ng ceiling area he substance and that could possible in linen that won of the clean lires onal jacket sto	ad a build up of a build up of a build up of bly drip down and as stored	!	Par	olfw (c. 10001)   1 Contiguation	ing sheet	Page 42 of 49
FORM CMS-2567(02-90/Previous	(batall	ADM		ran	3/18	116	

From:FLORDA AGENCY HEALTH 6614966925 15:40 #668 P. PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 8 WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFURENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETION DATE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG F 441 : Continued From page 42 F 441 housing clean linen (h) Observation of the door leading outside the (h) Door leading to outside door of clean clean linen storage area revealed a large gap under the door. There was potential for linen storage has been repaired. rodents/animal entry as well as debris blown from , the outside inside. During a medication pass observation on at 8:18 AM, Staff C was observed to 2) Staff was provided with an in-service on the proper decontamination of reusable clean cuff with a Clorox Bleach equipment. (see signing sheet attached) wipe sparsely for 10 seconds and discard the wipe while she allowed the pressure cuff dry. In addition, following resident Daily rounds to be completed by the use of the stethescope and cuff Control Nurse to ensure that with Resident #109, the reusable resident care staff is following proper procedure for equipment was not decontaminated and/or equipment. sterilized between residents, as per the facility policy titled, "Cleaning and Resident-Care Items and Equipment. Further, the manufacturer's guidelines states to wipe, by thoroughly wetting the exterior of the equipment or surface; allow the surface to stay wet for the 3 minutes and then dispose of used wipe and gloves F 464 The lunch schedule has been changed F 464 | 483.70(g) REQUIREMENTS FOR DINING & for the 2nd floor West wing and East SSEE ACTIVITY wing so that 2 East cart comes out first. The facility must provide one or more The carts with the east wing travs will designated for resident dining and activities. be brought up one after the other so that residents in that area can be served must be well lighted; be well

, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.

bv:

This REQUIREMENT is not met as evidenced

Event ID: S4XQ11

Fedity ID: 100611

ADMINISTRATOR

at the same time. No more than 17

residents will be permitted to sit in the 5 tables designated to accommodate no more than 20 residents.

> on shoot Page 43 of 49 3/18/16

To:15614965924 ;9549817229

/ / 15:41

# .5/ .3

#668 P.

5614965925

PRINTED: 03/10/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUR DING 105021 A WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 36TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) TAG F 464 Continued From page 43 F 464 A new rehab dining program has been Based on observation and interview, the facility implemented in order to assist up to 7 failed to ensure residents had edequate space residents with their meals in a separate during dining to accommodate them comfortably during the lunch meal, as without Staff educated on meal times and evidenced by observations of crowded dining In the second floor East and West Wings. assisting residents to their assigned dining area prior to food carts arriving. 3/18/16 The findings include: at 11:57 AM observations in the dining behind the nurse 's station on the second floor West Wing, revealed 18 15 of those 18 residents in the dining residents seated in wheelchairs. observed to have five 36 x The dining 36 tables; two tables across from the nurse's station and three tables along the glass windows. There were 2 residents in a wheelchair seated at the first table; 3 residents seated (2 residents in a wheelchair and 1 resident seated at a regular chair) at the second table; 4 residents seated (all 4 residents seated in wheelchairs) at the third table; 4 residents seated (2 residents in a wheelchair and 2 residents seated at a regular chair) at the fourth (in the middle of the dining ) table and 3 residents sealed (2 residents in a wheelchair and 1 resident seated at a regular chair) at the fifth table. In addition, there were 3 residents seated in wheelchairs in the dining from the second table, however these 3 residents were not seated at a table. Further observations revealed 2 residents seated in wheelchairs at a 12 x 60 table, located by the

there was not enough accompanies accompani (02/89) Previous Vinions Obsolete FORM CMS-2567(0)

wheelchairs facing the dining

window left of the elevator. A resident was sealed in a wheelchair was observed in front of the elevator and two other Residents were seated in

Event ID: \$4XQ11

MMin

accommodate

Facility ID: 100511

neel Page 44 of 49

6614965925 / 15:41 #668 P. /

		& MEDICAID SERVICES		D. C. COLUMN ICTION		IO. 0938-039
EMENT PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	\\"-"c	ATE SURVEY OMPLETED
		105021	B. WING _			
ME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
HABIL	ITATION CENTER AT	HOLLYWOOD HILLS, LLC		HOLLYWOOD, FL 33021		
(4) ID REFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE 1E APPROPRIATE	COMPLETIO DATE
464	Continued From pa	nge 44	F46	64		
·	employee pulled the not he second floo Resident #107 which elevator, out of the elevator, out of the elevator rear if the elevator rear if of the elevator rear if the elevator rear if the elevator rear if the elevator rear if the elevator rear if the elevator rear if the elevator rear if the elevator rear if the elevator rear if the elevator in the elevator rear if the elevator rear in the elevator rear i	was noted that after the the first table, there was a 2 een the resident 's wheelchair				
	made throughout to stop and wait to before moving into	tion counter. Observation was he dining time that the staff had r others (residents and staff) another task or serving ue to the crowded	,		٠	
	another resident in and as she the dining parked himself at	de was observed pushing n a wheelchair into the dining was wheeling the resident into asked the resident, who had the first table, to move for her al another resident into the				
	dining . The resident seated at	resident refused and another the table was wheeled out of accommodate the resident's			if continuation,	

To: 15614965924 :9549817229

From:FLORDA AGENCY HEALTH 6614965925 15:41 #668 P. ./. PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING \_ B. WING 105021 02/18/2016 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES COMPLETIO (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 464 Continued From page 45 F 464 At 12:42 PM the second tray cart was observed to arrive to the second floor West Wing, Staff was observed to be bumping into each other and into residents in the dining At 12:45 PM observations revealed aides were moving residents that had not had their lunch tray from the crowded dining the hallway and the front of the elevator At 1:06 PM an observation was made of a resident in a wheelchair in the dining the fourth and fifth tables garbling and mumbling out loud. The Resident was observed to be removed from the dining without eating or being fed. At 1:11 PM observations revealed 9 residents seated in wheelchairs by the space to the left of the elevator and in front of the elevator waiting for their meal trays to arrive. Residents in the dining be observed by the residents parked by the elevator from this vantage point.

At 1:34 PM observations revealed the aides were moving residents in and out of the dining accommodate those who had as yet not received their lunch.

In addition, those residents who were removed from the dining before their lunch trays arrived were in clear view of other residents being served and eating their lunch. F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST SS=D; CONTROL PROGRAM

The facility must maintain an effective pest

to minimize any potential pests from entering the kitchen

If continues on shoot Page 46 of 49

A new exit door has been purchased and

F 469; the existing air curtain that is in working order will be maintained on at all times

FORM CMS-280 (02-00) Provides Versione OSPANO

Event ID: S4XQ11 Facility ID: 100611 ADMINISTRATOR

// \_ ≥ 15:41 #668 P.

MENT AN D	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		105021	e. WING			18/2016
OF E	ROVIDER OR SUPPLIER	100011		STREET ADDRESS, CITY, STATE, ZIP		18/2016
			- 1	1200 N 35TH AVE		
ABIL	ITATION CENTER AT	HOLLYWOOD HILLS, LLC		HOLLYWOOD, FL 33021		
FIX :	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
	and rodents.  This REQUIREMEI by: Based on observal determined that the effective pest contint to ensure that the a The findings include During the kitchenil conducted on with the Food Servi numerous (flying ins production, food as areas (dry storage : compartment sink approximately 15 -	that the facility is free of pests  "I is not met as evidenced tions and interview, it was to list a facility falled to maintain an of program in the main kitchen rea was free of pests.	F4	A Pest Control company of	vice the entire ests. The m monthly to ited if more  hly schedule Pest control chen will be  ucted by the lesignee to tethen area.  and orate kitchen	
	compartment sink a covered with large; the door open propi gaps in the door op enter the kitchen ar Manager stated tha kitchen is an on-goi	or located near the 3- rice was wide open and plastic sheets that did not fit erly. There were numerous ening the would allow pests to ea. The Food Service t the pest control in the main ng problem.		Two blue lights designed to flyes were added to the kite		
:	review of the last 6 contracted pest con the kitchen areas as	month service by the strol company revealed that re serviced on a regular basis, ocumentation of on-going				

FORM

;- ;- ;09:28PM;From: From:FLORDA AGENCY HEALTH 5614965926 / 16:42 #668 P.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/10/2016 IAPPROVED : 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIN	PLE CONSTRUCTION	(X3) DAT	E SURVEY APLETED
		105021	6, WING _		02/	18/2016
	PROVIDER OR SUPPLIER LITATION CENTER AT	HOLLYWOOD HILLS, LLC	i	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021		10/2010
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROVING THE APPROPRIATE OF THE APPROPRIA	86	COMPLETION DATE
F 514	Continued From pa	ae 47	F 514			
F 514	483.75(I)(1) RES	ETE/ACCURATE/ACCESSIB	F 514			
	resident in accordar standards and pract	intain clinical records on each ice with accepted professional ices that are complete; ited; readily accessible; and itzed.		l-Staff was provided with educati- proper documentation of PRN medications. (see attendance attac		
	Information to identi- resident's assessme services provided; ti	nust contain sufficient by the resident; a record of the ints; the plan of care and he results of any hing conducted by the State;		2-A weekly audit tool was created ensure accuracy of all prn medica documentation, audit to be condu on a daily basis by nurse coordina for three months and to be turned weekly to DON or designee. ( see sample attached)	tion icted tors	
	by: Based on record re- falled to maintain ac- records as evidence medication Record for 1 of 5 sai	T is not met as evidenced view and interview, the facility curate and complete clinical d by falling to reconcile with the Controlled Drug mpled residents (Resident # unecessary Medications.		3-Reports of all inaccuracies to be discussed in monthly Q.A. meetings with appropiate follow- up needed		
	The findings include	±:		•		
	here requires chartin Review of the clinica revealed a Physician 5 milligra mouth every 4 hours Review of Resident I Medication Administr Jewealed	led "Each dose signed for go not medication record". I record for Resident #259 's order dated for ms (mg); one tablet (tab) by (hrs) as needed for pain. #256 's 2015 ation Record (MAR) 5, mg one tab was				
RM CMS-26	67/02-08) Provincia Vargiona C	House Event 10: 54x911 Co ATO H IN	STRIA 7	olley 10: 100811 If continuation	18	Age 48 01 49

5614965925

15:42

PRINTED: 03/10/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING\_ 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG COMPLETION DATE F 514 Continued From page 48 F 514 documented as administered twice on for a total of three doses of and once on documented as administered. Review of Resident #269 's Controlled Drug Record for the 5 mg tab revealed one tab was documented as administered on at 4:00 PM; one tab on at 4:15 PM: one at 8:45 PM; one tab on tab on at 10 PM; one tab on at 6:00 AM; one at 11 AM; one tab on tab on at at 4:40 PM for 3:15 PM; and one tab on a total of eight doses of . documented as administered, of which 6 were not documented 2016 MAR on the During an Interview with the Director of Nursing (DON) on at 12;41 PM, the DON was apprised of the inaccuracy of the medication reconciliation between the MAR and Controlled Drug Record for Resident #269. The DON confirmed that the nurses are to document all drugs given on the Controlled Drug Record as well as on the resident 's MAR.

FORM CMS-2587(02-96) Previous Versions Obsolote

Event ID: \$4XQ11 Facility ID: 100811

ADMINISTRATION

If continuation sheet Page 49 of 49

3/18/16

6614965925

/ /\_ . 15:42 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

100611 B. WING	•	
	02/18/2	016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. C  REHABILITATION CENTER AT HOLLYWOOD HI  HOLLYWOOD, FL		
(X4) ID: SUMMARY STATEMENT OF DEFICIENCIES ID: PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION IX (EACH CORRECTIVE ACTION SHOULD BE C	(XS) OMPLETE DATE
N 000 INITIAL COMMENTS N 000 : An unannounced Re-licensure survey was	This plan of correction constitutes our written allegation for compliance for the	
conducted on to et Rehabilitation Center at Hollywood Hills. The facility had deficiencies at the time of the visit.	deficiencies cited. Our submission of the Plan of Correction is not an admission that the deficiency exists or that one was	
N 054 59A-4.107(5), FAC Follow Physician Orders SS=0 All physician orders shall be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift.	cited correctly. This plan of corrections submitted to meet requirements established by state and federal laws.	
This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that the medication error rate was 259 percent. 7 medication errors were identified white observing a total of 27 opportunities, affecting Resident #268 and Resident #264.		
The findings include:		
On at 9:40 a.m. medication pass observation was conducted with Licensed Practical Nurse (LPN) Staff B for Resident #268. Resident #268 was chosen for observation as it was noted she had eve drops ordered. After		/18/16
reviewing the Medication Administration Record (MAR) for Resident #268, Staff B prepared the medications and placed an pill and pill into the medication cup and stated 'It looks like his is all the resident gets	RECEIVED MAR 1 8 2016	
right now, she only has 2 pills, do you still want to observe the medication pass? Staff B was advised this medication pass observation will be	BY:	
"CA FORM 3020-0001 ABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE  STATE FORM  MIN	ADMINISTI -502 SAXQII	18/

5614965926

...... 15:42 #688 P.

PRINTED: 03/10/2016 FORM APPROVED

igency f	or Health Care Adm	inistration	110 (12)	MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C		A. BUILDING:			PLETED
IND FUND	e,		1			1.	
		100611	e, w	ING		02/	18/2016
			TREET ADDRESS	CITY, ST	ATE, ZIP CODE		
IAME OF F	ROVIDER OR SUPPLIER		200 N 3STH A				
HARN	ITATION CENTER AT		OLLYWOOD,		1		
Comme			OLL THOOD,		PROVIDER'S PLAN OF C	ORRECTION	(X5)
(X4) ID PREFIX TAG		TEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION	LL P	REFIX TAG	CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE
N 054	Continued From pa	age 1	N C	054			
(4 034			- virad	-			
	included in the nun	nber of opportunities re-	doned				:
	to be observed. St	aff B then proceeded in	sident	- 1			:
	Resident #268's she had the	pill and iron pill for her	to	1			1
	sne nao ine take.	Pin one asi) pin ter ner	-				1
	(dne.		1	1			1
	On medic	cation reconciliation was	s	1			1
	conducted by revis	wing the physician orde	ers and	- 1			
	MARs. The physic	lan orders included	325				4
	mg due at 8:30 a.r	ո 325	mg due !				1
	at 8:30 a.m	C 500 mg twice dally	due at	1			1
	. 8:30 a.m.,	10 m) liquid daily	due at				}
	8:30 a,m, and	Tears one drop to	right eye	- 1			}
	every hour for dry	eyes which would have	peeu	- 1			1
	due at 10:00 a.m.	as the medication pass		1			
	, observation was c	onducted at 9:40 a.m. V	With	i			1
	reconciliation of th	e medications it was no	tea	- 1			ì
	Staff B did not adr	ninister the C,	1	1			!
		Tears during the	Further	- 1			1
	medication pass of			1			:
	review of the MAR	d off on the 3 medication	ne that	1			i
	: nag intgaled/signe	arod					į
	were not administ	ereo. Is not available for inten	vlew	1			1
	until at 3	:40 p.m. and when ask	ed how	i			1
	many nills she rec	elved during the medic	ation	1			
	pass observation	on she confirm	ned she	- 1			i
	only received 2 pi	is, the and the i	ron pill.	ì			
	On at at	proximately 4:00 p.m. a	ne	- 1			1
	Interview was con	ducted with the pharma	scy	1			į
	consultant who w	as apprised of the medi	cation	- 1			
	nace observation	conducted on	and }	-			i
	Staff B failing to a	dminister the 3 medical	tions,	1			:
	due at that time.	After checking his electr	OUIC				,
	medication record	he confirmed those	bould				1
	medications were	not discontinued and s Istered. He stated he co	auld not				ŧ
	have been admin	he nurse would omit the	nse				(
	understand why t	ne nurse would brist the they will speak with Star	ff B				
	about this lacider	nies will obeen will our					
	about this lucider	"-A-A-					wation sheet 2 o

STATE FORM

ADM in SAXOTT

3/18/16

From:FLORDA AGENCY HEALTH 8614965925 / 15:43 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
B. WING	02/18/2016
TH AVE	
ID PROVIDER* PREFIX (EACH CORRE	S PLAN OF CORRECTION COTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DEFICIENCY)  (X3) COMPLEYE COMPLEYE
N 054	
education on m administration	rovided with 1:1 ned pass to include of different types of ations. (see attached)
	re re-inserviced and education on med pass.
;	A BUILDING:  8. WING  DRESS, CITY, STATE, ZIP CODE  THA AVE  DOD, FL. 33021  PRETIX  AGREEM  2-Staff C was p education on in administration inhalant medic  3-All nurses we

. .../ ... / ... 15:43

#668 P. . . 7 . . . PRINTED; 03/10/2016 FORM APPROVED

IN PLAN OF	Health Care Adm F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI		DATE SURVEY COMPLETED
		100611	B. WING		02/18/2016
	VIDER OR SUPPLIER	1200 N 35		SYATE, ZIP CODE	
X4) ID REFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETE E DATE
in the second of	e 1 puffint e and ministering. an interview with 1:5 AM he statet halants should be yare in suspen ust be uniform th indistring. This e appropriate mi- redication. I addition, upon re redication Record in three types of in outel be delivered to the delivered the delivered inhaler, the ter the 1 in the truth of the He sta 5 minute pause the diction.  astly, in the Mete orm provided to it of the inserviced to the reserved to the	halled and Combinvent lated. Staff C failed to shake inhalants before the Pharmacist at at that all of the medication is shaken before used because sine form and the ingredients or used to be a shaken before used because sine form and the ingredients roughout, before ensures the resident receives ture and dose of the winew of Resident #264's, he stated that the resident is haler medications which in a specific order. He stated be given is the Agonist, second inhalant to be Anti Cholinergic, the in to be administered is the Advair. He also stated that haler the nurse should have heir mouth and split is out after ted that there needs to be a between each inhalant	N 054	4-Observations on med pass being conducted three times a week by DO or designet to ensure compliance of med pass policy and procedure for the next three months. Summary of observations to be reviewed with QA committee monthly.  5 - Resident # 264 and #268 suffered adverse reactions from cited incorreadministration of medication.	no

To:15614965924 ;9549817229

# 3/ 33

From:FLORDA AGENCY HEALTH

5614965925

/ 16:43 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

ency for Health Care Adm	neite sinic			FORM APPROVED	
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
	100611	B. WING		02/18/2016	
ME OF PROVIDER OR SUPPLIER EHABILITATION CENTER A	1200 N 35		STATE, ZIP CODE		
KA) ID SUMMARY STA REPIX (EACH DEFICIENC TAG REGULATORY OR I	atement of deficiencies y must be preceded by full .sc identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RF COMPLETE	
N 054 Continued From pa	age 4	N 054			
Class III					
N 082: 59A-4.110(3), FAC SS=O Qualifications	Dietary Serv - Supervisor	N 082		2 8	
who:  (a) is a qualified dil paragraphs 59A-4, (b) Has successful degree program wi standard establish Association; or (c) Has successful Assistant correspon program, approved Association; or (d) Has successful by an accredited or provided 80 or mor and has prior work Supervisor in a heat consultation from a (e) Has training amasupervision and mesurose equipment (3)(b), (c) (c) (c) (c) (c) (c) (c) (c) (c) (c)	by the American Dietelic ly completed a course offered lege or university that e hours of correspondence or in food service supervision, experience as a Dietary thit care institution with qualified dictitian; or d experience in food service langement in the military in content to the program in or offer offer offer offer offer offer ary manager who has eted the Dietary Manager's fied through the Certifying lanagers and is maintaining th continuing clock hours at 45		The Facility's Full-time Registere Dietitian was appointed in writin the Director of Food and Nutritic Services effective A consultant Dietician and CDM hired to provide support.  Ongoing evaluation will be conduly the Facility Administrator to e a Qualified Dietary Services Supe is maintained as defined by reguliguidelines.	g as on were acted assure	
A Form 3020-0001	x Carallo	n A D	saxan Mcnesta	3/18/16	

/ . . . . 15:43 #668 P. /

PRINTED: 03/10/2016 FORM APPROVED

ency to	or Health Care Adm	Inistration	Landana	Tank (CENTRALIAN)	3) DATE SURVEY
TEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		100511			02/18/2016
	ROYDER OR SUPPLIER	1200 N 3	STH AVE	STATE, ZIP CODE	
		HOLLIN	000, FL 33	PROVIDER'S PLAN OF CORRECTION	j (X5)
(4) ID REFIX TAG	FACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)	E COMPLETE
N 082	Continued From pa	ge 5	N 082		1
:	to meet the require Manager, who has Dietary Manager's the Certifying Boar maintain certification CEU's (Continuing				***
	facility's designate; was revealed that I valid certificate of a Manager's Course for Dietary Manage revealed the facility Dietary Services Soletary Manager. Freview, an interview Administrator reves Services Supervisa illuense expire and Further interview withal once the issue full time Registered.	of the employee file of the ableton Services Supervisor In the file did not contain a currer completion of the Dielary and certification by the Board rs. Further review of the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold to the file fold fold the file file fold to the file fold to the file fold to the file file fold to the file fold the file file file file file file file fil	t	The Facility's Full-time Registered Dietitian was appointed in writing Director of Food and Nutrition Ser effective.  A consultant Dietitian and CDM with hired to provide support in the Mongoing evaluation will be conduct the Facility Administrator to ensur Qualified Dietary Services Supervis maintained as defined by regulator guidelines.	vices ere then. ted by e a
	Class III				
SS=D	Medical Records 400.141(1)(j) FS Keep full records of discharges; medic including medical	59A-4.118(2), FAC Resident of resident admissions and al and general health status, records, personal and social y and address of next of kin or	N 101	1-Staff was provided with education proper documentation of PRN medications. (see attendance attack	

5614965925

/ - 16:44 #668 P.060/095

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Agency for Health Care Adm	inistration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		K BUILDING		1
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STORETAN	DEPCE CITY	STATE, ZIP CODE	
	1200 N 26		SINIC, EF GODE	
REMABILITATION CENTER AT		OD, FL 33	021	
PREFIX (EACH DEPICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DN (X5) DBE COMPLET PRIATE DATE
N 101 Continued From pa	ae 6	N 101		i
1	•		2-A weekly audit tool was create	d to
	may have responsibility for the nt; and individual resident		ensure accuracy of all prn medic	
care plans, including			documentation, audit to be cond	
	, service frequency and		on a daily basis by nurse coordin	
	e goals. The records must be		for three months and to be turne	
	pection. The licensee shall		weekly to DON or designee. ( see	
	ords on each resident in		sample attached)	
	cepted professional standards in the must be complete.		sample attached)	
	nted, readily accessible, and		3-Reports of all inaccuracies to b	. 1
systematically organ				
12			discussed in monthly QA meetin appropiate follow up as needed.	g with
59A-4.118(2) FAC			appropiate follow up as needed.	
	d shall contain sufficient ly identify the resident, his			1
	ment, and results. Medical			1
	mplete, accurate, accessible			
and systematically of				
	is not met as evidenced by:			i i
	curate and complete clinical			
	ed by failing to reconcile			1
	with the Controlled Drug	1		
	mpled residents (Resident #			į.
269) reviewed for U	nnecessary Medications.			
The findings include	id:			ì
Davidson -415 - 2	- 11-4 0			1
	olled Record form for aled "Each dose signed for	J		
	ng on the medication record".	j		
	al record for Resident #269			
revealed a Physician				
5 milligr	ams (mg); one tablet (tab) by	)		
Review of Resident	(hrs) as needed for pain. #269's 2016	Ì		
	ration Record (MAR)	1		
revealed	5 mg one tab was	1		
documented as adm				
HCA Form 3020-0007	11			
TATE FORM Congle	. No. 1 10 "		4XQ11	if continuation sheet 7 of
Congect	www-	MIHADA	15 TR 1865	3/18//
7 '				, , , ,

From:FLORDA AGENCY HEALTH 5614965926 / 15:44 #866 P.

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED ED
				•		
		100611	B. WING		02/18/2	016
	PROVIDER OR SUPPLIER	1200 N 3		STATE, ZIP CODE		
EHABI	LITATION CENTER A		000, FL 3:	3021		
(X4) ID PREFIX YAG	IEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE CO	(3/5) DAPLI DATE
N 101	Continued From pa	ige 7	N 101			
		for a total of three doses of ented as administered.				
	Record for the tab was documente at 4:00 PM; one tal				i	
	at 10 PM; one tab of	11 AM; one tab on at			:	
	a total of eight dose as administered, of	es of at 4.40 PM for es of documented which 6 were not documented 16 MAR.				
	(DON) on apprised of the inac medication	reconciliation between the			:	
	#269. The DON cor document all	d Drug Record for Resident firmed that the nurses are to drugs given on the cord as well as on the resident				
	Class III					
N 110 SS≈D	400,141(1)(h) FS; 5 Environment - Safe	9A-4.122(1) FAC Physical , Clean, Homelike	N 110	A Pest Control company conduc on-site visit to service the kitchen for any existing pests. Th	c entire !	
	400.141(1)(h) FS Maintain the facility conduct its operatio manner.	premises and equipment and ns in a safe and sanitary		schedule was changed from mon twice a month and as needed if n visits are needed.	thly to	
İ	- // ^	ivide a safe, clean, imelike environment, which			:	
Form :	3020-000/	1 17.				0 1ad

From:FLORDA AGENCY HEALTH 8614965925 / / / : 15:44 #668 P.062/096

Agency	for Health Care Adm	inistration				: 03/10/2016 APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		100611	B. WING		02/1	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REHABI	LITATION CENTER AT	HOLLYWOOD HI 1200 N 3	OOD, FL 33	021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE PRIATE	COMPLETE DATE
N 110	belongings to the ex- This Statute or Rule Based on observati determined that the effective pest certification and the effective pest consumer that the a The findings include During the kitchen/fic conducted on with the Food Servi numerous flying inse production, food ser areas (dry storage a rease (dry storage a were made in the were made in the the tour that exit do compartment sink a covered with large p the door open prope gaps in the door open prope gaps in the door open enter the kitche	to use his or her personal teen t possible.  Is not met as evidenced by: one and interview, it was facility failed to maintain and program in the main kitchen rea was free of pests.  Example of the main kitchen rea was free of pests.  It was noted that the main kitchen rea was free of pests.  It was noted that the main kitchen rea was free of pests.  It was noted that the main kitchen reas. The main reas, food storage and walk-in refligerator), 3 reas, and dish machine area. 20 individual observations areas. It was noted during or located near the 3-rea was wide open and lastic sheets that did not fit rily. There were numerous naing the would allow pests to lain the pest control in the main the pest control in the main.	N 110	At a minimum, a bi-monthly sch will be maintained by the Pest ce company to ensure the kitchen v free from pests.  A daily check will be conducted Food Service Director or design monitor for pests in the kitchen The Maintenace Director and Administrator will incorporate rounds in to their rounds schod Two blue lights designed to attr were added to the kitchen area.	by the se to area.	
	review of the last 6 r contracted pest cont the kitchen areas are	rol company revealed that e serviced on a regular basis, curnentation of on-going				
						- 1

ADM constant

5614965926

15:44 #668 P.063/DOK

PRINTED: 03/10/2016 FORM APPROVED Agency for Health Care Administration
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
IDENTIF (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 100611 B, WING ... 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HI HOLLYWOOD, FL 33021 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETE DATE N 111 Continued From page 9 N 111 N 111 59A-4.122(2), FAC Physical Environment - SS=E Specifics N 111 The facility shall provide: (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. (b) Clean bad and bath linens that are in good condition; (c) Private closet space for each resident; (d) Furniture, such as a bed-side cabinet, drawer space; (e) Adequate and comfortable lighting levels in all areas; (f) Comfortable and safe temperature levels; and (g) The maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the residentwill be tuned to stations of the resident's choice. This Statute or Rule is not met as evidenced by: Based on observation and interview conducted on it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary,

The findings included:

During an environmental tour conducted on at 10:05 AM and 1:00 PM accompanied with the Administrator, Engineer Director, Director of Nursing and Environmental Director, the following concerns were noted:

.... was

orderly, and comfortable interior in 4 (1 East, 1 West, 2 East, and 2 West) of 4 Resident Units.

1.) 1 East Wing:

a. - The wooden scratched and chipped.

54XQ11

If continuation whom 10 of 4:

3/18/16

has

STATE FORM Jorge Carballo

ADHUM

(a)

been fixed.

cntrance

From:FLORDA AGENCY HEALTH 5614966925 / 15:45 #668 P.064/GP6

PRINTED: 03/10/2016

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
	100611	8. WING _		02/18/2016
ME OF PROVIDER OR SUPPLIER	STREET A	DORESS, CITY	STATE, ZIP CODE	1 02 10/20/0
HABILITATION CENTER AT	HOLLYWOOD H: 1208 N 3	5TH AVE		
4) ID ; SUMMARY STAT	HOLLYW EMENT OF DEFICIENCIES	OOD, FL 3		
REFIX (BACH DEFICIENCY AG REGULATORY OR LE	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X3 .D BE COMPL PRIATE DATE
1111 Continued From pag	e 10	N 111		
b. ~ The a sink had missing and hole in the floor near	rea on the floor around the d cracked tile. There was a the sink.		(b) sink has been repa	ired and
was peeling. There v	eint on the /as not a trash can in the nd bed's dresser/night and worn.		(c) has been painted at trash can has been placed in the b . The bed dresser has been re	ath placed.
desilvering, black sor	irror above the sink was ets. The wall under the eeling and was seratched, tal was		(d)Room 119 mirror above the sir been replaced. Wall area under th television has been fixed and pain	
was in disrepair with s the wooden door. The sink was desilverizing	es on the floor near the recked. The cratches and gauges out of only existing milror at the black spots. The tile on the leven, slidhtly higher than the doorway to		(e) floor tiles near the been replaced, bat room door has been fixed. The mi by the sink has been replaced.	h
f. Corridor Hand Ralls throughout the 1 East deep scratches and so	The wooden wall railing Wing was in disrepair with uffs.		(f) Corridor hand rails in 1 East W have been painted.	ing
g. Storage # - the hallway contains feedings ( as tube feeding supplies	and fibersource) as well		(g) Storage # has been lock and appropriate staff given a key.	:
trash in bins and trash		1	(h)Building Service Staff and Clini Staff have been in serviced in prop trash disposal in Soiled Utility.	cal er
i. Community shower- wrapped around the ha	displayed a call bell cord nd rail.	- 1	(i) All were loosened and or replaced to be hanging by the floor in-serviced.	Staff

/ 15:46 #668 P.

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Agency for Health Care Adr				FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
	100511	B. WING_		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	STATE, ZIP CODE	
REHABILITATION CENTER A	T HOLLYWOOD H: 1200 N 3	STH AVE OOD, FL 3:	3021	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROCEDURE)	D BE COMPLETE
N 111 Continued From pa	3ge 11	N 111		1
were stored on the	four dirty "wet floor" signs floor next to the countertop, d freezer gaskets were full of		(j) Wet floor signs have been rem from Pantry. House Keeping staff inserviced. Signs moved to Janito closet.	f ,
k. 1East Activity were in disrepair w The back walls had	The wooden entry doors ith deep scrapes and scuffs. peeling paint.		(k) 1 East Activity h been repaired.	ave
Storage dirty floor.  2.) 1 West Wing:	- had a loose door knob and		(i) Lock has been replaced and flo cleaned.	oor
a. The and the floor at the	door jam 's paint was chipped, door was chipped. The d displayed the metal outside		(a) door jam's was fille painted. The rail bumper guard h fixed.	
	contained open bottles of hwash, lotion and wet paper		(b)Open shampoo bottles removed mouthwash removed, wet paper to removed staff in-serviced to discar items from shower when finished	wels
wall of bed 2 display and scrapped walls.	entry door was scraped. The yed 2 metal picture hangers There was a chair with torn anditioner vent was rusty.		bathing a resident (c) entry door has been the wall of the bed has been repaire and painted, metal picture hangers	d
	- 3 of 3 trash cans were te products with no cover.		removed and wall fixed, cushions discarded and A/C vent rust fixed.	
3.) 2 East:			(d) Medication waste covers purch and installed. Staff in serviced on v	ased vaste
Hallway Corridors- throughoutwere wor	The corridor handrails n.		level and disposal.	;
board of beds B and scratches and scrap wall in the disrepair.	wooden head board and foot I C were in disrepair with es. A hole was noted in the . The night table of bed 1 is in		(a) Wooden Head board and C have been replaced. The hole the been fixed. The r table of bed 1 has been replaced.	in
ATE FORM	Parallo "		exam no	3/18/13

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/ 15:46 #668 P.066/095

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Agency for Health Care Adn				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	100811	B, WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE ZIP CODE	
PENARU (TATION OF	4000 11 00			
REHABILITATION CENTER AT	HOLLYWOOD HI	OOD, FL 33	3021	
PRÉFIX IEACH DEFICIENC	atement of deficiencies Y must be preceded by Pull SC (Dentifying Information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CHOSS-REFERENCED TO THE APPROFIDERIC PROVIDER CORRECTION OF THE CORRECT OF THE APPROPRIES OF TH	DN (X5) DBE COMPLETE PRIATE DATE
N 111 ; Continued From pa	ige 12	N 111		
baseboard behind the night table for			(b) door has been fixed baseboard behind bed B cleaned a painted. Night table for bed C has cleaned.	nd ·
walls. The baseboa	re were staples and nails in the ird under the window had were numerous small holes in 		(c) staples and nails rer the wall was painted. Floor tiles in been replaced.	the
d, -The chipped and the wa The corner guard is	door is ill behind bed B is scratched.		(d) Entry door fixed, w behind bed B fixed, corner guard	rall fixed
e The night table of bed A	walls had paint peeling. The was in disrepair.		e) Walls fixed and paint night table bed A has been replace	ed, ! d. :
f. ~ The compelling paint.	overbed table 's legs were		f) The overbed table wa replaced.	s
gThe rusted, The tub was	solled.		(g) fran fixed and painted. The bath tub we cleaned.	ne was
h The v	wall behind bed A had paint		(h) wall behind bed A wand painted.	as fixed
l. Clean Linen Door handle was falling of	s- were in disrepair and the ff.		(i) Clean Linen doors handle fixed fixed.	doors
J. 2 East Dining door to the were dusty, and the	/Activity -The entry chipped.The air vents walls paint was peeling.	l l	<ul> <li>j) 2 East Dining entry fixed and painted, air vents of and walls painted.</li> </ul>	leaned
4.) 2 West Wing:		1		
a The	has missing		(b) fixed	fixed.
b The missing/broken tile.	The was		replaced. Baseboard was fixed. Soil wheelchair removed and cleaned.	ed
ICA Form 3020-0000				

AHEA FORM S020-0009 STATE FORM Jose Parallo

ADH C

17 contiguation pheet 13 of 42

From:FLORDA AGENCY HEALTH 6614965925 / 15:45 #660 P.067/095

PRINTED: 03/10/2016

3/18/2/

AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG:	(X3) DATE SUP COMPLET	(VEY
		100811	9 WING_		02/18/2	046
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CIT	Y. STATE, ZIP CODE	02/16/2	<u>v 11</u>
	LITATION CENTER AT	HOLLYWOOD H	35TH AVE WOOD, FL 3	33021		
(X4) ID PREFIX TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROP DEFICIENCY)	N D BE CO RIATE	(XS DMP)
N 111	Continued From page	ge 13	N 111		<del></del>	-
	uneven with the was observed in the loose.	A soiled wheelchair The baseboard was				
1	c basel metal exposed,	board outside of		(c) baseboard outside repaired.		
1	shower call lig	oilet seat was loose. The ght was too short.		(d)Shower scat was fix light cord was replaced.	ed, call	
	jacket, and more tha	d personal belongings, a n 4 purses.		(e)Staff in-serviced in all floors no place personal belongings in Pante		
	f. 2 West Activity The window sills wer	<ul> <li>wall paper was bubbled.</li> <li>stained.</li> </ul>		(See in-service) (f)2 West Activity pape	r has	
	During an interview di environmental tour or	at 2:00 PM with		been fixed window sills replaced. All other facility in common	3/1	8/
	the Administrator, En Environmental Direct were acknowledged	gineer Director, or, all of the findings above Further interview revealed		areas have been assessed and all nessesary repairs have been comple		
	that the procedure wa	is for staff reporting broken	1	To ensure continued compliance, t Director of Maintenancewill maint	ain.	
	Director of Engineering	d responded that each		a preventative maintenance manua	l i	
	are placed, then he re	box in which work orders strieves them dally. The g stated that the staff		with a log for daily rounds. In addithe ADM will make weekly rounds	to	
- 1	needs a refresher cou	rse/in service on how to		observe Maintenance and Housekeeping provided.	!	
	auality assurance tool	hat only recently was a		mousekeeping provided.	1	
	Class III					
				1- Resident #269 went to a urolo	zist	
SS=D A	100.022(1)(I), FS Righ Appropriate Health Ca	t to Adequate and re	N 201	appointment on / / and can back with orders to remove	ne :	
, 1	he right to receive ad	equate and appropriate	1	back with others to remove		
Form 30: FORM	en in Sarla	11.				_

5614965926

15:46 #G68 P.

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Agency for Health Care Adm	inistration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	B. WING_		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS CITY	STATE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD H: 1200 N 3	STH AVE	***	
(X4) ID SUMMARY STA	TEMENT OF DEPICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D RF COMPLETE
N 201 Continued From pa	ge 14	N 201	Continue from page 14	!
health care and pro	tective and support services, vices; mental health services.		was discontinu	
if available: planned	recreational activities; and		/ / . (see order and progre	288
therapeutic and reh	abilitative services consistent		note attached)	
recognized practice	re plan, with established and standards within the		2- Staff was educated on ensur	
community, and with agency.	h rules as adopted by the		that residents who enter the fa	cility
agency.			without an	are
. This Statute or Rule	Is not met as evidenced by:	ļ	not catherized unless the resid	ent's
Based on observation	on, interview and record alled to ensure the appropriate		condition demonstrates that	
provision of	care for 1 of 1 residents		catherization is necessary. (see	e
reviewed for	(Residents #46)		attendance signing sheet attacl	ned)
as evidenced by fail	ing to perform care in			
a manner to prevent	the potential for wounds for Resident #46:		3- Restorative assessment form	was
and failure to reasse	ess the need for a		updated to reflect residents the	at are
and	consult for 1 of 1 sampled			nd the
residents (Resident	#269), reviewed for		diagnosis with proper follow u	p.
-	l	-	Restorative Nurse educated on	the
The findings include	d:		need for assessment of all resid	
Review of the facility	rapiley for		that are admitted to the facility	with
Handwashing/Hand	Hygiene states in part,	i	an indwelling fo	
'Employees must wa	ish their hands for at least	1	proper follow up and care plan	
fifteen (15) seconds	using or ap and water under the			·
	Before and after changing a	1	4- An audit was conducted of	an l
dressing'. The Proce	edure states: 'Vigorously	1	current residents in the facility	
lather hands with so	ap and rub them together,	1	ensure proper follow up	
(15) seconds under	surfaces, for at least fifteen a moderate stream of running		appointments have been sched	uled
water, at a comfortat	ole temperature'.	İ	for the residents without a diag	
Review of the facility		1	to support an indwelling	
	policy for Care in the Procedure for	1	. (See attached)	1 1
non-disposable supp	lies to Include: Wipe			i 1
reusable supplies wit		:		1
CA Form 3020-0001	atalk ;			
porsic	araw "	าทผน	4XQ11 (r	2/10/1
70	,		-	4/8/4

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Agency for Health Care Admir				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
l i		ĺ		
	100611	8. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	
	1200 N 35			
REHABILITATION CENTER AT	HOLLYWOOD HI HOLLYWO	OOD, FL 33		
PREFIX (EACH DEFICIENCY)	ement of deficiencies Must be preceded by full C identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DE COMPLETE
N 201 Continued From pag	je 15	N 201	Continue from page 15	
putsides of container	rs that were touched by		C. A. consideration 124 (11.1)	
unclean hands, sciss	sor blades etc.)		5-A weekly audit will be condi	
			by DON or designee of all resi	dents
	admitted to the facility on		with a to ensure	the
with hospita			proper diagnosis are in place f	
through an			use of and orde	
readmission back to				
. Keview of the clinica i #46 was admitted wi	I record revealed Resident		attempts of removal from MD	
	n unstageable left heel		place for those that are not nee	essary,
	suspected deep tissue injury			<b>*</b> 1
to the right heel.	obopostou doep noode mje.y			
			1- care nurse was provide	d with
: On at 10;30	a.m., with the consent of		1:1 education on proper c	
the resident, observa	ation of care was		procedure to prevent	
	Care Registered Nurse,			and
	Istance of an aide, the		avoid cross contamination to incl	ude '
	oned to his left side and the		proper handwashing with return	1
	ved. It was observed there		demonstration. (see attendance sl	neet (
was no dressing on t	the sacral The size of 2 quarters placed side		attached)	
by side with a smalle				1 1
	and to the right of the larger		2 Campatana - 173 - 17	. !
	were observed to be draining		2-Competency validation of dress	ing
a small amount of	drainage, Staff		changes was performed on both	
	s, washed her hands for 10		care nurses to ensure compliance.	(see
	new gloves. She then		competencies attached)	! '''
	i saline on a wad of gauze			. 1
	eanse the wounds with ption and then a swiping		3-Weekly observations to	
	e wounds. She dabbed the		done by DON or designee for the	next
	ze. She then removed her		three months to ensure proper	
	nands for 4 seconds and		care procedure is being followed,	reports
donned new gloves.	She squeezed . wound		will be taken to QA monthly. (see	sample
	edication cup and with a		observation attached)	
	sced the cintment on the			. [
	motion. She then picked up			
	e and with her gloved fingers			:
	the gauze that was going to			
HCA Form 3020-0001	, she placed the			

STATE FORM

Jose Carello " ADM L

3/18/11

To:15614965924 :9549817229

# 3/ 13

From:FLORDA AGENCY HEALTH

5614965925

15:46

#668 P.

PRINTED: 03/10/2016 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 A. BUILDING: B. WING \_\_ 100611 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HI HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES 10 COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 201 N 201 Continued From page 16 gauze over the wounds and secured with an Omni fix dressing. She then removed her gloves, did not wash her hands, and dated the outside of the dressing. She then donned new gloves without washing her hands and repositioned the resident's left leg on a pillow to have access to the left heel. She removed her gloves, washed her hands for 6 seconds, donned new gloves and with scissors cut off the Kling wrap dressing over the left heel. The left heel was observed to . She placed the used be an unstageable scissors on the clean care supply field and without removing her gloves, washing her hands and donning new gloves, she cleansed the left with sterile normal and dried the area with dry gauze. In reaching for the dry gauze, the plastic bag containing ointment sitting on the clean field, on the floor. She proceeded to pick up the plastic bag off the floor and placed it back on the clean supply field. She then took a box of gloves sitting on the clean supply field and placed the box on the resident's bed next to the left leg. She then removed her gloves, washed her hands for 4 seconds and donned new gloves. She placed the cintment in a medication cup and then with the same scissors she used to cut off the old dressing with, cut a piece of the Omni fix dressing and secured the Kling, placed the previously used scissors back on the clean field and with a tongue depressor placed the ointment on the with a wad of gauze , covered the and secured with Kling wrap. She then removed her gloves, dated the outside of the dressing and washed her hands for 5 seconds. She then proceeded to place the box of gloves sitting on the bed next to the resident's left leg, on the supply clean field. She donned new gloves

the dressing from the left heel, cut off the

ACA FORM 3020-0001 Jura Carballo

and with the same scissors she used to remove

" S4XQ11 ADM Man 3/18/11

From:PLORDA AGENCY HEALTH 6614965925 / 15:46 #668 P.

PRINTED: 03/10/2016

Agency for Health Care Adm	inistration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND FORM OF CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE. ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35			
	HOLLYWO	DOD, FL 330	121	
(X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	(0	PROVIDER'S PLAN OF CORRECTION	
TAG REGULATORY OR LE	C IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROP	DBE COMPLETE
			DEFICIENCY)	
N 201; Continued From page	ge 17	N 201		ì
dressing on the righ	t heel and placed the scissors			
back on the clean fit	eld next to a clean wad of			
gauze. She then pla		1		
the right heel	with a tongue depressor			
however did not clea	anse the first. She , washed her hands for 3			1
seconds, donned ne	washed her hands for 3			, i
wad of gauze sitting	next to the used scissors on			:
the clean field, place	d the gauze over the right	1		!
heel and sec	ured with Kling wrap. Using he cut a piece of the Omni fix	1		i i
dressing and secure	d the Kling, placed the	ì		1 1
previously used scis	sors back on the clean field	i		,
placed the Omni fix	ressing over the Kling wrap	1		i 1
and dated the dressi	ng. She closed up the red			
washed her heads fo	ag, took her gloves off and or 6 seconds. She took the	1		: I
bag out of the	came back in, washed her			1
hands for 5 seconds	and proceeded to nick up			1 1
the paper package o	f clean gauze and box of			
them back on the cie	them to her body then put an field. She then went out	1		
of the return	med with another red	1		١ ١
biohazard bag and pl	aced some of the used	1		
supplies in the bao th	en picked up the paper			! !
package of gauze, O	mni fix tape, and ointments, ite foam tray and placed the			
box of gloves that ha	d been sitting on the			
resident's bed, on top	of the supplies and took the	- 1		į (
biohazard bag out of	the She then returned	1		i
back to the , ren	noved her gloves and r 5 seconds, She then took	1		1
the box of gloves now	sitting on top of the			; j
supplies and put it in	the rack above the sink.			1
picked up the cintmer	nts, paper package of gauze	- 1		
and Omni fix tape, we	ent to the care aced the supplies back into	- 1		: 1
the cart. Returning ba	ck to the went to			
the sink and rinsed the	ne scissors for 4 seconds	-		
under running wate	them in a paper			- :
CA Form 3020-0001/	/			
ATE FORM Jung Cau	alla "	S4X	Q11 Ka	onthruggion ships 18 of 42
Jo-2 ( 10)	140	Min	_	3/18/12
,				1 1.0

5614965925

15:47

PRINTED: 03/10/2016 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY B. WING \_\_\_ 100611 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HI HOLLYWOOD, FL 33021 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID Pope COMPLETE N 201 Continued From page 18 N 201 towel, returned to the care treatment cart, opened the top drawer and placed the scissors. still in a paper towel in the top drawer and closed the cart. She then documented the care had been rendered in the Treatment Record. at approximately 4:00 p.m. the Director of Nurses was apprised of the care observation of Staff A with Resident #46 to which she responded she cannot understand why Staff A did as poorly as she personally watched her perform care in the past with no issues identified. 2. Record review revealed Resident #269 was admitted to the facility on n with an , with the indication of indwelling , with the mulculum. retention noted in the Physician Orders. A follow up Physician's progress note does not address the resident's status, a diagnosis/plan nor if the resident has an indwelling present. The Nursing note entry's only mention the indwelling foley twice; once in the admission note and the second time in a nursing entry dated No nursing entries show that the physician was contacted to discuss the follow up care or plan related to the resident's Indwelling No consults had been made to address the resident's urological status The Minimum Data Set (MDS) reveals that the resident has a (BIMS) summary score of 15, which indicates Resident #269 as able to be interviewed and

catheter is present.

AHCA Form 3020-0001
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intact. In addition, the bowel and section shows an indwelling

" ADTITUS TRAFE

If continuous sheet, 18 of 43

To:15614965924 ;9549817229

# \_1/ \_3

From:FLORDA AGENCY HEALTH 6614965925

1/ 16:47 #668 P. //

PRINTED: 03/10/2016 FORM APPROVED

Agency for Health Care Adm	inistration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	8. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35			
		OOD, FL 330		
PREFIX : (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D RE COMPLETE
N 201 · Continued From pa	ige 19	N 201		'
addressing	ealed two care plans status were initiated, however, o keep drainage bag below t indicated.			
Director of Nursing is Ret	43 PM, the ADON (Assistant ) stated that the reason for ention and that this is an			;
should be follow-up chart but was unab regarding the plan i restoration of her that they have morn meetings regarding concerns; however	le to find any indication to assist the resident in the function. She stated ning meetings and clinical residents to discuss care and this was not identified. The ney need to contact the doctor			
Indicated, attempt t ADON acknowledg	o remove the . The ed the lack of documentation rt and that she too could not			
1 East Desk Nurse the for resident may have not sure and could information. She st	53 PM in an interview with the stated that the resident has retention and thinks the a doctors appointment but is not locate any additional tated that she was not sure as an's plan is for the resident.			
In an Interview on C, she stated she is has an indwelling Know what the plan	at 2:47 PM with Staff s not sure why the resident and does not ls, if any.			
several times durin and in her room wit At 2:56 PM the ses	tesident #269 was observed g the day at Physical h the indwelling dent stated she had a good			:
HCA FORM 3020-0001	and all	ו אדו מו	x9115Frol	1 continuation sheet 20 of 42

STATE FORM

5614965925

.../ ./ ... 15:47

PRINTED: 03/10/2016

Agency for Healt	Core Adm	inistration				
STATEMENT OF DEFI	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING.		(X3) DATE SURVEY COMPLETED	
		100611	B. WING		02/18/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021						
DOEDLY (FAC	H DEFICIENC	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE	
N 201 Continu		age 20 eyor inquiry regarding the	N 201			
Indwelli	ng ospital beca	she stated they put it in suse she was having difficulty				
8	bout It now regard	r, she is not sure what they are and has not seen the doctor or ang it since she has been				
: On	ged from th at 4:	18 PM, the ADON confirmed				
which we the Phy been so	as confirm sician's offi neduled or					
would b willing t contact	e seen on	or Inquiry that the resident If the facility were e visit. She was going to and make them aware. The				
they ac	dministrate knowledged d the Indw	p:30 PM in an interview with the or and Corporate Consultant, if that Resident #269 should elling looked into				
stated t appoint The DO	hat they we ment and p IN acknowl	valuated. The Administrator re keeping the aying for it through the facility. edged that best practice would				
If Indica	ted or set u st earlier if i the continu	v up with the MD and do a trial, p an appointment with the ndicated but understood that a ned use of the was not				
Class II						
N 203, 400.02	2(1)(n), FS	Right to be Treated with Dignity	N 203		1	
. The rig	nt to be trea	ited courteously, fairly, and			1	

AHCA Form 3020-0001 STATE FORM Jose Carallo

S4XQ11 ADMin

3/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100811	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	STORETAN	Apres am		02/1	8/2016	
	TATION CENTER AT	HOLLYWOOD H. 1200 N 35		STATE, ZIP CODE			
MERINDIL		HOLLYW	DOD, FL 3:	3021			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION OF MOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION LD BE PRIATE	COMPL	
N 203	Continued From pa	ge 21	N 203		<del></del>		
	written statement	and an oral explanation of the		1	1		
	ervices provided b	V the licenses, including these		1			
,	equired to be offere	ed on an as-needed basis.			:		
		1		1			
i i	Based on observable	is not met as evidenced by:			1		
: 6	eview the facility fai	led to ensure recidente ware			:		
<b>1</b>	eated with dignity v	vith respect for their					
47	idividuality and pre	ferences for 1 out of 1					
b	v failure to include	Resident #265) as evidenced Resident #265 in preferred					
а	CUVILIES. BS 255P551	and tunon admirections follows to					
P	rovide activities of a	fally living (ADL) to include		l	- [		
1 11	air care and snaving	1 for 1 out of 1 regidente	1		- [		
165	ilure to oddroos re	wed for ADL care; and sidents in a respectful			i		
m	anner on the secon	nd floor east wing during	- 1		1		
d	ning observation.	o noor east waig during	- 1				
T	ne findings Include:				;		
R	eview of the facility	policy litled Quality of Life -	- 1				
: 0	gnity, states, Resid	ents shall be assisted in	- 1				
ati	ending the activitie	s of their choice'	i		- [		
D.							
01	/20/16 with diagnos	dmitted to the facility on		•	- 1		
Dy	sphagla, requiring	es to include and feeding tube for					
nu	trition and hydration	1.					
1	Davidson of the 1-20		1		- :		
"	completed by	Activity Assessment dated y an Activity Assistant,		1)Resident was assigned to a sense	rv		
do	suments the curren	t activity interests of		stimulation program in a small gr	oup of		
Re	sident #265 include	Exercise Being Outdoors		5 to 8 residents and in smaller tim	e ·		
VVa	tching TV, Movies	and Music. The		increments to better meet the resid	dents		
200	maryr-rogram inc	sludes, Resident will receive group programming to	i	needs.	4		
' ent	iance and/or maint	ain his or her level of	1		1		
. 500	lalization and intera	Iction with others Resident			- 1		
Will	be escorted to and	from activities as needed.					
FORM /	Jose Conta	010		***************************************			
/	procula	νυ «···	Min	(Q11 If a	onlinuation she	mi 22 of	

From:FLORDA AGENCY HEALTH 5614965925 / ..... 15:48 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

Agency for Health Care Administ	tration				
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	100611	B. WING		02/18/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
REHABILITATION CENTER AT HO	LLYWOOD HI 1200 N 36 HOLLYWO	TH AVE	021		
PREFIX (EACH DEPICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER (CROSS-REFERENCE)	D BE COMPLETE	
N 203 Continued From page 2		N 203			
p.m. multiple observation	1:00 e.m. through 2:00 ons were made of		Audit was conducted of all ac residents to insure that the activity		
Resident #265. On eac resident was observed in			that are being provided are adequ	ate	
with her night gown on.			with their cognition and function		
which was not turned or	n. The were		status in order to improve their o	uality	
turned off and the windo	ow drapes were pulled	- 1	of life. (Audit form attached)	; 1	
her In bed, having	resident was observed in tube feedings	1			
infused via pump, next t	to the bed. She remained		<ol><li>To ensure that all resident are</li></ol>		
in her nightgown facing	the TV which was not	- 1	attending the proper activities based on their evaluation Staff was in-service on		
turned on and the window drapes closed. I	remained off and	j			
clinical record revealed	she receives tube	ı	new activity calendar and a list of residents with their assign activity		
feedings via feeding pump starting at 2 PM and			area will be provided weekly to n		
concluding at 6 AM for a total of 16 hours per day.			coordinator, (staff in-service atta		
uay.	1	- 1	coordinator, (start mi-service atta	cheu)	
Review of the 1st Floor	Activity Calendar revealed	1	4) Daily rounds will be conducte	d by	
the scheduled activities		- 1	activities director or designee to e		
Resident #265 was asset in, to include at 10:45 a.			attendance and any absenteeism	will be	
Body Exercise; at 2:30 p	.m. Creative Art; and at		communicated immediately to II	T for	
4:00 p.m. a group watch	4:00 p.m. a group watching of a TV show.		further intervention.	1	
Review of the Sensory S	Himulatina Atlandana	1	If any resident doesn't wish to	1 1	
record received from the	Activity Director on			their	
documents on	the resident		assigned activities an activity staff		
participated in Group act documented), however F	livity (no time was		member will provide appropriate activities in	: 1	
observed to be in bed as		1	activities in		
observations, in her nigh		1			
the Activity Participation	not turned on. Review of				
the resident was					
On at 10:00 a.m.	. Resident #265 was				
observed to be up in a w	heelchair in street			: [	
clothes parked between the HCA Form 3020-0061	the 2 beds opposite her				
TOTE CODY // / /	1 / 41	n 54	IXQ11	continuation phast 23 of 42	
Jorce Carlel	6	ADM		, .	
July Carrow	-	JUNA	~	3/18/16	

5614965926

/ / 15:48 #688 P.

PRINTED: 03/10/2016 FORM APPROVED

Agency for Health Care Adm	inistration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35	5TH AVE OOD, FL 33021	1	
PREFIX (EACH DEPICIENCY	Atement of Deficiencies I must be preceded by full SC Identifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ON (X4) D BE COMPLETE PRIATE DATE
N 203 Continued From pa	•	N 203		
heed TV however, were out and the width of the country of the coun	rved to be facing the over the TV was not on. The lights indow curtains were closed. 1 a.m. Resident #256 was the same spot, with the TV still erd of the same spot with 2 p.m. Resident #265 was in the same spot with working on connecting the p.m. Resident #265 was in the same spot. the resident in the next bed £265 could not see it from her overhead TV above Resident			
Review of the Sens record received from documents in her no Review of the Activi documented on sensory stimulation read to Resident #	ory Stimulation Attendence in the Activity Director on the activity Director on the resident was activity indicated. by Participation record the resident received the resident received the second to music, and was see was not observed to have to between the 2 beds			
observed in her The lights were out closed. On at 11:00 observed in her The overhead Tv w and the window cur On at 12:15 observed remaining the TV not gn. The	a.m. Resident #205 was bed in her nightgown. and the window curtains were a.m. Resident #265 was bed in her nightgown. as not on. The lights were out tains were closed. p.m. Resident #265 was in bed, in her nightgown with			
TATE FORM	entallo.	100 M SAX	215 H	3/18/ 11

STATE FORM

3/18/ 11

5614965926

1/ 15:46 #668 P.076/095

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	100611	B. WING			
name of provider or supplier	RTREET A	000000	STATE, ZIP CODE		18/2016
REHABILITATION CENTER AT	HOLLYMAN 1200 N 3	STH AVE	STATE, ZIP CODE		•
	HOLLYM	OOD, FL 330	124		
(X4) ID SUMMARY STA		ID.			
THE THEODITORY OR ES	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TON SHOULD BE	COMPLETE DATE
N 203 Continued From pag	ge 24	N 203		·	
window curtains wer	e closed				i
On at 2:15 a	m Danisters sans	1 1			
observed remaining	in had in has wished	1 1			
window curtains wen		1 1			
' FURDET, observation	was made -				
C.ZU D.M. of the Action	itine Disastas				
				i	
	ng activity on the first floor	1		,	
, anioide pario,	į į	- 1		ì	
On at 3:00 p.	m. Resident #265 was	- 1		j	
the TV not on Register	n bed, in her nightgown with ant #265 was not included in	- 1		-	
the singing activity on	the outside not included in	- 1		i	
		1		!	
Review of the Senson	Stimulation Attendance	1		1	
LOUI DAMAGE LOUP	De Activity Director on	- 1			
		- 1		j.	
documents no	the Participation record an				
Review of the 1st Floor	r Activity Calendar revealed	- 1		(	
		- 1		i	
#265 was assessed as				1	- 1
		1			- 1
a TV show	10 p.m. a group watching of	- 1		j .	- 1
a · v Show,	- 1				ł
On at 10:00 a	.m. Resident #265 was	1		1	- 1
					- 1
	ere off and window			i	- 1
, variants closed,		1		į	- 1
ut 10,45 a.ii	n. Resident #265 was	1			- 1
her bed. The TV was no	in a wheelchair next to	- 1		i	- 1
	drawn	- 1			- 1
On at 1:27 p.m	Resident #265 was	1		i	i
		-		!	1
THE TO WAS OF	20d foring the ather	- 1		*	- 1
m 3020-0001	and the window curtains				
	. 1,				
// //	1.16 "	54XQ11		If continuation shee	
Gorge Cen	JVW-	MPMI	~	3/18/	1

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From:FLOADA AGENCY HEALTH 5614965925 / 18:48

#668 P.

PRINTED: 03/10/2016

NAME OF PROVIDER OR SUPPLIER  THE HABILITATION CENTER AT HOLLYWOOD M  SUMMARY STATEMENT OF DEFICIENCES PACE OF DEFINITION OF DEFINITION OF THE PROVIDER'S PLAN OF CORRECTIVE ACTIONS TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDER ACTION TO BE CONTINUED FROM THE PROVIDE ACTION TO BE CONT	ECTION	COMPLE DATE
AME OF PROVIDER OR SUPPLIER  EHABILITATION CENTER AT HOLLYWOOD H  1200 N 35TH AVE  HOLLYWOOD, FL. 33921  PROVIDER OF SUMMARY STAYEMENT OF DEPICIENCES.  FREER STATES OF DEPICE OF STATES.  REGULATORY OR LSC IDENTIFYING INFORMATION).  PROVIDER PAID OF CORRESPONDER OF THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION.  N 203 Continued From page 25  drawn. A nurse and an aide were observed in the the resident of the door bed back.  Into her bed. The nurse stated they are getting the resident back to bed so she can start the tube feeding.  Review of the 1st Floor Activity Calendar revealed the days activities on which Resident #265 was assessed as having interest in, to include at 10-45 p.m. Sit & Fit Exercise.  On at 3:20 p.m. an interview was	ECTION	(X6)
EHABILITATION CENTER AT HOLLYWOOD H  1200 N 35TH AVE  120	ECTION	(X6)
MOLLYWOOD, FL 33021  FROMBERS TATABLETY OF DESCRIPTION OF THE PROPERTY OF THE	IDIUD BE	
IN 203  Continued From page 25  drawn. A nurse and an aide were observed in the the resident of the door bad back into her bed. The nurse stated they are getting the received by the tube feeding.  Review of the 1st Floor Activity Calendar revealed the days activities on which Resident first fi	IDIUD BE	
drawn. A nurse and an aide were observed in the thick the resident of the coor bed back into her bed. The nurse stated they are getting the resident back to bed so she can start the tube feeding.  Review of the 1st Floor Activity Calendar revealed the days activities on which Resident #265 was assessed as having interest in, to include at 10:45 a.m. Sit & Fit Exercise.  On at 3:20 p.m. an interview was		
into her bed. The nurse stated they are getting the resident back to bed so she can start the tube feeding.  Review of the 1st Floor Activity Calendar revealed the days activities on which Resident #265 was assessed as having interest in, to include at 10.45 a.m. Sit & Fit Exercise.		
conducted with the Activity Director who stated they have a "Slim" book and the residents are seen daily or 3-5 times a week. She stated everybody can come to a group activity that is scheduled and the residents that are are visited in their at least 3 times a week and they will turn on the TV for them if they can't participate themselves so they take them to entertainment, take them outside and do word games with them. She stated residents with tubes are not eliminated from group activities. She stated residents with tubes are not eliminated from group activities. She stated resident #265 has "omething" done every day however, Resident #265 was not observed from through to be out of her participating in any group exercise or music activities that dwere observed to be attended by other residents that did not have l'feeding tubes and who did not have the "tube feedings commencing at 2 PM in the afternoon.		

AHCA Form 3020-0001 STATE FORM

5814965925 / 15:49 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

Agency for Health Care Adm	inistration			
STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLI A. BUILDING:	CONSTRUCTION	(XX) DATE SURVEY COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYW	STH AVE OOD, FL 330	21	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REPERENCED TO THE APPROVIDENCY)	D BE COMPLETE
N 203 ' Continued From pa	ge 26	N 203		
yellowish spongy sti fingermalis. Addition he had not been sh on his arms was no no multiple and inquiry was made if himself with his lon, skin scratches easil he has not scretche resident stated he li shaved "today" and will cut his fingernal record revealed Re- admitted to the facil admissions on	through and dmission back to the facility on			
fingernalls on both t jagged with the blac the right hand finger	a.m. the resident 's nands remained long and its substance remaining under mails and the thick yellowish under the left hand fingernails. ven.			
observed In his time he had a shave the hospital and he (name of aids) to co that she will shave he nails were observed the blacklsh substatifingemails and his trick spongy substates in the state of the head of	p.m. the resident was bed. He stated the last was lest Thursday while in a walfing for a walfing for a walfing for a de he knode in man and cut his fingernalis. His to still be long, jagged with nee under the right hand aft hand fingernalis with the noce under the right hand aft hand fingernalis with the noce under his nalls. The ne of alde) will help him led Nursing Assistant			
HC4 Form 3020,0004	en tanionin vasigiant			

STATE FORM Graft Carballo

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If continuation sheets 27 of 42 3/16/11 L

From:FLORDA AGENCY HEALTH 6614965925 / 15:49 #688 P.

PRINTED: 03/10/2016

Agency for Health Care Adm STATEMENT OF DEFICIENCIES				- ORM	APPROV
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING.		(X3) DATE COMP	SURVEY LETED
	100611	B. WING		02/1	8/2016
name of provider or supplier	STREET AC	DRESS, CITY, S	TATE, ZIP CODE	1 0411	0/2016
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 3:				
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REPERENCED TO T DEFICIENCY	ION SHOULD BE	COMPLET DATE
documentation the inassistance with ADL include shaving even Nail Care there was resident's long finger on the training finger of the training finger of the training finger of the training finger of the training finger of the training finger of the training finger of the training finger of the training to their for example, Staff J loud from inside the gwho was out in the he she is a finer of the training finer of	2016 and r "excaval" and the second of the s	N 203	DEFICIENCY	9	
On at 1:18 delivering a tray into exited, she was heard feeder?, as the Certific entered the	PM. Staff K was observed tray. As she asking foudly, "is 201A is a ad Nursing Assistant (CNA) her. At 1:22 PM she was aying, "202B is a feeder".			, ·	
Form 3020-0001	a sall "	S4XQ	11	If coglinuation sho	

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3/18/12

From:FLORDA AGENCY HEALTH 6614966925 / 3 16:49 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		E SURVEY APLETED
		100611	9. WNG	02	/18/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
REHABI	LITATION CENTER AT	HOLLTWI	TH AVE	9021 PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	TEACH DEFICIENCY	Tement of deficiencies Y must be preceded by full sc identifying information)	PREFIX TAG	COMPLETE	
N 203	Continued From pa	ge 28	N 203		
	assistance by the C interview Staff K re-	is someone who needs NA to eat. During further realed that she did not find in calling residents' feeders			
	Cless III				;
N 407	400.141(1)(i), FS D	ietary Services	N 407		
35=E	applicable standard shall:  (i) If the licensee tu wholesome and no wholesome and no for its residents and deta as may be pre-physicians. In makin paragraph, the age standards recommerprofessional groups from the properties of details the standards recommerprofessional groups of details. This Statute or Rule Based on observation and the proposed of the standards review, it was detern approved menu was standards.	is not met as evidenced by: on, interview, and record mined that the resident s not being followed.		The dinner menu was adjusted for to ensure the residents received adequate protein for the day.  The current 4- week menu cycle was reviewed by the Consultant Dietitian. All menus have been adjusted to meet minimum standards. All therapeutic and mechanically altered diet extensions have been reviewed and revised as needed to ensure all residents receive the correct diet as ordered.	
1	in the main kitchen accompanied with t	ion of the lunch meal service on at 11:30 AM he Administrator it was proved menu was not being	•	A consultant Dietitian and new CDM were hired to assist with plan of correction and implement systems issues to ensure compliance.	
ICA Form 3		1-1/2			on sheet 29 pf

To:15614965924 :9549817229

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From:FLORDA AGENCY HEALTH

5614965925 / 15:49 #668 P.

Agency for Health Care Adm	inistration			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTH	PLE CONSTRUCTION	(X3) DATE	SURVEY
	100611	B. WING			10/0046
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE	02/1	18/2016
REHABILITATION CENTER AT	HOLLYW	TH AVE	3021		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DAE	COMPLETE DATE
that it appeared to be per serving). Further packaging box was Further investigation documented Nutritio contained only 8 grail at 1.6	e Chicken Enchilada revealed e an ega roll appetizer (2 rolls review revealed that the labeled "Chicken Ega Rolls". of the box revealed in Facts that 1 egg roll am of protein which may of protein per resident in the Food Service Manager servation revealed that he e approved menu entree a residents did not meet the 4 to the contract of the contract	N 407	The Dietary staff was in-serviced following the menu with proper and menu extensions. Daily monitor by the Food Servic Director or designee will be condensure the approved menus are foe each day.	e ucted to ollowed	3/18/16
gone	A.	DMG		3/18/	12

From:FLORDA AGENCY HEALTH 6614965925 / 15:50 #668 P.

Agency for Health Care Adm	inistration			(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
AND PLAN OF CORRECTION	DENTIFICATION NUMBER:	A BUILDING		
	l			
	100611	B. WING		
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	1200 N 35	TH AVE		
REHABILITATION CENTER A	THOLLYWOOD HI HOLLYWO	000, FL 33	021	
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	: ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD	ON (X5)
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPRO	
TAG REGULATORY OR I	COURT INC III CHANGE	1	DEFICIENCY	
N 407 Continued From a	20 20	N 407		1
N 407 Continued From p				
that the Issue with	the dinner rolls was an error as			
	nu was to be followed by the	1	1	;
dietary staff for lun	ch meal preparation.	ļ	1	
E) During on inten-	iew conducted with the Food	1	1	
Service Manager	at the time of the observation of	1	1	
the lunch meal ser	vice it was revealed that he		i	
was unaware the p	curee diets to be served is for		1	1
all food menu item	s in a pureed form. The			:
manager was una	ware the the rice was to be			
pureed and that a	vegetable juice and cooked	ĺ		
the salad menu ite	nave been prepared in place of			
the salad menu ite	ms.		1	
Class III		ĺ		1
NZ815: 408.809; 435.02(2	): 435,06 FS Background	NZ815	i	4
SS=C; screening; prohibit	ed offenses		1	
		1	The RCHH policy was reviewed	with the
	nd screening; prohibited		HR Manager and Department F	
offenses	arrad componium pressured to			
(1) Level 2 Dackgr	ound screening pursuant to be conducted through the		All employees are required to ha	
agency on each of	the following persons, who are		AHCA Level II. A reference che	
considered emplo	yees for the purposes of		also be obtained. If a former em	
conducting screen	ing under chapter 435:		not willing to comply with a ref	
(a) The licensee, i	f an individual.		check request, this information	will be
(b) The administra	tor or a similarly titled person	1	added in the employee file.	1
	for the day-to-day operation of	1	1	
the provider.	fficer or similarly titled individual			
who is responsible	for the financial operation of		•	
the licensee or pro				
(d) Any person wh	io is a controlling interest if the	i		
agency has reaso	n to believe that such person	i		
has been convicte	d of any offense prohibited by	1		
s. 435.04. For eac	h controlling interest who has			
been convicted of	any such offense, the licensee agency a description and	-	i	
/1		į .	ļ .	
HCA Form 3020-0001	outable			If continuation sheet 31 of
TATE FORM / LOZ CE W	outalle	1000	84XQ11 N1STKATIX	ii cominuation ander 31 di
4		ו זין שדיין	NISIKATON	2/18/16
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From:FLORDA AGENCY HEALTH 5614965925

/ / 15:50

PRINTED: 03/10/2016 FORM APPROVED

#668 P.

Agency for Healt		ninistration				
STATEMENT OF DEFIN	CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	_
		100611	B. WING		02/18/2016	
NAME OF PROVIDER	OR SUPPLIER	STREET A	DORESS, CITY, S	STATE, ZIP CODE		
REHABILITATION	CENTER A	THOLLYWOOD N: 1200 N 3	5TH AVE 100D, FL 330			
	**************************************	TEMENT OF DEFICIENCIES				
PREFIX (EAC	H DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI IEACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE COMPLET	E
NZ815 Continue	ed From pa	ige 31	NZ815		;	_
explanal	tion of the o	conviction at the time of	!!		1	
	application.		1 1		į.	
(e) Any p	person, as	required by authorizing	1 1		:	
provider,	seeking ei	mployment with a licensee or ected to, or whose	1 1			
resnonsi	hilities may	require him or her to, provide	1 1			
personal	care or se	rvices directly to clients or	1 1			ı
have acc	ess to clie	nt funds, personal property, or	1 1		i	
flying are	as; and an	y person, as required by	!!		1	
authorizi	ng statutes	, contracting with a licensee	1 1		1	- 1
berte se	er wnose r	esponsibilities require him or onal care or personal services	1		1	- 1
directly to	cilents. E	vidence of contractor	1 1		Į	ı
screenin	g may be n	stained by the contractor 's	1		1	- 1
employe	or the lice	nsee.	1			- 1
(A) F			i l			- 1
(2) Every	ont or ont	flowing his or her licensure, ry into a contract in a capacity	l i			- 1
that unde	ir subsectir	on (1) would require level 2	1		1	- 1
backgrou	nd screeni	ng under chapter 435, each	1		ì	- 1
such per:	on must e	ubmit to level 2 background	1		!	- 1
rescreen	ng as a co	ndition of retaining such	1		1	-1
license o	continuing	in such employment or			!	1
contractu	al status, F	or any such rescreening, the the Department of Law				ŧ
Enforcem	ent to forw	ard the person 's fingerprints	1		!	1
to the Fed	deral Bures	u of Investigation for a	ı			1
national c	riminal hist	tory record check unless the	- 1			-
person 's	fingerprint	s are enrolled in the Federal	- 1			1
bureau o	invesugat	on 's national retained print ogram. If the fingerprints of	- 1			1
such a ne	rsne are n	of retained by the				1
Departme	nt of Law E	Enforcement under s.	- 1			1
; 943.05(2)	(g) and (h).	the person must submit	1			1
fingerprini	s electroni	cally to the Department of			!	1
Law Enfo	rcement for	state processing, and the			İ	1
the finoan	orints to the	Federal Bureau of	1			1
Investigat	on for a na	tional criminal history record	1			Í
			i			ł
ICA Form 3020-0001 TATE FORM	71	// //				נ
IN E PONT	1 for	ellaralle "	ADME	Q11 H	continuption of 32 of 4	2
	7		MOME	_	3/18/1	
	/				/ . • / / *	

# 137 13

From:FLORDA AGENCY HEALTH 5614966926

#668 P.086/095

PRINTED: 03/10/2016 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER  REHABILITATION CENTER AT HOLLYWOOD H  A SULUNIC.  D. WING.  D. WING.  1001  T. WING.  T. WIN	SURVEY LETED  8/2016  (XS) COMPLETE
NAME OF PROVIDER OR SUPPLIER  REHABILITATION CENTER AT HOLLYWOOD H  1200 N 35TH AVE HOLLYWOOD, FL 33021	: (36)
REHABILITATION CENTER AT HOLLYWOOD H: 1200 N 35TH AVE HOLLYWOOD, FL 33021	: (X6)
REHABILITATION CENTER AT HOLLYWOOD HI HOLLYWOOD, FL 33021	(36)
HOLLYWOOD, FL 33021	(36)
MALIN SUMMARY STATEMENT OF DESIGNACIES IN PROVIDED S OF AN OF COORECTION	(X5)
(A) ID SUMMANY SYMEWHAY OF DEPICENCIES   D   PROVIDER'S PLAN OF CORRECTION   FREETY   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   DEFINED CHOICE   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPRO	DATE
NZ815 Continued From page 32 NZ815	
check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(a) and fi) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. Until a specified agency is fully implemented in the cleaning-buse created under s. 485.12, the agency may accept as satisfying the requirements of this excellon proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with the Department of Children and Families, or the Department of Children and Families, or the Department of Screening	

Grip Karall " ADMIN

if continuation street 33 of 42

/ / 15:50 #668 P.

PRINTED: 03/10/2016 FORM APPROVED

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	100611	B. WING		02	18/2016
ME OF PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, ST	TATE, ZIP CODE		
EHABILITATION CENTER A	T HOLLYWOOD HI 1200 N 3				
Va to . Clantary ex		OOD, FL 330:			
REFIX (EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
NZ815 Continued From pa	ige 33	NZ815			Ī
request shall be ma qualifying or disqua named in the reque	of the person named in the aintained in a database. The alifying status of the person set shall be posted on a secure by the licensee or designated ee's behalf.				-
(4) In addition to the all persons requires screening pursuant statutes must not his disposition for mus of, regardless of administration for must not been adjudicated of have been scaled or following offenses or another jurisdiction.  (a) Any authorizing i follow, (b) This chapter, if it (c) Section 409,920 fraud.	orifenses listed in s. 435.04, 16 underge background to this part or authorizing ave an awaiting final that have been found guild understand to the record not published to the record not rexpunged for any of the ray similar offense of statutes, if the offense was a the offense was a felony, relating to Medicald provider				The state of the s
(e) Section 741.28, (f) Section 777.04, r solicitation, and conlisted in this subsect (g) Section 817.034, through mall, wire, r photoelectionic, or p (h) Section 817.234, fraudulent insurance	spiracy to commit an offense ion. relating to fraudulent acts adio, electromagnetic, hotooptical systems. relating to false and claims.				
using a false or expli device, if the offense (i) Section 817.50, re	relating to obtaining goods by red credit card or other credit e was a felony. slating to fraudulently ervices from a health care				

From:FLORDA AGENCY HEALTH 6614965925 / 18:51 #668 P. / . . .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY
	100611	e. WING		02/1	8/2016
AME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY S	TATE, ZIP CODE		0,2010
REHABILITATION CENTER AT					
ENABLIATION CENTER A	HOLLYW	000, FL 330	21		
PREFIX (EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLE DATE
NZ815 Continued From pa	ge 34	NZ815			-
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Form 3020-0001	ce Carallo ""	5400	211	if contiguation și	10 35 of -

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	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100611	8. WINO		02/18/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
REHAB	ILITATION CENTER AT	HOLLYW	6TH AVE 100D, FL 3302	1	
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NZ815	Continued From pa	ige 35	NZ815		į
	by the agency no la of the rescreening r	iter than 30 days after receipt results by the person.			
	of, is employed by, 2010, who qualified according 435.03 or s. 435.04 31, 2015, in complete in control of the c	e at the time of the last unrent disqualitying offense before the last screening, he ra nexemption from the g agency and, if agreed to by continue to perform his or her sing agency renders a lication for exemption if the apply for an exemption and ast is received by the agency receipt of the rescreening n. The rescreening schedule			
-	conducted on or bef must be rescreened (b) Individuals for wit conducted was between 1, 2008, 31, 2014.	by 1, 2013. nom the last screening reen 1, 2005, and must be rescreened by		·	
	conducted was between	nom the last screening reen , 2009, 1, must be rescreened by			
	required screening n	ated with obtaining the nust be borne by the licensee t to screening. Licensees			
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PRINTED: 03/10/2016 FORM APPROVED

Agency for Health Care A				FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLI		DRESS, CITY, S	TATE, ZIP CODE	
REHABILITATION CENTER	AT HOLLYWOOD HE HOLLYW	5TH AVE 100D, FL 330:	21	
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Department of L agency for scree The agency for scree The agency shal cover the costs ( (7)(a) As provide may grant an ext person who is su 1. Does not have or certification from not providing a service certification from not providing a service (b) As provided ir regulatory board or the departmen grant an exemptip person who is su received a profes from the Departmen stream of the service of the control icensed or certific (6) The agency ar may adopt rules p 120.54 to implem and authorizing st screening and to lo relating to retainin 943.05(2).  (9) There is no rec monetary liability acition for damage that, upon notice tunder chapter 435  (6) The service of the control o	ersons for these costs. The aw Enforcement shall charge the ining pursuant to s. 943.053(s), establish a schedule of fees to f screening, d in chapter 435, the agency umption from disquallification to a bleet to this section and who: an active professional license an active professional license and the professional license and the professional license and the professional license thricks within the scope of that the Department of Health, to the professional thricks of the title of the professional within the Department of Health, titled if there is no board, may an from disqualification to a jeet to this section and who has slonal license or certification ent of Health or a regulatory lepartment and that person is within the scope of his or her	NZ815		
TATE FORM	all telle :	S4XI	211 #6	onliquesion styles 37 of 42

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From:FLORDA AGENCY HEALTH 5614965925 / 15:61 #668 P.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		100811	B. WING		02	/18/2016	
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EHABIL	ITATION CENTER AT		5TH AVE 700D, FL 330	21			
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NZ815	Continued From pa	ge 37	NZ815		***************************************	-	
:	whether or not that	m the report was issued, person has filed for an Department of Health or the					
-	435.06 Exclusion from employment- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notly the employee in writing, stating the specific record that indicates noncompliance with the			·			
i :	standards in this cha the affected employ disqualification or to disqualification. The disqualification is pro-	anter. It is the responsibility of ee to contest his or her request exemption from only basis for contesting the oof of mistaken identity, may not hire, select, or					
ì	otherwise allow an e any perse employee in a role to screening until the s	imployee to have contact with on that would place the nat requires background creening process is onstrates the absence of any					
: 1	employment. If the s grounds for the deni employment, the em or otherwise allow th	creening process shows any					
1	employee in a role the screening unless the exemption for the dis as provided under s.	nat requires background employee is granted an equalification by the agency 435.07.				:	
6	employee has been offense, the employer from contact with an	comes aware that an for a disqualifying er must remove the employee y person that in a role that requires				· ·	

AHCA Form 3020-0001 STATE FORM

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To:15614965924 ;9549817229 # \_ J/ . J

From:FLORDA AGENCY HEALTH 6614985926

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Agency	for Health Care Adm	Inistration			FORM	APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		100611	B. WING		02/1	8/2016
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	LITATION CENTER AT	HOLLYW	STH AVE OOD, FL 330	21		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BE IDENTIFYING INFORMATION)	PREFIX TAG	Provider's Plan of Correction (Each Corrective action shoul Cross-referenced to the approl Deficiency)	D BE	COMPLETE CATE
	employee is still edje this chapter, (c) The employer m (d) The employer m of any of its person of any of its person oncompliance with this chapter or piace for which backgroun unless the employee from disqualification (d) An employer mey position that requires before the employee process for training; screening process is employee demonstra to behaviors that we termination of employ information necessa including fingerprinis information necessa including fingerprinis disqualified for emple employed, must be de (d) There is no reem monetary liability on disqualifying offense terminates the perso action for damages a upon notice of a com- disqualifying offense terminates the perso action for damages a upon notice of a com- disqualifying offense terminates the perso assissued or who w whether or not that p exemption pursuant: 435.02 Definitions.F-	ng until the is resolved ployer determines that the bible for employment under ust terminate the employment under the found to be in the employment in the employer in a position of acreening is not required a signated an exemption pursuant to s. 435.07, where an employee to a sheckyround screening completes the screening and drientation purposes, yee may not have direct persons until the completed and the test that he or she exhibits wrant the denial or ymment. The denial or ymment is used to the propose of the	NZ815			
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Agency	for Health Care Adm	ninistration		i	PRINTED: 03/1 FORM APPI	
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		100611	B. WING		02/18/20	116
NAME OF	PROVIDER OR SUPPLIER	STREET AT	DORESS, CITY, S'	STATE, ZIP CODE		110
REHABI	LITATION CENTER AT	HOLLYW	5TH AVE /OOD, FL 330:	D21		
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NZ815	Continued From pa	age 39	NZ815			
	faw to be screened including, but not lin contractors, license the contractors, license the contractors, license the contractors with the facility failed to a Personnel conducte checks and/or initial Care (AHCA) Level pursuant to chapter through the agency persons, who are courses, who are courses of conductors, for 4 out of 10. (Staff E, F, G, and Including Country Care Country Care Country Care Country Care Country Care Care Care Care Care Care Care Care	e is not met as evidenced by: rand employee record review, ensure the Human Resources ad employment reference ted a new Agency for Heath III background screening 1435 that must be conducted on each of the following onsidered employees for the onsidered employees for the pring screening under Chapter employee records reviewed II);Whose responsibilities may o, provide personal care or				
!	The findings include	1				
	on at 11 at revealed the following	AM employee record reviews ing documentation:				
	date- background screenii date as 2) Staff F, a Cer date- and background screenii date as 3) Staff G, a Reg an A	ensed Practical Nurse, hire dd an AHCA Level II ing eligibility determination ruffied Nurse Assistant, hire d an AHCA Level II ing eligibility determination ingistered Nurse, hire date- AHCA Level II				
		na eliability determination	. 1			1

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From:FLORDA AGENCY HEALTH 5614966928 ... / / 18:62

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Agency for Health Care Adn	ninistration		<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
REHABILITATION CENTER A	T HOLLYWOOD H: 1200 N 35			
	HOLLIWI	OOD, FL 33	PROVIDER'S PLAN OF CORRECTION	ON : (X5)
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NZ815 Continued From p	age 40	NZ815		
	nd an AHCA Level II ning eligibility determination			
review revealed St applications each employers whom t dates of their AHC	1:15 AM employee record aff E, F, G, and H's job documented a list of previous hey worked for between the A Level II background eir hiring date the facility.			
Reference Checks and effective as of obtain additional at that helps determin employability, ensu- current people, pro- organization." Full on Reference Che- immediately, refer- conducted on ever- Reference Check (Copies of policy of	oplicant-related information to the spill-can'ts overall tring the protection of the perfy, and information of the her review of the facility's policy cks indicates "Effective since checks are to be y job applicant and the emplate must be utilized," btained).		The RCHH policy was reviewed v	aith the
Staff E, F, G and H documentation that reference checks of places employment Director of Human 11:30 AM she conf	t indicates verification of conducted on their former it. In an interview with the		The ROLL POLICE WAS REVIEWED A two HR Managers. All employees had a reference check and are on file.	have
conducted with the of Human Resource error of failing to no reference checks a Level II backgroun	:45 AM, an interview was Administrator and the Director e. They acknowledged the ot follow their policy on job and not initiating a new AHCA d screening for employees who			i
AHCA FO	orge Centallo	10	s4xa11 M — 3	If continuation stees 41 of 42

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		100611	8. WING	·	02/	18/2016
ME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		10,00,10
EHABI	LITATION CENTER AT		35TH AVE NOOD, FL 330.	24		
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ELIZABETH DUDEK SECRETARY

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

## RE: Recertification & Relicensure Surveys

Dear Administrator:

On , 2016 through , 2016, Recertification and Relicensure 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 not 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 , 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 Phone: (561) 381-5840; Fax: (561) 496-5924 AHCA.MyFlorida.com



Facebook.com/ACHAFlorida ......AHCAFlorida Twitter.com/AHCA\_FL SlideShare.pet/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 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 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 §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. Rehabilitation Center At Hollywood Hills, Llc

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 <a href="http://lahca.myflorida.com/Publications/Forms.shtml">http://lahca.myflorida.com/Publications/Forms.shtml</a> as 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  $(561)\ 381-5840$ .

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD Enclosure

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