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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105481	A. BUILDING **01 - MAIN FED** B. WING _____	**11/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	**375 NW 51ST STREET BOCA RATON, FL 33431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted November 15 -16, 2016 at Manor Care Health Services, a nursing home in Boca Raton, Florida. Manor Care Health Services is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 edition) requirements for nursing homes. Initial Plan Review: 1984 /1989 Existing NFPA 220 Construction Type: II (222) Number of beds: 180 Census: 154	K 000		
K 211 SS=F	The following is description of the noncompliance. NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the building exit egress. This deficient practice affected all occupants in these areas. Findings include: On November 16, 2016 during the observation tour accompanied by the Maintenance Director	K 211	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. K 211 (a)What corrective action(s) will be accomplished for those residents found to	12/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/07/2016

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K 211	Continued From page 1 the following exit corridor and egress violations were noted: (1) From 8 a.m. until 11 a.m., in the Williamsburg 1st floor corridor, a linen cart was stored blocking the means of egress from being continuously maintained free of all obstructions to full use in case of emergency. (2) From 8 a.m. until 11 a.m., in the Thalia unit 1st floor, a 64 gallon trash container on wheels was stored blocking the means of egress from being continuously maintained free of all obstructions to full use in case of emergency. (3) At 10 a.m., the patio exit egress to the exterior parking lot was blocked by a vehicle blocking the means of egress from being continuously maintained free of all obstructions to full use in case of emergency. Based on interview with the Maintenance Director at these same times, he acknowledged that the exit egress access failed to meet code requirements for an unobstructed egress. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on November 16, 2016. Actual NFPA Standards: NFPA 101 LSC (2012) 19.7., ch. 7.	K 211	have been affected by the deficient practice: (1) The linen cart located in the Williamsburg 1st floor corridor was moved from the means of egress. (2) The 64gallon trash container on wheels located on Thalia unit 1st floor was moved from the means of egress. (3) The vehicle blocking the patio exit egress was moved and yellow strips were painted on the asphalt to indicate no parking is allowed. (b)How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Audits have been completed by the Maintenance Director or designee to ensure that there are no other concerns related to blocking the egress. (c)The measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Reeducation has been provided by the Maintenance Director or designee to staff regarding the need to ensure the egress is kept clear and unobstructed within the facility. Reeducation has been provided to the Maintenance Director by the Administrator or designee to ensure that vehicles do not block the means of egress & is free of	

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K 211	Continued From page 2	K 211	all obstructions . (d)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: Random Observation Audits will be conducted by the Director of Maintenance or designee weekly times 4 weeks then monthly times 2. The audits will be presented to the Quality Assurance & Improvement Committee monthly until compliance is achieved and maintained.	
K 362 SS=F	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7	K 362		12/17/16

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K 362	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects 11 of 13 smoke compartments, all staff, visitors and all residents. Findings include: During a tour of the facility on November 16, 2016, accompanied by the Maintenance Director it was noted that there were improper and/or unsealed fire/smoke-stop penetrations observed. Examples include but are not limited to the following: (1) At 8 a.m., in at least 3 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor Williamsburg corridor fire/smoke walls. (2) At 8:15 a.m., in at least 4 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor by room 120 Williamsburg corridor fire/smoke walls. (3) At 8:35 a.m., in at least 2 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor by room A wing corridor fire/smoke walls. (4) At 9 a.m., in at least 3 areas where piping through the fire/smoke, wall fire-stop material occurred in the 1st floor by room A wing corridor elevator room fire/smoke walls. (5) At 10 a.m., in at least 6 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor electrical room Thalia	K 362	K 362 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. (a)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The improper fire stopping voids were repaired in the following areas: 1. 3 areas 1st floor Williamsburg corridor fire/ smoke walls. 2. 4 areas 1st floor by room 120 Williamsburg corridor fire/smoke walls. 3. 2 areas 1st floor by room A wing corridor fire/smoke walls. 4. 3 areas 1st floor by A wing corridor elevator room fire/ smoke walls. 5. 6 areas 1st floor electrical room Thalia wind corridor fire/smoke walls. 6. 3 areas 2nd floor Edison North West stairwell corridor fire/smoke walls. 7.3 areas 2nd floor Edison North West stairwell corridor fire/smoke walls. (b)How you will identify other residents having potential to be affected by the	

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K 362	Continued From page 4 wing corridor fire/smoke walls. (6) At 11 a.m., in at least 3 areas where piping through the fire/smoke wall, fire-stop material occurred in the 2nd floor Edison Nursing station stairwell corridor fire/smoke walls. (7) At 11 a.m., in at least 3 areas where piping through the fire/smoke wall, fire-stop material occurred in the 2nd floor Edison North West stairwell corridor fire/smoke walls. Improper fire stopping voids a fire barrier rating and is considered a zero hour rating. An interview with the Maintenance Director at the time of observation(s) revealed he could not produce any type of documentation showing the fire stopping was installed per the manufactures specifications for the fire walls. No additional written documentation to support the fire rated protection by fire-stopping of the fire-stop penetrations was provided at the time of exit. The findings were acknowledged and verified by the Maintenance Director at the time of observation and at the exit conference with the Administrator and Maintenance Director on November 16, 2016. Actual NFPA Standards: NFPA 101 LSC (2012) 19.7., 8.3.5.1.	K 362	same deficient practice and what corrective action will be taken: Audits have been completed by the Maintenance Director or designee to ensure that there are no other concerns related to improper fire stop voids. Identified areas with improper fire stop voids will be repaired. (c)The measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Reeducation by the Administrator or designee has been provided to the Maintenance Director & Assistant to ensure that voids will not occur when fire walls are penetrated. (d)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: (e)Scheduled preventative maintenance audit will be conducted monthly times 4 months. The audits will be presented to the Quality Assurance & Improvement Committee monthly until compliance is achieved and maintained.	

Agency for Health Care Administration

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	95021	A. BUILDING: **03 - MAIN LIC** B. WING _____	**11/16/2016**

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K 000	Initial Comments An unannounced Fire & Life Safety re-licensure survey was conducted on November 15-16, 2016 at Manor Care Health Services, state license: #1313096 a nursing home in Boca Raton, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012 edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes. (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2012 edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101 , Chapter 2. The following is a description of the deficiencies, found at the time of the visit.	K 000		
K 072 SS=F	NFPA 101- LSC 2012 EGRESS RELIABILITY The means of egress including every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7 unless otherwise modified by 18.2.2 through 18.2.11 & 19.2.2 through 19.2.11. The means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency, and shall be accessible to the extent necessary to ensure reasonable safety for occupants having impaired mobility. NFPA 101 Life Safety Code (2012) 18.2.1, 19.2.1, 7.1.10.1 & 4.5.3.2 NOTE: SEE NEW PROVISIONS DESCRIBED IN K-39 which are applicable to licensure only. The	K 072		12/17/16

AHCA Form 3020-0001			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
Electronically Signed			12/07/16

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K 072	Continued From page 1 CMS requirement is more stringent unless the Facility has completed the requirements for the Categorical Waivers in accordance with S&C 13-58 and 12-21.***	K 072		
	This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the building exit egress. This deficient practice affected all occupants in these areas. Findings include: On November 16, 2016 during the observation tour accompanied by the Maintenance Director the following exit corridor and egress violations were noted: (1) From 8 a.m. until 11 a.m., in the Williamsburg 1st floor corridor, a linen cart was stored blocking the means of egress from being continuously maintained free of all obstructions to full use in case of emergency. (2) From 8 a.m. until 11 a.m., in the Thalia unit 1st floor, a 64 gallon trash container on wheels was stored blocking the means of egress from being continuously maintained free of all obstructions to full use in case of emergency. (3) At 10 a.m., the patio exit egress to the exterior parking lot was blocked by vehicle blocking the means of egress from being continuously maintained free of all obstructions to full use in case of emergency.		The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. (a)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: (1) The linen cart located in the Williamsburg 1st floor corridor was moved from the means of egress. (2) The 64 gallon trash container on wheels located on Thalia unit 1st floor was moved from the means of egress. (3)The vehicle blocking the patio exit egress was moved and yellow strips were painted on the asphalt to indicate no parking is allowed. (b)How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Audits have been completed by the Maintenance Director or designee to	

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K 072	Continued From page 2 Based on interview with the Maintenance Director at these same times he acknowledged that the exit egress access failed to meet code requirements for an unobstructed egress. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the times of observation and at the exit conference on November 16, 2016. Class III Actual NFPA Standards: NFPA 101 LSC (2012) 19.7., ch. 7.	K 072	ensure that there are no other concerns related to blocking the egress. (c)The measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Reeducation has been provided by the Maintenance Director or designee to staff regarding the need to ensure the egress is kept clear and unobstructed within the facility. Reeducation has been provided to the Maintenance Director by the Administrator or designee to ensure that vehicles do not block the means of egress & is free of all obstructions . (d)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: Random Observation Audits will be conducted by the Director of Maintenance or designee weekly times 4 weeks then monthly times 2. The audits will be presented to the Quality Assurance & Improvement Committee monthly until compliance is achieved and maintained.	
K 317 SS=F	NFPA101-2012LSC,FAC 58A-2.025,F.B.C-2011 REPAIR, RENO, MOD, CHNG OF USE OR OCC, & ADD (1) When construction is contemplated for new	K 317		12/17/16

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K 317	Continued From page 3 buildings or for additions, conversions, renovations, or alterations to existing buildings, the plans and specifications for the contemplated construction shall be prepared by Florida-registered architects and engineers. (2) All contemplated additions, conversions, renovations, or alterations shall be submitted for approval or exemption from the plans review process. Rehabilitation work on existing buildings shall be classified as one of the following work categories in accordance with 43.2.2.1: (1) Repair (2) Renovation (3) Modification (4) Reconstruction (5) Change of use or occupancy classification (6) Addition Rehabilitation work on existing buildings shall comply with Chapter 43 of NFPA 101, Life Safety Code. NFPA 101 Life Safety Code (2012) 4.6.7.1 & 4.6.7.2, Florida Administrative Code 58A-2.025 & Florida Building Code 2010 edition. ***NOTE ADD LANGUAGE FOR ICRA & ILSM* This Statute or Rule is not met as evidenced by: Based on observation, written document review, blue-print review and staff interview, the facility failed to notify the Agency of changes to the building made from the original approved plans. The work identified, was not approved or reviewed by the Agency. Findings include: During observations and record review on	K 317	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. K317 (a)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

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K 317	Continued From page 4 November 16, 2016 at 1 p.m. the facility was not able to produce any documentation to substantiate that plans were approved by the Agency for Health Care Administration (AHCA) Office of Plans and Construction (OPC) for work done at the facility, which include: (1) The facility has removed the two bathrooms in the 1st floor employee lounge and created locker rooms without doors. (2) The 1st floor physical therapy room storage room door was removed and converted to an office. (3) Resident rooms 163, 213 and 216 bathroom doors were removed and cubicle curtains were installed. The facility is required to obtain approval and requires revised construction documents or shop drawings, which shall be prepared and submitted for review and approved to illustrate corrections or modifications necessitated by field conditions or other provisions to approved plans. Based on interview with the Maintenance Director at this same time he was unable to produce any written documentation to substantiate the installations had been approved, or that plans were approved for the installation of these changes. No additional paperwork was provided at the time of exit from the facility. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on November 16, 2016. Class III	K 317	practice: (1) The two bathroom doors in the 1st floor employee lounge were rehung. (2)The first floor physical therapy room storage room door was re hung. (3)Resident room 163, 213,& 216 bathroom doors were rehung and curtains were removed. (b)How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Audits have been completed by the Maintenance Director or designee to ensure there were no other areas affected. Identified areas will be made compliant. (c)The measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Education has been provided by the Administrator or designee to the Maintenance Director & Assistant to ensure modifications to the existing building go through the approval or exemption from the plans review process. (d)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:	

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K 317	Continued From page 5 Actual NFPA Standards: NFPA 101 Life Safety Code (2012) 4.6.7.1 & 4.6.7.2, Florida Administrative Code 58 A-2.025 & Florida Building Code 2010 edition.	K 317	When construction is contemplated for alterations to the existing building structure the Administrator will ensure the proper process occurs and plans are submitted to the Office of Plans and Construction. Changes will be presented to the Quality Assurance & Improvement Committee monthly until compliance is achieved and maintained.	
K 318 SS=F	NFPA 101- 2012 LSC FIRESTOP SYSTEMS AND DEVICES Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. NFPA 101 Life Safety Code (2012) 8.3.5.1. This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the building fire wall separations. This deficient practice affects 11 of	K 318	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	12/17/16

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MANORCARE HEALTH SERVICES	**375 NW 51ST STREET** **BOCA RATON, FL 33431**

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K 318	Continued From page 6 13 smoke compartments, all staff, visitors and all residents. Findings include: During a tour of the facility on November 16, 2016 accompanied by the Maintenance Director it was noted that there were improper and/or unsealed fire/smoke-stop penetrations observed. Examples include but are not limited to the following: (1) At 8 a.m., in at least 3 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor Williamsburg corridor fire/smoke walls. (2) At 8:15 a.m., in at least 4 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor (by room 120) Williamsburg corridor fire/smoke walls. (3) At 8:35 a.m., in at least 2 areas where piping through the fire/smoke, wall fire-stop material occurred in the 1st floor by room A wing corridor fire/smoke walls. (4) At 9 a.m., in at least 3 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor by room A wing corridor elevator room fire/smoke walls. (5) At 10 a.m., in at least 6 areas where piping through the fire/smoke wall, fire-stop material occurred in the 1st floor electrical room Thalia wing corridor fire/smoke walls. (6) At 11 a.m., in at least 3 areas where piping through the fire/smoke wall, fire-stop material occurred in the 2nd floor Edison Nursing station	K 318	alleged deficiencies herein. K 318 (a)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The improper fire stopping voids were repaired in the following areas: 1.3 areas 1st floor Williamsburg corridor fire/ smoke walls. 2.4 areas 1st floor by room 120 Williamsburg corridor fire/smoke walls. 3.2 areas 1st floor by room A wing corridor fire/smoke walls. 4.3 areas 1st floor by A wing corridor elevator room fire/ smoke walls. 5.6 areas 1st floor electrical room Thalia wind corridor fire/smoke walls. 6.3 areas 2nd floor Edison North West stairwell corridor fire/smoke walls. 7.3 areas 2nd floor Edison North West stairwell corridor fire/smoke walls. (b)How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Audits have been completed by the Maintenance Director or designee to	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95021	A. BUILDING: **03 - MAIN LIC** B. WING	**11/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	**375 NW 51ST STREET** **BOCA RATON, FL 33431**

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K 318	Continued From page 7 stairwell corridor fire/smoke walls. (7) At 11 a.m., in at least 3 areas where piping through the fire/smoke, wall fire-stop material occurred in the 2nd floor Edison North West stairwell corridor fire/smoke walls. Improper fire stopping voids a fire barrier rating and is considered a zero hour rating. An interview with the Maintenance Director at the time of observation(s) revealed he could not produce any type of documentation showing the fire stopping was installed per the manufactures specifications for the fire walls. No additional written documentation to support the fire rated protection by fire-stopping of the fire-stop penetrations was provided at the time of exit. The findings were acknowledged and verified by the Maintenance Director at the time of observation and at the exit conference with the Administrator and Maintenance Director on November 16, 2016. Class III Actual NFPA Standards: NFPA 101 LSC (2012) 19.7., 8.3.5.1.	K 318	ensure that there are no other concerns related to improper fire stop voids. (c)The measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Reeducation by the Administrator or designee has been provided to the Maintenance Director & Assistant to ensure that voids will not occur when fire walls are penetrated. (d)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: Scheduled preventative maintenance audit will be conducted monthly times 4 months. The audits will be presented to the Quality Assurance & Improvement Committee monthly until compliance is achieved and maintained.	

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 30, 2016

Administrator
Manorcare Health Services
375 NW 51st Street
Boca Raton, FL 33431

Dear Administrator:

On November 14, 2016 - November 17, 2016, Recertification, Licensure and Life Safety Code surveys were conducted in your facility by representatives from 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.

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 December 17, 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
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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 **February 17, 2017** if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 17, 2017** if substantial compliance is not achieved by that time.

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

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

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

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

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

and valued, as our goal is to ensure the professional and consistent application of the survey process.

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

Sincerely,
Monica Thurman-Smith for
Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

R6WB