PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAR OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING 01 - MAIN FED 105067 R MING 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2839 S SEACREST BLVD BOULEVARD REHABILITATION CENTER BOYNTON BEACH, FL 33435 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TEACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 An unannounced Fire & Life Safety re-certification survey was conducted 09/18-19/2017 at Boulevard Rehabilitation Center, a nursing home in Boynton Beach, Florida. Boulevard Rehabilitation Center, is not in substantial compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012) requirements for nursing homes. Deficiencies were found at the time of the visit. Initial Plan Review: 1963/1999 Existina NFPA 220 Construction Type: II (000) Number of beds: 167 Census: 149 The following is description of the deficiencies. found at the time of the visit. K 211 NFPA 101 Means of Egress - General K 211 10/19/17 SS=F 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 Corrective Action: facility failed to maintain the building exit egress. We purchased "NO EXIT" signage and This deficient practice affects all smoke installed them on doors 1, 2 and 3. We compartments, staff, visitors and all residents. have reinstalled the previous mag locks

LAROPATORY DIRECTOR'S OR PROVIDERISHED HER REPRESENTATIVE'S SIGNATURE

DATE (MX)

on the new fence to allow for proper

TITLE

Electronically Signed 09/29/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other asfeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossable 90 days, to following the date of survey whether or not a plan or correction is provided. For nursing homes, the above findings and plans or correction are disclossable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/02/2017 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED		(X3) DATE SURVEY COMPLETED		
		105067	B. WING			09	/19/2017
	ROVIDER OR SUPPLIER	ENTER	,	2	TREET ADDRESS, CITY, STATE, ZIP CODE 839 S SEACREST BLVD BOYNTON BEACH, FL 33435	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K211	exit doors were not sistate NO EXIT so as emergency. These distances of mistaken for an exit. Examples include: 1. At 9 A.M. the accelexterior door facing E 2. At 10 A.M. the Priv. Courtyard. On 09/19/17 during it doors which have the were not signed as re 3. At 9 A.M. smoking 3 doors to interior egg 2/4/7. 4. At 11 A.M. East co can trap residents an emergency. Based on interview at Maintenance Director required signage was code for areas that dor yards, courts, ope of the exit discharge, width and size to prov safe access to a publication.	is the facility tour the have the appearance of gned as required by code to to not cause confusion in an oors are likely to be assected to not cause confusion in an oors are likely to be assected to not cause confusion in an oors are likely to be assected to the facility tour the following appearance of exit doors quired by code. area exterior courtyard has eas, only 1 is accessible urtyard gate is locked and did staff in courtyard in an an acknowledged that the not posted as required by not allow safe exit egress in spaces, or other portions that shall be of the required ride all occupants with a coway.	K	211	egress. Identification of others potentially affec All of the doors were audited for proper signage throughout the facility. Systems to ensure compliance: The Maintenance Staff was in-serviced on ensuring that the prope signage is on all doors and that exit danl patios have the proper egress mechanism. The Maintenance staff w conduct weekly reviews of the doors tensure that the signage is in place and egress is working propletly. How the system will be monitored: The copies of the audits will be reviewed at the monthly QA meeting b the QA team to include the Administra for 90 days.	r pors iill p d all	

Director at the time of observation and at the exit

		D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 10/02/2017 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION 01 - MAIN FED	(X3) DATE	
		105067	B. WING		09/	19/2017
NAME OF P	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
BOULEVA	RD REHABILITATION CE	ENTER	1	2839 S SEACREST BLVD BOYNTON BEACH, FL 33435		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 211	conference on 09/19/ Actual NEPA Standar	2017. ds:	K 21			
K 324 SS=F	7.10.8.3.2.7.7.1.1 NFPA 101 Cooking Facilities Cooking Facilities Cooking Guipiment is with NFPA 96, Stands and Fire Protection of Operations, unless: residential cooking appliances such as re toasters) are used for cooking in accordanc cooking facilities or cooking facilities in or cooking facilities in or cooking facilities in or cooking facilities in for cooking facilities in for cooking facilities in for per 9.2.3 are not requ hazardous areas, but corridor.	protected in accordance ord for Ventilation Control Commercial Cooking equipment (i.e., small icrowaves, hot plates, food warming or limited with 18.3.2.5.2, 19.3.2.5.2 an to the corridor in smoke or fewer patients comply der 18.3.2.5.3, 19.3.2.5.3, smoke compartments with omply with conditions under elected according to NFPA 96 irred to be encloseed as shall not be open to the .3.2.5.4, 19.3.2.5.1 through	K 324			10/19/17

This STANDARD is not met as evidenced by: Based on observation, written document review

and staff interview, the facility failed to maintain

the building kitchen cooking suppression system

Corrective Action:

We contacted the vendor to adjust the

chemical protection nozzles and they fixed

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAR OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING 01 - MAIN FED 105067 R MING 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2839 S SEACREST BLVD BOULEVARD REHABILITATION CENTER BOYNTON BEACH, FL 33435 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TEACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY K 324 | Continued From page 3 K 324 suppression nozzles for protection of the cooking them on 9/22/17. appliances. This deficient practice can affect all Identification of other potentially affected: smoke compartments, all staff, visitors and all residents. The Kitchen Manager and Maintenance Director will ensure that all Findings include: other protection systems in the kitchen are working properly and in the proper On 09/19/2017 at 9:15 A.M. accompanied by the place. Maintenance Director when touring the kitchen area the following issues were noted with the Systems to ensure compliance: cooking appliance protection. Wet chemical The Kitchen Manager or designee will protection system nozzles are not aligned to inspect the chemical protection nozzles to protect the appliances in the event of discharge ensure that they are directly over the stove.

for a fire. During interview with the Maintenance Director at these same times he acknowledged the discharge nozzles were improperly aligned. No additional paperwork was provided to substantiate compliance at the time of exit.

The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and record review additionally, at the exit conference on 09/19/17.

Actual NEPA Standards:

NFPA LSC 101 (2012) 9.2.3; 19.3.2.5, NFPA 96. K 345 NFPA 101 Fire Alarm System - Testing and SS=F Maintenance

> Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code, Records of system acceptance, maintenance and testing are readily

10/19/17

How the system will be monitored:

by the QA team at the monthly QA meeting for 90 days for compliance.

A copy of the rounds will be reviewed

PRINTED: 10/02/2017

K 345

PRINTED: 10/02/2017

		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVED O. 0938-0391
			0.000 5.00 0.000	V V CALLERY COURT		E SURVEY
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN FED		PLETED
		105067	B. WING		01	9/19/2017
NAME OF P	ROVIDER OR SUPPLIER	'		STREET ADDRESS, CITY, STATE, ZIP CODE		
				2839 S SEACREST BLVD		
BOULEVA	RD REHABILITATION C	ENTER		BOYNTON BEACH, FL 33435		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 345	K 345 Continued From page 4 available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation, written document review, and staff interview, the facility failed to maintain the building fire alarm system to code requirements. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include: On 09/18/2017 at 11:15 A.M. during the review of the facility documentation it was determined the facility was unable to substantiate and did not maintain the required fire alarm system functional		КЭ	Corrective Action: Our fire alarm contractor was complete the testing of the maglo include the 9 doors that were not Identification: The Maintenance Director or designee to review all fire safety the ensure that the vendors are send complete report. System to ensure compliance: The Maintenance Director or designee will audit all reports record	eks to tested. eports to ing a	
	interface equipment arrangements- delay tested or certified as	ed egress locks) being functional. Based on the		life safety inspections for complet monthly and report the results to meeting monthly.	he QA	
	are 25 devices connu arrangements of thos as passing, the other or functional. The M acknowledged that it to properly test and of annual inspection test electromechanical re- be tested annually.	ne fire alarm company failed locument the required		How the system will be monitored. The Maintenance Director or designee will audit all reports reculife safety inspections for complet monthly and report the results to meeting monthly for 90 days.	eived for eness	

not produce any additional documentation at the exit conference to substantiate compliance.

Facility ID: 95004

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAR OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN FED 105067 R MING 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2839 S SEACREST BLVD BOULEVARD REHABILITATION CENTER BOYNTON BEACH, FL 33435 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TEACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 345 | Continued From page 5 K 345 The findings were acknowledged by the Administrator and verified by the Maintenance Director at the times of written document review and at the exit conference on 09/19/2017. Actual NEPA Standards: NFPA LSC 101 (2012) 19.3.4 & 9.6. NFPA 72 (2010) 4.5.2.3 and 10.4.4.21 and 69 A-48.005 requires documentation. K 363 NFPA 101 Corridor - Doors K 363 10/19/17 SS=F Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes, Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors

meeting 19.3.6.3.6 are permitted.

Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In

PRINTED: 10/02/2017

		D HUMAN SERVICES MEDICAID SERVICES				APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED			
		105067	B. WING		09/	19/2017
NAME OF PRO	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
			2	839 S SEACREST BLVD		
BOULEVAR	RD REHABILITATION CE	INTER	6	BOYNTON BEACH, FL 33435		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	frames in window ass 19.3.6.3, 42 CFR Par and 485 Show in REMARKS of protection ratings, aut etc. This STANDARD is I Based on testing, obte facility failed to motor opening assemt affects all smoke com and all residents. Findings include: On 09/19/2017 accon Director when touried following control of the door frame. Door requirement of provid keep the door closed. (1) At 8:15 A.M. the doors. (3) At 8:45 A.M. the room doors. (4) At 10 A.M. the Schools. (5) At 10.15 A.M. the Schools. (6) At 10.15 A.M. the Schools. (7) At 10.15 A.M. the follows.	ents there are no fire resistance of glass or embiles. Its 403, 418, 460, 482, 483, tetalls of doors such as fire omnatics closing devices, tot met as evidenced by: servation and staff interview aintain the building corridor lies. This deficient practice partments, staff, visitors The panied by the Maintenance the facility, when tested the residence of the code ing a means suitable to staff break room corridor kitchen to dining rooms kitchen to dining rooms kitchen the chemical storage buth wing janitor closet	K 363	Corrective Action: 1. Staff break room door was adjus close. 2. The kitchen door leading into the dining room was adjusted to close. 3. The kitchen chemical storage ro door was adjusted to close. 4. The south wing janitor closet do was adjusted to close. 5. The south wing corridor doors be nursing station were adjusted to close. 7. The east wing corridor door was adjusted to close. 7. The east wing unit storage room corridor door was adjusted to close. Identification of others: All doors will be tested monthly Maintenance Director or designee to ensure that they close properly. System to ensure compliance: The Maintenance Director or designee will conduct a random audi 50% of the doors monthly to ensure they close property.	oom or y the e. by the	

(7) At 11:15 A.M. the East wing corridor

(8) At 11:30 A.M. the East linen corridor doors.

How the system will be monitored:

The Maintenance Director or

designee will present the audit to the QA

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED STAT

CENTERS FOR MEDICARE &	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED	(X3) DATE SURVEY COMPLETED

B. WING 105067 09/19/2017

NAME OF B	POVIDED OD GUDGUED		1 6	TERRY ADDRESS OUT CTATE TID CODE	03/13/2011
NAME OF PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE	
BOIL EVA	RD REHABILITATION CENTER		2839 S SEACREST BLVD		
BOOLEVA	RO REMADIEMATION CENTER		B	SOYNTON BEACH, FL 33435	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
К 363	Continued From page 7 (9) At 11:45 A.M. the East unit storage room corridor door. An interview was conducted at this time with the Maintenance Director who acknowledged and witnessed that the corridor doors did not meet the code requirement of providing a means suitable to keep the door closed. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit conference on 09/19/2107. Actual NFPA Standards: NFPA LSC 101 (2012) 19.3.6.3.3, 19-3.6.3.5	к	363	team at the monthly QA meeting for 90 days.	

FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 04 - MAIN LIC 95004 B. WING_ 09/19/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
BOULEVARD REHABILITATION CENTER		2839 S SEACREST BLVD					
BOOLEVA	AND REMADILITATION CENTER	BOYNTON BEACH, FL 3	13435				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licenss survey was conducted on 09/18-19/2017 at Boulevard Rehabilitation Center, State licens 1058096, a nursing home in Boynton Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (20 and applicable requirements of Florida State Marshal's Rules and Regulations, Florida Administrative Code (F.A.C.) 69 A-3, F.A.C. 6. 4-53, F.A.C. 59 A-4, and Florida Statute 6F, 400 Part II, and F.S. 633.0215, adopting Nati Fire Protection Association (NFPA) 1 and 101 (2012) known as the Florida Fire Prevention Code and all NFPA referenced standards an requirements adopted per NFPA 101, Chapte The following is description of the deficiencie found at the time of the visit.	e: 112) Fire 9 SS.) onal 1					
K 211 SS=F	Means of Egress - General Aisles, passageways, corridors, exit discharge exit locations, and accesses are in accordant with Chapter 7, and the means of egress is continuously maintained free of all obstruction full use in case of emergency, unless modifie 18/19.2.2 through 18/19.2.11. This Statute or Rule is not met as evidenced Based on observation and staff interview the facility failed to maintain the building exit error This deficient practice affects all smoke compartments, staff, visitors and all residents Findings include:	ns to d by by:	Corrective Action: We purchased "NO EXIT" signage and installed them on doors 1, 2 and 3. We have reinstalled the previous mag locks on the new fence to allow for proper egress.	10/19/17			
	On 09/18/2017 during the facility tour the		Identification of others potentially affected:				
AHCA Form 3	020-0001						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 09/29/17 STATE FORM 6890 CQLT21 If continuation sheet 1 of 8

Agency fo	or Health Care Adminis	tration				: 10/02/2017 APPROVEE
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: 0	CONSTRUCTION D4 - MAIN LIC	(X3) DATE S COMPLI	
		95004	B. WING		09/1	9/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	NTE, ZIP CODE		
BOULEVA	ARD REHABILITATION CE	NTER	ACREST BLVE			
			BEACH, FL 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
K 211	Continued From page	1	K 211			
	exit doors were not sistate NO EXIT so as semergency. These dimistaken for an exit. Examples include: 1. At 9 A.M. the accelexterior door facing E 2. At 10 A.M. the Priv courlyard. On 09/19/17 during it doors which have the were not signed as re 3. At 9 A.M. smoking 3 doors to interior egr 24/7. 4. At 11 A.M. East coucan trap residents an emergency. Based on interview at Maintenance Director required signage was code for areas that do reyards, courts, ope courts, o	ast, aste dining room to exterior ast, atte dining room to exterior as facility tour the following appearance of exit doors quired by code, area exterior courtyard has ess, only 1 is accessible rityard gate is locked and d staff in courtyard in an these same times, the acknowledged that the not posted as required by not allow safe exit egress a spaces, or other portions		All of the doors were audited for proper signage throughout the facility. Systems to ensure compliance: The Maintenance Staff was in-serviced on ensuring that the prope signage is on all doors and that exit d and patios have the proper egress mechanism. The Maintenance staff w conduct weekly reviews of the doors t ensure that the signage is in place an egress is working proplerly. How the system will be monitored: The copies of the audits will be reviewed at the monithly QA meeting the QA team to include the Administrator 90 days.	er poors vill o d all	
		hat shall be of the required ride all occupants with a				

Class III

The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of observation and at the exit

conference on 09/19/2017.

STATE FORM CQLT21 If continuation sheet 2 of 8

09/19/2017

Agency for Health Care Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: 04 - MAIN LIC B. WING ___

95004

	30004				03/13/2017		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
BOULEVA	RD REHABILITATION CENTER	2839 S SEACREST BLVD					
		BOYNTON BE	ACH, FL 33	1435			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FL 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) COMPLETE DATE		
K 211	Continued From page 2	۱ ۱	C 211				
	Actual NFPA Standards:						
	NFPA LSC 101 (2012) 7.10.8.3.1 NO EXIT. 7.10.8.3.2 -7.7.1.1						
K 324 SS=F	NFPA 101 Cooking Facilities	k	C 324		10/19/17		
	Cooking Facilities Cooking equipment is protected in accordan with NFPA 96, Standard for Ventilation Contr and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limite cooking in accordance with 18.3.2.5.2, 19.3. *cooking facilities open to the corridor in sm compartments with 30 or fewer patients com with the conditions under 18.3.2.5.3, 19.3.2.5 or *cooking facilities in smoke compartments with 30 or fewer patients com yith the conditions under 18.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.4, 19.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.5, 9.2.3, TIA 12-2 This Statute or Rule is not met as evidenced Based on observation, written document revial staff interview, the facility failed to maint the building kitchen cooking suppression sysuppression nozzles for protection of the cocappliances. This deficient practice can affect	d 2.5.2 2.5.2 coke ply 5.3.3, ifith under 2A 96 e e cough d by: ever weight teem kiking teed		Corrective Action: We contacted the vendor to adjust the chemical protection nozzles and they fixed them on 9/22/17.			
	all smoke compartments, all staff, visitors an residents.	d all		Identification of other potentially affected: The Kitchen Manager and Maintenance Director will ensure that all			
	220 0004		- 1				

AHCA Form 3020-0001

STATE FORM 6920 CQLT21 If continuation sheet 3 of 8

09/19/2017

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 04 - MAIN LIC

NAME OF PROVIDER OR SUPPLIER

B. WING_ STREET ADDRESS, CITY, STATE, ZIP CODE

95004

2839 S SEACREST BLVD

BOULEVA	RD REHABILITATION CENTER	EACREST BLV N BEACH, FL		
(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) COMPLETE DATE
K 324	Continued From page 3	K 324		
	Findings include: On 09/19/2017 at 9:15 A.M. accompanied by the Maintenance Director when touring the kitchen area, following issues were noted with the cooking appliance protection: Vet chemical protection system nozzles are not aligned to protect the appliances in the event of discharge for a fire. During interview with the Maintenance Director at these same times he acknowledged the discharge nozzles were improperly aligned. No additional paperwork was provided to substantiate compliance at the time of exit. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time observation and record review additionally, at the exit conference on 09/19/17. Class III Actual NFPA Standards: NFPA LSC 101 (2012) 9.2.3; 19.3.2.5 , NFPA 96 . NFPA 101 Fire Alarm System - Testing and Maintenance	K 345	other protection systems in the kitchen are working properly and in the proper place. Systems to ensure compliance: The Kitchen Manager or designee will inspect the chemical protection nozzles to ensure that they are directly over the stove. How the system will be monitored: A copy of the rounds will be reviewed by the QA team at the monthly QA meeting for 90 days for compliance.	10/19/17
	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.5, 9.6.7, 9.6.8, and NFPA 70, NFPA 72			

PRINTED: 10/02/2017 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 04 - MAIN LIC B MING 95004 09/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2839 S SEACREST BLVD BOULEVARD REHABILITATION CENTER BOYNTON BEACH, FL 33435 (X43.ID SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD RE COMPLETE PREFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 345 Continued From page 4 K 345 This Statute or Rule is not met as evidenced by: Based on observation, written document review. Corrective Action: and staff interview the facility failed to maintain Our fire alarm contractor was called to the building fire alarm system to code complete the testing of the maglocks to requirements. This deficient practice affects all include the 9 doors that were not tested. smoke compartments, staff, visitors and all residents. Identification: The Maintenance Director or designee Findings include: to review all fire safety reports to ensure that the vendors are sending a complete On 09/18/2017 at 11:15 A.M. during the review of report. the facility documentation it was determined the facility was unable to substantiate and did not System to ensure compliance: maintain the required fire alarm system functional The Maintenance Director or designee documentation as required by code. Paperwork will audit all reports received for life safety reviewed did not correctly indicate number of inspections for completeness monthly and interface equipment (special locking report the results to the QA meeting arrangements- delayed egress locks) being monthly, tested or certified as functional. Based on the documentation provided the form indicated there How the system will be monitored: are 25 devices connected as special locking The Maintenance Director or designee arrangements of those 25 only 16 are indicated will audit all reports received for life safety as passing, the other 9 are not indicated as failing inspections for completeness monthly and or functional. The Maintenance Director report the results to the QA meeting acknowledged that the fire alarm company failed monthly for 90 days.

AHCA Form 3020-0001

Class III

to properly test and document the required annual inspection testing of the electromechanical releasing devices which shall be tested annually. Documentation reviewed did not indicate required information. The facility did not produce any additional documentation at the exit conference to substantiate compliance. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of written document review and at the exit conference on 09/19/2017.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

DENTIFICATION NUMBER:

95004

B. WING

09/19/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2839 S SEACREST BLVD

BOULEVA	BOULEVARD REHABILITATION CENTER BOYNTON BEACH, FL 33435						
(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) COMPLETE DATE			
K 345	Continued From page 5	K 345					
	Actual NFPA Standards:						
	NFPA LSC 101 (2012) 19.3.4 & 9.6. NFPA 72 (2010) 4.5.2.3 and 10.4.4.21 and 69 A-48.005 requires documentation.						
K 363 SS=F	NFPA 101 Corridor - Doors	K 363		10/17/17			
	Corridor - Doors 2012 EXISTING Doors proteeting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations (only for Federal survey citation) only on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Norrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3.42 CFR Parts 403, 418, 460, 482, 483,						

FORM APPROVED Agency for Health Care Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: 04 - MAIN LIC

В

		95004	B. WING		09/19/2017			
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
DOI!!! C1/4	DULEVARD REHABILITATION CENTER 2839 S SEACREST BLVD							
BUULEVA	RD REHABILITATION CE	BOYNTON	BEACH, FL 3	3435				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
K 363	Continued From page	6	K 363					
		etails of doors such as fire omatics closing devices,			TATAL PARTICIPATION OF THE PAR			
	covering is not exceed impediment to the clos devices that release we pulled are permitted. Doors shall be provide positive latching hardwell plates of unlimited hei doors meeting 18.3.6. latches are prohibited	he passage of smoke, ottom of door and floor ding i inch. There is no sing of the doors. Hold open hehe the door is pushed or ad with self-latching and ware. Nonrated protective ght are permitted. Dutch 3.6 are permitted. Roller by CMS regulations (only titon) on corrifor doors and						
	18.3.6.3, 42 CFR Part and 485	s 403, 418, 460, 482, 483,						
	Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.							
This Statute or Rule is not met as evidenced by: Based on testing, observation and staff interview the facility failed to maintain the building corridor door opening assemblies. This deficient practice affects all smoke compartments, staff, visitors and all residents. Findings include:			Corrective Action: 1. Staff break room door was adjuste close. 2. The kitchen door leading into the dining room was adjusted to close. 3. The kitchen chemical storage roor door was adjusted to close.					
	On 09/19/2017 accom Director when touring	panied by the Maintenance the facility, when tested the rs did not close and latch in		The south wing janitor closet door adjusted to close. The south wing corridor doors by the nursing station were adjusted to close.				

AHCA Form 3020-0001

STATE FORM 6920 CQLT21 If continuation sheet 7 of 8

Agonou f	or Woolth Caro Administr	tration				: 10/02/2017 1APPROVEE	
Agency for Health Care Adminis STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		95004	B. WING		09/19/2017		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE			
ROIII EVA	RD REHABILITATION CE	2839 S S	EACREST BLVI				
DOULLY	TETROLETATION OF	BOYNTO	N BEACH, FL	33435			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	LD BE COMPLETE		
K 363	Continued From page 7		K 363	6. The east wing corridor door was adjusted to close. 7. The east wing unit storage room corridor door was adjusted to close. Identification of others: All doors will be tested monthly by the Maintenance Director or designee to ensure that they close properly. System to ensure compliance: The Maintenance Director or designee will conduct a random audit of 50% of the doors monthly to ensure that they close properly. How the system will be monitored: The Maintenance Director or designee will present the audit to the QA team at the monthly QA meeting for 90 days.			
	the door frame. Doors did not meet the code requirement of providing a means suitable to keep the door closed. (1) At 8:15 A.M. the staff break room corridor door. (2) At 8:30 A.M. the kitchen to dining rooms closes. (3) At 8:45 A.M. the kitchen chemical storage room doors. (4) At 10 A.M. the South wing janitor closet doors. (5) At 10:15 A.M. the South wing corridor fire/smoke doors. (6) At 10:30 A.M. the South wing corridor fire/smoke doors by the nursing station. (7) At 11:15 A.M. the East wing corridor fire/smoke doors. (8) At 11:30 A.M. the East linen corridor doors. (9) At 11:45 A.M. the East unit storage room corridor corridor corridor corridor doors.						
	An interview was con- Maintenance Director witnessed that the co- code requirement of p to keep the door close The findings were ack						

Director at the time of observation and at the exit

NFPA LSC 101 (2012) 19.3.6.3.3, 19-3.6.3.5

conference on 09/19/2107.

Class III Actual NFPA Standards:

STATE FORM 6920 CQLT21 If continuation sheet 8 of 8