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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105021	A. BUILDING _____ 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

(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
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on [redacted] to [redacted] at Rehabilitation Center at Hollywood Hills. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	This plan of correction constitutes our written allegation for compliance for the deficiencies cited. Our submission of the Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This plan	
F 241 SS=E	[redacted](a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were treated with dignity with respect for their individuality and preferences for 1 out of 1 sampled residents (Resident #265) as evidenced by failure to include Resident #265 in preferred activities, as assessed upon admission; failure to provide activities of daily living (ADL) to include nail care and shaving for 1 out of 1 residents (Resident #46), reviewed for ADL care; and failure to address residents in a respectful manner on the second floor east wing during dining observation. The findings include: Review of the facility policy titled Quality of Life - Dignity, states, 'Residents shall be assisted in attending the activities of their choice...' Resident #265 was admitted to the facility on	F 241	of corrections submitted to meet requirements established by state and federal laws. 1)Resident #265 was assigned to a sensory stimulation program in a [redacted] group of 5 to 8 residents and in smaller time increments to better meet the residents [redacted] needs. Resident #46 was provided with nail care and was shaved, Staff provided with education on ADL including nail care and shaving (see signing sheet attached). Staff was provided with education on addressing residents with dignity and respect. (see attendance sheet attached).	[redacted]/[redacted]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: for Carballo — TITLE: ADMINISTRATOR — (X6) DATE: 3/18/16

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

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F 241	Continued From page 1 [redacted] with diagnoses to include [redacted] and [redacted], requiring a [redacted] feeding [redacted] for nutrition and hydration. 1. Review of the initial Activity Assessment dated [redacted] completed by an Activity Assistant, documents the current activity interests of Resident #265 include Exercise, Being Outdoors, Watching TV, Movies and Music. The Summary/Program includes, Resident will receive appropriate structured group programming to enhance and/or maintain his or her level of socialization and interaction with others. Resident will be escorted to and from activities as needed. On [redacted] between 11:00 a.m. through 2:00 p.m. multiple observations were made of Resident #265. On each observation, the resident was observed in her [redacted] in bed with her night gown on, facing the overhead TV which was not turned on. The [redacted] were turned off and the window drapes were pulled closed. At 2:30 p.m. the resident was observed in her [redacted], in bed, having [redacted] feedings [redacted] via [redacted], next to the bed. She remained in her nightgown facing the TV which was not turned on and the [redacted] remained off and window drapes closed. Review of the resident's clinical record revealed she receives [redacted] feedings via feeding [redacted] starting at 2 PM and concluding at 6 AM for a total of 16 hours per day. Review of the 1st Floor Activity Calendar revealed the scheduled activities on [redacted], which Resident #265 was assessed as having interest in, to include at 10:45 a.m. Move & Groove Your Body Exercise; at 2:30 p.m. Creative Art; and at 4:00 p.m. a group watching of a TV show.	F 241	2) Audit was conducted of all active residents to insure that the activities that are being provided are adequate with their cognition and functional status in order to improve their quality of life. (Audit form attached) 3) To ensure that all residents are attending the proper activities based on their evaluation, staff were in-service on updated activity calendar and a list of residents with their assigned activities area will be provided weekly to nurse Coordinator. (Staff in-service attached) Staff was provided with education on addressing residents with dignity and respect. (see attendance sheet attached)	[redacted]

Jorge Valdes ADMINISTRATOR 3/18/16

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	10S021	A. BUILDING _____ B. WING _____	02/18/2016

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

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F 241	Continued From page 2	F 241		

Review of the Sensory Stimulation Attendance record received from the Activity Director on [redacted] documents on [redacted] the resident participated in Group activity (no time was documented), however Resident #265 was observed to be in bed as noted during observations, in her nightgown facing the overhead TV which was not turned on. Review of the Activity Participation record documented on [redacted] the resident was watching TV.

On [redacted] at 10:00 a.m. Resident #265 was observed to be up in a wheelchair in street clothes parked between the 2 beds opposite her bed. She was observed to be facing the over [redacted] TV however, the TV was not on. The lights were out and the window curtains were closed.
On [redacted] at 11:19 a.m. Resident #265 was observed sitting in the same spot, with the TV still not on. The lights were out and the window curtains were closed.
On [redacted] at 1:30 p.m. Resident #265 was observed in her [redacted] in the same spot with 2 nurses at her side working on connecting the [redacted] feeding.
On [redacted] at 3:11 p.m. Resident #265 was observed in her [redacted] in the same spot. The TV was on for the resident in the next bed however Resident #265 could not see it from her vantage point. The overhead TV above Resident #265 remained off.

Review of the Sensory Stimulation Attendance record received from the Activity Director on [redacted], documents on [redacted] the resident was in her [redacted] no activity indicated.
Review of the Activity Participation record documented on [redacted] the resident received

4) Daily rounds will be conducted by activities director or designee to ensure attendance and any absenteeism will be communicated immediately to IDT for further intervention.

If any resident doesn't wish to participate on any [redacted] day their assigned activities an activity staff member will provide appropriate activities in [redacted].

In adition, DON, designee, Nurse Supevisor and Administrator or designee will observe during daily rounds, all residents remaining in their [redacted] lengthly periods without receiving stimulation activities. Any findings will be reported to the Activities Director.

[redacted]

3/18/16

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F 241	Continued From page 3 sensory stimulation, listened to music, and was read to. Resident #265 was not observed to have moved from the spot between the 2 beds opposite her bed. On [redacted] at [redacted] a.m. Resident #265 was observed in her [redacted] bed in her nightgown. The lights were out and the window curtains were closed. On 2/17/16 at 11:00 a.m. Resident #265 was observed in her [redacted] bed in her nightgown. The overhead TV was not on. The lights were out and the window curtains were closed. On [redacted] at 12:15 p.m. Resident #265 was observed remaining in bed, in her nightgown with the TV not on. The lights were out and the window curtains were closed. On [redacted] at 2:15 p.m. Resident #265 was observed remaining in bed in her nightgown with the TV not on. The lights were out and the window curtains were closed. Further, observation was made on [redacted] at 2:20 p.m. of the Activities Director walking down the first floor hall recruiting residents to participate in an interactive singing activity on the first floor outside patio. On [redacted] at 3:00 p.m. Resident #265 was observed remaining in bed, in her nightgown with the TV not on. Resident #265 was not included in the singing activity on the outside patio. Review of the Sensory Stimulation Attendance record received from the Activity Director on [redacted] at 3:20 p.m., documents on [redacted] no interaction. Review of the Participation record on [redacted] documents no interaction. Review of the 1st Floor Activity Calendar revealed the days activities on [redacted], which Resident	F 241		

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F 241	Continued From page 4 #265 was assessed as having interest in, to include, 10:45 a.m. Morning Stretch; at 2:30 p.m. Sing-A-Long and at 4:00 p.m. a group watching of a TV show. On [redacted] at 10:00 a.m. Resident #265 was observed in bed in her nightgown. The TV was not on and the lights were off and window curtains closed. On [redacted] at 10:45 a.m. Resident #265 was observed in her [redacted] in a wheelchair next to her bed. The TV was not on, the lights were out and the window curtains drawn. On [redacted] at 1:27 p.m. Resident #265 was observed in her [redacted] in a wheelchair next to her bed. The TV was off and facing the other way; the lights were out and the window curtains drawn. A nurse and an aide were observed in the [redacted] the resident of the door bed [redacted] into her bed. The nurse stated they are getting the resident [redacted] to bed so she can start the [redacted] feeding. Review of the 1st Floor Activity Calendar revealed the days activities on [redacted], which Resident #265 was assessed as having interest in, to include at 10:45 a.m. Sit & Fit Exercise. On [redacted] at 3:20 p.m. an interview was conducted with the Activity Director who stated they have a "Stim" 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 [redacted] are visited in their [redacted] at least 3 times a week and they will turn on the TV for them if they can't get out of the [redacted]. She stated they target people that really need it because they can't participate themselves so they take them to	F 241		

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F 241	Continued From page 5 entertainment, take them outside and do word games with them. She stated residents with [redacted] are not eliminated from group activities. She stated Resident #265 has "something" done every day however, Resident #265 was not observed from [redacted] through [redacted] to be out of her [redacted], participating in any group exercise or music activities that were observed to be attended by other [redacted] residents that did not have [redacted] feeding [redacted] and who did not have the [redacted] feedings commencing at 2 PM in the afternoon. 2) On [redacted] at 11:30 a.m. Resident #46 was observed in his [redacted] bed. His [redacted] on both of his [redacted] were observed to be long with the right [redacted] worse, with long jagged sharp edges and a black unknown [redacted] observed under the nails of his right [redacted] and a thick yellowish spongy [redacted] under the [redacted]. Additionally, the resident looked like he had not been shaven for a few days. The [redacted] on his [redacted] was noted to be very fragile with multiple [redacted] and scratches on both [redacted]. An inquiry was made if he had [redacted] scratched himself with his long [redacted] and he stated his [redacted] 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 [redacted]. Review of the clinical record revealed Resident #46 was initially admitted to the facility on [redacted] with hospital admissions on [redacted] through [redacted]; and [redacted] with a readmission [redacted] to the facility on [redacted]. On [redacted] at 9:51 a.m. the resident's [redacted] on both [redacted] remained long and	F 241		

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F 241	Continued From page 6 jagged with the black [redacted] remaining under the right [redacted] and the thick yellowish spongy [redacted] under the [redacted]. He remained unshaven. On [redacted] at 3:15 p.m. the resident was observed in his [redacted] bed. He stated the last time he had a shave was last Thursday while in the hospital and he is waiting for a [redacted] aide (name of aide) to come tomorrow and he knows that she will shave him and cut his [redacted]. His nails were observed to still be long, jagged with the blackish [redacted] under the right [redacted] and his [redacted] with the thick spongy [redacted] under his nails. The resident stated (name of aide) will help him tomorrow. Review of the Certified Nursing Assistant Tracking Form for [redacted] 2016 and [redacted] 2016 revealed under 'Personal Hygiene' documentation the resident was receiving assistance with ADLs (activities of daily living) to include shaving every shift. Additionally under Nail Care there was no documentation the resident's long [redacted] nails were being addressed. On [redacted] at 11:15 a.m. during an interview with Resident #46, observation was made of his [redacted] which had now been manicured and his [redacted] had been shaven. The resident stated an aide cut his [redacted] and gave him a shave yesterday as he held out his right [redacted] stating 'They look pretty good don't they?' 3) Upon dining observations in the 2E dining [redacted] at 12:38 PM during tray delivery, it was noted that residents were being referred to by the staff as "feeders" and identified according to their room number, not their name.	F 241		

Jyd Caballe ADmin 3/18/16

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F 241	Continued From page 7 For example, Staff J was heard announcing out loud from inside the 2E dining [redacted] Staff K, who was out in the hallway next to the tray cart, "she is [redacted]" as she pointed to a resident. In return, Staff K stated loudly [redacted] 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 [redacted] those who were listening, "who are the other feeders?" On [redacted] at 1:18 PM, Staff K was observed delivering a tray into [redacted] tray. As she exited, she was heard asking loudly, "is 201A is a feeder?, as the Certified Nursing Assistant (CNA) entered the [redacted] her. At 1:22 PM she was heard in the hallway saying, "202B is a feeder". In an interview on [redacted] at 12:52 PM, Staff K stated that a feeder is someone who needs 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 241		
F 250 SS=D	[redacted](g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, [redacted], and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide	F 250	A grievance was done for Resident #118 regarding Dentures, Glasses and Hearing Aid unanswered requests. Resident #118 was seen by mobile [redacted] care on [redacted]. Examination revealed that glasses would not improve resident vision due to [redacted] in both [redacted]. (See attached consult) Resident was seen and evaluated by Dentist on [redacted]. Dentures will be delivered on [redacted]. (See attached Forms)	[redacted]

Jorge Calzado ADHC 3/18/16

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F 250	Continued From page 8 medically-related social services that included [redacted] services, hearing, and vision for 1 (Resident #118) of 1 sampled residents reviewed for social services. The findings included; During an interview conducted with Resident #118's designated health care surrogate (HCS) on [redacted] at 3:31 PM, it was revealed that she has been requesting dentures, glasses, and hearing [redacted], 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 dentures, but that is not what the HCA wanted. Resident #118 has dentures, but they no longer fit due to the residents ongoing [redacted]. The HCS stated that she initially requested a [redacted] evaluation, hearing [redacted], and glasses about 3-4 months ago. During an interview conducted with the Director of Social Services on [redacted] 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 [redacted] contractors. During the Interview, the Director initially, had no recollection of Resident #118's needs for dentures, hearing aid, or glasses. When questioned if the HCS for Resident #118 had spoken to anyone the previous day, she was unaware. The surveyor informed the Director of Social Services that Resident #118's relative spoke to Staff I.	F 250	Resident was seen by Hearing USA on [redacted]. Consult recommended for wax removal. (See Attached) Resident was seen by [redacted] for evaluation of poor hearing. Cerumen dissipation was done. Grievance was resolved to family satisfaction.	[redacted]

Jorge Valdes ADM 3/18/16

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F 250	Continued From page 9 During an interview with Staff I on [redacted] at 02:30, she confirmed that Resident #118's HCS did come to the business office to inquire again about dentures, hearing [redacted] and glasses. Staff I stated she told Resident #118's HCA to see the Social Services Director on Monday because they were in the middle of a survey. During an interview with the Director of Social Services and Director of Nursing on [redacted] at 2:35 (in the Director of Social Services office), it was confirmed that there should have been a grievance filed concerning the issues of glasses, dentures, and hearing [redacted] for Resident #118 . The Director of Social Services located a [redacted] Services Patient Progress Report dated [redacted] that documents"patient presents for [redacted] prophylaxis today. Patient seen in bed...brushed and polished dentures..." The Director of Social Services then showed a "[redacted] Services Dentist Visit List" dated [redacted] that had Resident #118 listed for a consult for "repair current dentures-needs adjustment" and set of denture first impression. When questioned about documentation in the chart and informing the residents HCA, she confirmed that there was none. When questioned about Resident #118's hearing [redacted] and glasses, the Director of Nursing stated they would do a grievance, make a hearing and vision appointment and contact Resident #118's HCA. During an interview with the Director of Social Services on [redacted] at 11:45 AM, she stated that an appointment was made for hearing, but she does not remember the date. She also stated that Resident#118 was already assessed for glasses. Documentation was shown for an [redacted]	F 250	An audit of all active Residents was conducted by Social Service Director to ensure that no other Resident was identified with hearing, vision or [redacted] without proper follow up. To ensure compliance, QA Committee will audit sample charts of residents identified with having vision hearing and [redacted] related concerns. Facility will assess the need for hearing [redacted], [redacted] services, and [redacted] care upon admission, and as needed during ADL's. Staff provided with in-Service related to communicating any [redacted] noted by IDT to Social Services immediately for proper follow-up.	[redacted]

ADMINISTRATOR 3/18/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 10	F 250		

examination dated [redacted] that stated "patient is not a [redacted] for [redacted] surgery. Glasses will not improve vision..." [redacted] questioned why this was not relayed to Resident #118's HCA, the Director of Social Services did not know. Documentation was also shown for orders for a hearing consult dated [redacted], [redacted] consult second opinion dated [redacted], and for a hearing appointment, on [redacted] at 11:00 AM, dated [redacted], and a resident grievance/complaint for dentures, glasses, and hearing [redacted] dated [redacted]. When questioned about follow up with Resident #118 dentures and vision appointment, the Director of Social Services stated there was no follow up and no appointment made at this time. She stated the [redacted] services usually call them, but she would give them a call and make the vision appointment.

During an interview with the Director of Social Services on [redacted] at 3:30 PM, the Director provided documentation of "eyecare examination" dated 11/5/2015. She stated that when she called to make an appointment they informed her that Resident #118 was seen on that date. They faxed over another documentation of eyecare examination, dated [redacted] " documenting patient was seen on [redacted]. Examination revealed that glasses would not improve patients vision due to the presence of [redacted] in both [redacted]." Documentation also provided with [redacted] services dates from a [redacted] Services company with appointment dates [redacted] at 11:00 AM, [redacted] at 11:00 AM, and [redacted] at 11:00 AM. The Director of Social Services stated she would give Resident #118 HCA a call to inform her.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105021	A. BUILDING _____ B. WING _____	02/18/2016

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F 250	Continued From page 11 During a review of he clinical record or Resident #118 on [redacted] it was noted an admission date of [redacted] that included [redacted] of Altered [redacted] Status, [redacted], and Anorexia. Record further revealed the resident is [redacted] and a total assist for Activities of Daily Living.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on [redacted] it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior in 4 (1 East, 1 West, 2 East, and 2 West) of 4 Resident Units. The findings included: During an [redacted] tour conducted on [redacted] at 10:05 AM and 1:00 PM accompanied with the Administrator, Engineer Director, Director of Nursing and [redacted] Director, the following concerns were noted: 1.) 1 East Wing: a. [redacted]- The wooden [redacted] was scratched and chipped. b. [redacted]- The area on the floor around the	F 253	RCHH will make every effort to ensure Housekeeping and Maintenance Services are provided to maintain a sanitary, orderly and conformable environment. 1. (a) [redacted] entrance [redacted] has been fixed. (b) [redacted] sink has been repaired and cracked tile replaced.	[redacted]

Jorge Caballo ADMINISTRATOR 3/18/16

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F 253	Continued From page 12 sink had missing and cracked tile. There was a hole in the floor near the sink. c. [redacted]- The paint on the [redacted] was peeling. There was not a trash can in the [redacted]. The second bed ' s dresser/night stand was scratched and worn. d. [redacted]- The mirror above the sink was desilvering, black spots. The wall under the television had paint peeling and was scratched. The bottom of the [redacted] was rusted. e. [redacted]- The tiles on the floor near the [redacted] were cracked. The [redacted] was in disrepair with scratches and gauges out of the wooden door. The only existing mirror at the sink was desilverizing, black spots. The tile on the [redacted] was uneven, slightly higher than the tile on the floor of the [redacted] the doorway to the [redacted]. f. Corridor [redacted] Rails- The wooden wall railing throughout the 1 East Wing was in disrepair with deep scratches and scuffs. g. Storage [redacted] #[redacted]- An unlocked supply [redacted] the hallway contained 10 cases of [redacted] feedings ([redacted] and fibersource), as well as [redacted] feeding supplies. h. Soiled utility [redacted]- contained overflowing trash in bins and trash on the floor. i. Community shower- displayed a call bell [redacted] wrapped around the [redacted] rail. j. Kitchen Pantry- four dirty " wet floor " signs	F 253	(c) [redacted] has been painted and a trash can has been placed in the bath [redacted]. The bed dresser has been replaced. (d) [redacted] mirror above the sink has been replaced. Wall area under the television has been fixed and painted. (e) [redacted] floor tiles near the [redacted] been replaced, bath [redacted] has been fixed. The mirror by the sink has been replaced. (f) Corridor [redacted] rails in 1 East Wing have been painted. (g) Storage [redacted] #[redacted] has been locked and appropiate staff given a key. (h)Building Service Staff and Clinical Staff have been inserviced in proper trash disposal in Soiled Utility. (see attached) (i) All [redacted] pull [redacted] have been loosened and Housekeeping Department Director has in-serviced staff on keeping [redacted] free and untied.	[redacted]

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F 253	Continued From page 13 were stored on the floor next to the countertop. The refrigerator and freezer gaskets were full of dirt and debris. k. 1East Activity [redacted]-The wooden entry doors were in disrepair with deep scrapes and scuffs. The [redacted] walls had peeling paint. l. Storage [redacted] #[redacted]- had a loose door knob and dirty floor. 2.) 1 West Wing: a. [redacted]- The door jam ' s paint was chipped, and the floor at the door was chipped. The railing/bumper guard displayed the [redacted] outside of [redacted]. b. Shower [redacted]- contained [redacted] bottles of shampoo (2), mouthwash, lotion and wet paper towels. c. [redacted]- The entry door was scraped. The wall of bed 2 displayed 2 [redacted] picture hangers and scrapped walls. There was a chair with torn cushions. The air conditioner vent was rusty. d. Medication carts- 3 of 3 trash cans were observed full of waste products with no cover. 3.) 2 East: Hallway Corridors- The corridor handrails throughoutwere worn. a. [redacted]- The wooden [redacted] board and [redacted] board of beds B and C were in disrepair with scratches and scrapes. A hole was noted in the wall in the [redacted]. The night table of bed 1 is in disrepair.	F 253	(j) Wet floor signs have been removed from Pantry. House Keeping staff inserviced. Signs moved to Janitors closet. (Staff in-serviced) (k) 1 East Activity [redacted] have been repaired. (l) Lock has been replaced and floor cleaned. 2.) 1 West (a) [redacted] door jam's was filled and painted. The rail bumper guard has been fixed. (b) [redacted] shampoo bottles removed, mouthwash removed, wet paper towels removed staff in-serviced to discard all used items after residents shower. (c) [redacted] entry door has been fixed, the wall of the bed has been repaired and painted, [redacted] picture hangers removed and wall fixed, cusheons discarded and A/C vent rust fixed. (d) Medication waste covers purchased and installed. Staff inserviced on waste level and disposal. Hallway corridors have been fixed and painted. (a) [redacted] Wooden [redacted] boards B and C have been replaced. The hole in the [redacted] been fixed. The night table of bed 1 has been replaced. [redacted]	

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F 253	Continued From page 14	F 253		

b. [redacted]- The entry door was scrapped. The baseboard behind bed B was dirty and chipped. The night table for bed C was dirty.

c. [redacted]- There were staples and nails in the walls. The baseboard under the window had black stains. There were numerous [redacted] holes in the floor tile in the [redacted].

d. [redacted]- The [redacted] door is chipped and the wall behind bed B is scratched. The corner guard is [redacted].

e. [redacted]- The walls had paint peeling. The night table of bed A was in disrepair.

f. [redacted]- The overbed table ' s [redacted] were peeling paint.

g. [redacted]-The [redacted] ' s door frame was rusted. The tub was soiled.

h. [redacted]- The wall behind bed A had paint peeling.

i. Clean Linen Doors- were in disrepair and the handle was falling off.

j. 2 East Dining [redacted]/Activity [redacted]-The entry [redacted] to the [redacted] chipped. The air vents were dusty, and the walls paint was peeling.

4.) 2 West Wing:

a. [redacted]- The [redacted] has missing tile.

b. [redacted] 1- The [redacted] has

(b) [redacted] door has been fixed. The baseboard behind bed B cleaned and painted. Night table for bed C has been cleaned.

(c) [redacted] staples and nails removed the wall was painted. Floor tiles in the [redacted] been replaced.

(d) [redacted] Entry door fixed wall behind bed B was fixed and corner guard fixed.

(e) [redacted] Walls fixed and painted, night table bed A has been replaced.

(f) [redacted] The overbed table was replaced.

(g) [redacted] [redacted] frame was fixed and painted. The bath tub was cleaned.

(h) [redacted] behind bed A was fixed and painted.

(i) Clean Linen doors handle fixed doors fixed.

(j) 2 East Dining [redacted] [redacted] door entry fixed and painted, air vents cleaned and walls paitned.

4.)

(a) [redacted] [redacted] tiles fixed.

(b) [redacted] fixed, tiles replaced. Soiled wheelchair removed and cleaned. [redacted]

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F 253	Continued From page 15 missing/broken tile. The [redacted] was uneven with the [redacted]. A soiled wheelchair was observed in the [redacted]. The baseboard was loose. c. [redacted]- baseboard outside of [redacted] exposed. d. Shower [redacted]- toilet seat was loose. The shower [redacted] call light was too short. e. Pantry [redacted]- had personal belongings, a jacket, and more than 4 purses. f. 2 West Activity [redacted]- wall paper was bubbled. The window sills were stained. During an interview directly following the [redacted] tour on [redacted] at 2:00 PM with the Administrator, Engineer Director, [redacted] Director, all of the findings above were acknowledged. Further interview 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 course/in service on how to report housekeeping/maintenance. The Administrator stated that only recently was a quality assurance tool developed and implemented for housekeeping/maintenance.	F 253	(c)Room 225 baseboard outside [redacted] was repaired. (d)Shower [redacted] seat was fixed, call light [redacted] was replaced. (e)Facility staff in-serviced not to place personal belongings in Pantry [redacted]. (f)2 West Activity [redacted] paper has been fixed window sills replaced. All other facility [redacted] in common areas have been assessed and all nesessary repairs have been completed. To ensure continued compliance, the Director of of Maintenance will maintain preventative maintenance manual with a log for daily rounds. In addition the Administrator will make weekly rounds to observe Maintenance and Housekeeping provided by facility.	[redacted]
F 314 SS=D	[redacted](c) TREATMENT/SVCS TO PREVENT/HEAL [redacted] SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

ADMINISTRATOR 3/18/16

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F 314	Continued From page 16 who enters the facility without [redacted] sores does not develop [redacted] sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having [redacted] sores receives necessary treatment and services to promote healing, prevent [redacted] and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the appropriate provision of [redacted] care was provided for 1 of 1 Residents reviewed for [redacted] wounds, (Residents #46), as evidenced by failing to perform [redacted] care in a manner to prevent the potential for contamination of the wounds for Resident #46. The findings included: Review of the facility policy for Handwashing/[redacted] Hygiene states in part, 'Employees must wash their [redacted] for at least fifteen (15) seconds using [redacted] or non-[redacted] soap and water under the following conditions: Before and after changing a dressing'. The Procedure states: 'Vigorously lather [redacted] with soap and rub them together, creating [redacted] to all surfaces, for at least fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature'. Review of the facility policy for [redacted] Care documents the Steps in the Procedure for non-disposable supplies to include: Wipe reusable supplies with [redacted] as indicated (i.e. outsides of containers that were touched by	F 314	1. Resident # 46 was not affected by cited [redacted] care procedure as evidenced by [redacted] heal [redacted] resolved, [redacted] improved and right heal [redacted] improved. 2-[redacted] care nurse was provided with 1:1 education on proper [redacted] care procedure to prevent [redacted] and avoid cross contamination to include proper handwashing with return demonstration. (see attendance sheet attached) 3-Competency validation of dressing changes was performed on both [redacted] care nurses to ensure compliance. (see competencies attached) 4-Weekly [redacted] observations to be done by DON or designee for the next three months to ensure proper [redacted] care procedure is being followed, reports will be taken to QA monthly. (see sample observation attached)	

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F 314	Continued From page 17 unclean [redacted], scissor blades etc.) Resident #46 was admitted to the facility on [redacted] with hospital admissions on [redacted] through [redacted] and [redacted] with a readmission [redacted] to the facility on [redacted]. Review of the clinical record revealed Resident #46 was admitted with a [redacted] to the sacral area, an unstageable [redacted] heel [redacted] and a suspected deep [redacted] to the right heel. On [redacted] at 10:30 a.m., with the consent of the resident, observation of [redacted] care was commenced with [redacted] Care Registered Nurse, Staff A. With the assistance of an aide, the resident was repositioned to his [redacted] side and the adult brief was removed. It was observed there was no dressing on the sacral [redacted]. The [redacted] was noted to be the size of 2 quarters placed side by side with a smaller [redacted] the approximate size of a dime below and to the right of the larger [redacted]. The wounds were observed to be draining a [redacted] amount of [redacted]. Staff A removed her gloves, washed her [redacted] for 10 seconds and donned new gloves. She then poured sterile normal [redacted] on a wad of gauze and proceeded to cleanse the wounds with initially a dabbing motion and then a swiping motion over the entire wounds. She dabbed the wounds with dry gauze. She then removed her gloves, washed her [redacted] for 4 seconds and donned new gloves. She squeezed [redacted] care ointment in a medication cup and with a [redacted] depressor placed the ointment on the wounds in a swiping motion. She then picked up another wad of gauze and with her gloved [redacted] touching the side of the gauze that was going to be in contact with the [redacted], she placed the	F 314		

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F 314	Continued From page 18	F 314		

gauze over the wounds and secured with an Omni fix dressing. She then removed her gloves, did not wash her [redacted], and dated the outside of the dressing. She then donned new gloves without washing her [redacted] and repositioned the resident's [redacted] on a pillow to have access to the [redacted] heel. She removed her gloves, washed her [redacted] for 6 seconds, donned new gloves and with scissors cut off the Kling wrap dressing over the [redacted] heel. The [redacted] heel [redacted] was observed to be an unstageable [redacted]. She placed the used scissors on the clean [redacted] care supply field and without removing her gloves, washing her [redacted] and donning new gloves, she cleansed the left heel [redacted] with sterile normal saline and dried the area with dry gauze. In reaching for the dry gauze, the plastic bag containing [redacted] [redacted] ointment sitting on the clean field, fell on the floor. She proceeded to pick up the plastic bag off the floor and placed it [redacted] on the clean [redacted] care supply field. She then took a box of gloves sitting on the clean [redacted] supply field and placed the box on the resident's bed next to the [redacted]. She then removed her gloves, washed her [redacted] for 4 seconds and donned new gloves. She placed the [redacted] ointment 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 [redacted] on the clean field and with a [redacted] depressor placed the [redacted] ointment on the [redacted], covered the [redacted] with a wad of gauze and secured with Kling wrap. She then removed her gloves, dated the outside of the dressing and washed her [redacted] for 5 seconds. She then proceeded to place the box of gloves sitting on the bed next to the resident's [redacted], on the [redacted] supply clean field. She donned new gloves and with the same scissors she used to remove

Administrator 3/18/16

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the dressing from the [redacted] heel, cut off the dressing on the right heel and placed the scissors [redacted] on the clean field next to a clean wad of gauze. She then placed the [redacted] ointment on the right heel [redacted] with a [redacted] depressor however did not cleanse the [redacted] first. She removed her gloves, washed her [redacted] for 3 seconds, donned new gloves and picking up the wad of gauze sitting next to the used scissors on the clean field, placed the gauze over the right heel [redacted] and secured with Kling wrap. Using the same scissors she cut a piece of the Omni fix dressing and secured the Kling, placed the previously used scissors [redacted] on the clean field, placed the Omni fix dressing over the Kling wrap and dated the dressing. She closed up the red biohazard garbage bag, took her gloves off and washed her [redacted] for 6 seconds. She took the bag out of the [redacted], came [redacted] in, washed her [redacted] for 5 seconds and proceeded to pick up the paper package of clean gauze and box of Omni fix tape holding them to her body then put them [redacted] on the clean field. She then went out of the [redacted] returned with another red biohazard bag and placed some of the used supplies in the bag then picked up the paper package of gauze, Omni fix tape, and ointments, placed them on a white foam tray and placed the box of gloves that had been sitting on the resident's bed, on top of the supplies and took the biohazard bag out of the [redacted]. She then returned [redacted] to the [redacted], removed her gloves and washed her [redacted] for 5 seconds. She then took the box of gloves now sitting on top of the supplies and put it in the rack above the sink, picked up the ointments, paper package of gauze and Omni fix tape, went to the [redacted] care treatment cart, and placed the supplies [redacted] into the cart. Returning [redacted] to the [redacted] went to

MDH1N 3/16/16

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20 the sink and rinsed the scissors for 4 seconds under running water, wrapped them in a paper towel, returned to the [redacted] 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 [redacted] care had been rendered in the Treatment Record. On [redacted] at approximately 4:00 p.m. the [redacted] Director of Nurses was apprised of the [redacted] 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 [redacted] care in the past, with no issues identified.	F 314		
F 315 SS=D	[redacted](d) NO [redacted], PREVENT [redacted], RESTORE [redacted] Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling [redacted] is not [redacted] unless the resident's clinical condition demonstrates that [redacted] was necessary; and a resident who is [redacted] of [redacted] receives appropriate treatment and services to prevent [redacted] and to restore as much normal [redacted] function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide follow up care and determine the indication/necessity of [redacted] use for 1 of 1 residents reviewed for [redacted] Use (Resident #269).	F 315	1- Resident #269 went to a urologist appointment on [redacted] and came back with orders to remove [redacted]. [redacted] was discontinued on [redacted]. (see order and progress note attached)	[redacted]

ADMINISTRATOR

3/18/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 21 The findings include: Record review revealed Resident #269 was admitted to the facility on [redacted] with an indwelling [redacted], with the indication of "[redacted] retention" noted in the Physician Orders. A follow up Physician's progress note does not address the resident's [redacted] status, a [redacted]/plan nor if the resident has an indwelling [redacted] present. The Nursing note entry's only mention the indwelling [redacted] twice; once in the admission note and the second time in a nursing entry dated [redacted]. No nursing entries show that the physician was contacted to discuss the follow up care or plan related to the resident's indwelling [redacted]. No [redacted] consults had been made to address the resident ' s urological status The Minimum Data Set (MDS) reveals that the resident has a [redacted] (BIMS) summary score of 15, which indicates Resident #269 as able to be interviewed and [redacted] intact. In addition, the [redacted] and [redacted] shows an indwelling [redacted] is present. Record review revealed two care plans addressing [redacted] status were initiated, however, a plan, other than to keep [redacted] bag below [redacted] level, is not indicated. On [redacted] at 1:43 PM, the ADON (Assistant Director of Nursing) stated that the reason for [redacted] is [redacted] Retention and that this is an acceptable [redacted]. She stated that there should be follow-up regarding the [redacted] in the chart but was unable to find any indication regarding the plan to assist the resident in the	F 315	2- Staff was educated on ensuring that residents who enter the facility without an indwelling [redacted] are not catherized unless the resident's condition demonstrates that catherization is necessary. (see attendance signing sheet attached) 3- Restorative assessment form was updated to reflect residents that are admitted with [redacted] and the [redacted] with proper follow up. Restorative Nurse educated on the need for assessment of all residents that are admitted to the facility with an indwelling [redacted] for proper follow up and care plan. 4- An audit was conducted of all current residents in the facility to ensure proper follow up appointments have been scheduled for the residents without a [redacted] to support an indwelling [redacted]. (See attached) 5-A weekly audit will be conducted by DON or designee of all residents with a [redacted] to ensure the proper [redacted] are in place for the use of [redacted] and orders for attempts of removal from MD are in place for those that are not necessary.	[redacted]

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F 315	Continued From page 22 [redacted] of her [redacted] function. She stated that they have morning meetings and clinical meetings regarding residents to discuss care and concerns; however, this was not identified. The ADON stated that they need to contact the doctor and make a follow up [redacted] appointment and if indicated, attempt to remove the [redacted]. The ADON acknowledged the lack of documentation throughout the chart and that she too could not see a clear picture of the plan of care. On [redacted] at 2:53 PM in an interview with the 1 East Desk Nurse stated that the resident has the [redacted] for [redacted] retention and thinks the resident may have a doctors appointment but is not sure and could not locate any additional information. She stated that she was not sure as to what the Physician ' s plan is for the resident. In an interview on [redacted] at 2:47 PM with Staff C, she stated she is not sure why the resident has an indwelling [redacted] [redacted] and does not know what the plan is, if any. On [redacted] the Resident #269 was observed several times during the day at Physical Therapy and in her [redacted] the indwelling [redacted] [redacted]. At 2:58 PM the resident stated she had a good day and upon surveyor inquiry regarding the indwelling [redacted] [redacted] she stated they put it in in the hospital because she was having difficulty [redacted]. However, she is not sure what they are doing about it now and has not seen the doctor or a [redacted] regarding it since she has been discharged from the hospital. On [redacted] at 4:18 PM, the ADON confirmed that a follow up appointment had been made which was confirmed by the surveyor in calling	F 315		

Jorge Valdes ADMin 3/18/16

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F 315	Continued From page 23 the Physician's office to verify. The resident had been scheduled on [redacted] and the receptionist stated upon surveyor inquiry that the resident would be seen on [redacted] if the facility were willing to pay for the visit. She was going to contact them [redacted] and make them aware. The DON was notified. On [redacted] at 10:30 PM in an interview with the DON, Administrator and Corporate Consultant, they acknowledged that Resident #269 should have had the indwelling [redacted] [redacted] looked into and its necessity evaluated. The Administrator stated that they were keeping the [redacted] appointment and paying for it through the facility. The DON acknowledged that best practice would have been to follow up with the MD and do a trial, if indicated or set up an appointment with the Urologist earlier if indicated but understood that a plan for the continued use of the [redacted] was not in place.	F 315		
F 332 SS=D	[redacted](m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the medication error rate was 25.9 percent. 7 medication errors were identified while observing a total of 27 opportunities, affecting Resident #268 and Resident #264.	F 332	1-LPN Staff B was provided with 1:1 education on med pass. (see attached) 2-Staff C was provided with 1:1 education on med pass to include administration of different types of inhalant medications. (see attached)	[redacted]

3/18/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC	1200 N 35TH AVE HOLLYWOOD, FL 33021

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F 332	Continued From page 24 The findings include: 1) On [redacted] at 9:40 a.m. medication pass observation was conducted with Licensed Practical Nurse (LPN) Staff B for Resident #266. Resident #266 was chosen for observation as it was noted she had [redacted] drops ordered. After reviewing the Medication Administration Record ([redacted]) for Resident #268, Staff B prepared the medications and placed an [redacted] pill and [redacted] pill into the medication cup and stated 'it looks like this is all the resident gets 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 included in the number of opportunities required to be observed. Staff B then proceeded into Resident #268's [redacted] stated to the resident she had the Aspirin pill and [redacted] pill for her to take. On [redacted] medication reconciliation was conducted by reviewing the physician orders and MARs. The physician orders included [redacted] 325 mg due at 8:30 a.m., [redacted] [redacted] 325 mg due at 8:30 a.m., [redacted] C 500 mg [redacted] due at 8:30 a.m., [redacted] 10 ml liquid daily due at 8:30 a.m. and [redacted] one drop to right [redacted] every hour for dry [redacted] which would have been due at 10:00 a.m. as the medication pass observation was conducted at 9:40 a.m. With reconciliation of the medications it was noted Staff B did not administer the [redacted] C, [redacted] or [redacted] during the medication pass observation on [redacted]. Further review of the MARs for [redacted] revealed Staff B had initialed/signed off on the 3 medications that were not administered. Resident #268 was not available for interview	F 332	3-All nurses were provided with education on med pass. 4 - Observations on med pass being conducted three times a week by DON or designee 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 no adverse reactions from cited incorrect administration of medication.	[redacted]

ADMINISTRATOR 3/19/16

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 332	Continued From page 25 until [redacted] at 3:40 p.m. and when asked how many pills she received during the medication pass observation on [redacted] she confirmed she only received 2 pills, the [redacted] and the [redacted] pill. On 02/1[redacted] at approximately 4:00 p.m. an interview was conducted with the pharmacy consultant who was apprised of the medication pass observation conducted on [redacted] 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. 2) During a medication administration pass observation on [redacted] at 9:04 AM, Staff C prepared Resident #264's medication as prescribed. The medication included: [redacted] 0.4mg/24 hour 1 [redacted] [redacted] QD. Staff C stated as she was getting ready to apply the newly opened [redacted] [redacted], that the previous [redacted] had been removed at 7:55 AM for morning care. She then proceeded to apply the new [redacted] to the resident's right [redacted] at 9:17AM and then dated and initialed the [redacted]. Upon interview with Staff C at 10:00 AM she stated that she had not waited to remove the [redacted] until the new one was being placed because she misjudged the time and figured she was getting ready to give the resident 's mediations, but that it took much longer than	F 332		

ADMIN 3/18/16

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F 332	Continued From page 26 expected and that the resident did go without the medication during that time. Upon interview with the Pharmacist, on [redacted] at 11:12 AM he states that based on the current [redacted] order, the old [redacted] should have been removed just prior to the new [redacted] being placed. 3) During a medication administration pass observation on [redacted] at 8:04 AM with Resident #264, Staff C was observed to administer three [redacted] inhalants [redacted] to [redacted], in the following order with less than 35 seconds between each to include: [redacted] Handheld 18mcg capsule 1 capsule; [redacted] Diskus Aer 1 puff [redacted] and Combinvent [redacted] 1 puff [redacted]. Staff C failed to shake the [redacted] and [redacted] inhalants before administering. In an interview with the Pharmacist at [redacted] at 11:15 AM he stated that all of the medication inhalants should be shaken before used because they are in [redacted] form and the ingredients must be uniform throughout, before administering. This ensures the resident receives the appropriate mixture and dose of the medication. In addition, upon review of Resident #264's Medication Record, he stated that the resident is on three types of inhaler medications which should be delivered in a specific order. He stated that the first type to be given is the [redacted] Agonist, the [redacted]; the second inhalant to be administered is the Anti Cholinergic, the Spiriva and third medication to be administered is the [redacted] inhaler, the [redacted]. He also stated that	F 332		

3/18/16

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F 332	Continued From page 27 after the [redacted] inhaler the nurse should have the resident rinse their [redacted] and spit it out after the [redacted]. He stated that there needs to be a 2-5 minute pause between each inhalant medication. Lastly, in the Metered Dose Inhaler's (MDI'S) form provided to the surveyor by the Pharmacist and inserviced to the staff after the surveyor's interview with the Pharmacists states to shake canister six times before each inhalation; give MDI's in this sequence: [redacted] dilators first and Steriods last; after Steriod, rinse [redacted]; and to wait one minute between puffs of the same medication and 5 minutes between different medications.	F 332		
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure meals were provided timely and as scheduled for 4 of 4 Resident Wings (1 and 2 East and 1 and 2 West), specifically affecting Resident #45, #60, #118, #186 and one additional unsampled resident. The findings include: 1) During dining observations on [redacted], it was noted that the tray schedule provided for 2 East	F 362	The Meal Schedule was reviewed and revised based on resident needs. The Dietary staff was in-serviced on the importance of following the meal schedule. Dietary staffing was reviewed and job tasks were revised as needed to ensure that the current meal schedule/times will be followed.	[redacted]/[redacted]

Jorge Carballo ADHC 3/18/16

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F 362	Continued From page 28 read 11:40 AM for first tray deliver and 11:50 AM for the second lunch tray delivery. On [redacted] at 12:38 PM, the first of two food carts arrived to the 2 East dining [redacted]/hallway. Food service delivery was being conducted by Staff J, K and various certified nursing assistants. At this time, when Resident #45 was observed being moved out the of dining [redacted] second time since 11:35 AM and placed in the hallway just outside the dining [redacted], as her tray did not arrive per Staff K. At 12:53 PM the Administrator walked by and saw the resident sitting outside the dining [redacted] the hall. He inquired if the resident had eaten and if the food was good. The resident shook her [redacted] and stated no and continued speaking in Spanish. Staff K then informed the Administrator that they were going to get her a tray, however, it was never asked of or assigned to obtain the tray during this dining. At 1:22 PM the resident received her lunch tray and was taken [redacted] into the dining [redacted] eat. On [redacted] at 1:40 PM, Resident #60 was observed in the 2 East hallway screaming she wants lunch as she strolled [redacted] and forth with her wheelchair dressed in a patient gown. She was yelling that she was hungry. At 1:48 PM the second hot food cart arrived to the 2 East and the food was distributed to the residents '. At 1:50 PM Resident #118, who was sitting outside the dining [redacted] since 11:35 AM, was taken via wheelchair to her [redacted] eat lunch. Further observations revealed that the last tray was served at 2:01 PM and retrieved at 2:14 PM from the resident in [redacted]. 2) On [redacted] at 8:34 AM, Staff L was observed standing with four residents in wheelchairs outside of the partially curtained off	F 362	A daily check will be conducted by the Food Service Director or designee in conjunction with ongoing monitor by the Consultant Dietitian on routine visits to ensure the meal schedule is followed. A consultant Dietitian and new CDM were hired to assist with plan of correction and implement systems issues to ensure compliance.	[redacted]/[redacted]

Jorge Pastalle ADMa 3/16/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 362	Continued From page 29	F 362		

dining [redacted] the 2 West Wing. Resident #186 was observed calling out for food, "come, come...I want food, food, food...". Upon surveyor inquiry Staff L closed the dining [redacted] further to obstruct the view. She stated that the residents in the hall near the elevator are waiting for 2nd dining. She said that they had moved Resident #186 from the dining table a few moments ago because it is not fair for her to see others eat. She stated that this is normally how it is done. She stated that she could see how the smell of the food would be a tease and that she may want to eat too. She then entered the nurse ' s station and called downstairs to see if the residents ' tray could be brought up early.

The Administrator; Corporate Consultant and 2 West Desk Manager then walked over to the resident and spoke with her. He stated her tray would be coming. In an interview on [redacted] at 8:48 AM the Administrator acknowledged that this is not the best system for residents. He stated the trays should come up at the same time, although space could be of concern. He ' suggested maybe that activities could be provided while residents are waiting and done in another space, out of the stream of the dining [redacted]. The Corporate Consultant agreed. Staff L then came over to the surveyor and stated that she sent the certified nursing assistant downstairs for the resident's tray. In the meantime, the resident had been wheeled [redacted] to the dining [redacted] placed at the third table with two others residents who were in the midst of eating. Resident #186 then laid her [redacted] down on the table and stayed there until her food arrived at 08:56 AM on the second tray cart delivery. The certified nursing assistant then delivered her tray to the table and assisted her with eating at 9:01 AM.

Jorge Valadle ADMin 3/18/16

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F 362	Continued From page 30 3) Review of the lunch dining schedule, provided by the facility, documented for those residents who eat in their [redacted] the first lunch cart tray delivery on the One East unit was to arrive at 12:05 p.m. with a second lunch cart to arrive at 12:30 p.m. On 02/15/16 at 12:05 p.m. observation of the One East lunch tray delivery was commenced however the lunch trays did not arrive. At 12:30 p.m. observation of the second lunch cart tray delivery was commenced however the lunch cart trays did not arrive. On [redacted] at 12:55 p.m. both lunch cart trays had not been delivered to the One East unit. On [redacted] at 1:00 p.m. while surveyor was standing at the One East Nursing Station a resident's family member was overheard stating to the desk nurse "When are the lunch trays arriving, my mother is hungry? Can I take her to the dining [redacted] is it too late? Have they closed that down already?" The desk nurse was observed to call the kitchen to see if they were still accepting residents in the dining [redacted] lunch and it was confirmed they were. The desk nurse then stated to the family member, "If you want to take your mother to the dining [redacted] will get her food there." The first lunch cart trays were not delivered to the One East unit until [redacted] p.m., an hour and 5 minutes after the scheduled time of 12:05 p.m.	F 362		
F 363 SS=E	[redacted](c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition	F 363	The dinner menu was adjusted for [redacted]/16 to ensure the residents received adequate [redacted] for the day.	[redacted]

Jorge Caballero ADH Consultant 3/18/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10S021	A. BUILDING _____ 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

(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
F 363	Continued From page 31 Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the resident approved menu was not being followed. The findings include: During the observation of the lunch meal service in the main kitchen on [redacted] at 11:30 AM accompanied with the Administrator it was revealed that the approved menu was not being as evidenced by the following: 1) Observation of the Chicken Enchilada revealed that it appeared to be an egg roll appetizer (2 rolls per serving). Further review revealed that the packaging box was labeled "Chicken Egg Rolls". Further investigation of the box revealed documented Nutrition Facts that 1 egg roll contained only 8 grams of [redacted] which [redacted] at 1.6 grams of [redacted] per resident serving. Interview with the Food Service Manager at the time of the observation revealed that he was unaware that the approved menu entree [redacted] serving to the residents did not meet the 4 ounce (28 gram) portion and only 16 grams (2 ounce) of entree [redacted] was being served. Interview with the Administrator at the time of the observation revealed that the entree being served was not a chicken enchilada. 2) Observation of the lunch tray line revealed that the 4 ounce of salad was not prepared for all	F 363	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. The Dietary staff was in-serviced on following the menu with proper portions and menu extensions. Daily monitor by the Food Service Director or designee will be conducted to ensure the approved menus are followed each day. A consultant Dietitian and new CDM were hired to assist with plan of correction and implement systems issues to ensure compliance.	[redacted]

George Caballo ADMinistrator 3/18/16

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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.	F 363		
F 364 SS=E	[redacted](d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364		

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F 364	Continued From page 33 value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to prepare cooked vegetables by methods that conserve nutritive value, flavor, appearance, and that food is palatable. The findings include: During the kitchen sanitation tour on [redacted] at 8:50 AM, accompanied with the facility's Food Service Manager, it was noted that three [redacted] pans of carrots were observed boiling on top of the stove. The surveyor questioned why the carrots were being cooked approximately 3 hours 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 pureed and then reheated for meal service. The manager then stated that the vegetables are then cooled down and are reheated/re-cooked just prior to the beginning of the meal service. The 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 [redacted] of nutritive value, appearance, 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 also noted that the majority of the lunch meals	F 364	The facility will prepare cooked vegetables by methods that will conserve nutritive value, flavor, appearance and palatability. The Dietary staff who prepares vegetables was in serviced on proper cooking methods to conserve nutritive value, appearance and palatability. Ongoing monitoring by the Food Service Director or designee will be conducted to ensure that vegetables are cooked by methods that conserve nutritive value, flavor, appearance and palatability. Ongoing monitor by the Consultant Dietitian on routine visits will be conducted as well. A consultant Dietitian and new CDM were hired to assist with plan of correction and implement systems issues to ensure compliance.	[redacted]

Jorge Caballero NDH minister 3/18/16

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F 364	Continued From page 34 observed by the surveyors revealed that there was poor consumption of the carrots by the residents.	F 364		
F 369 SS=D	[redacted](g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide physician ordered adaptive eating utensils (Rocker Knife) for 1 (Resident #87), of 1 sampled residents who require adaptive eating utensils. The findings include: During the observation of lunch meal in the main dining [redacted] at 12:15 PM, it was noted the the lunch meal card for Resident #87 documented adaptive equipment to include: 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 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.	F 369	The facility will provide adaptive eating equipment/utensils as ordered. The Occupational Therapist along with the facility's full-time Registered Dietitian have reviewed all residents with current orders for adaptive eating utensils. An audit was conducted of the tray tickets to ensure all residents with a current order for adaptive eating utensil(s) are on the tray ticket to indicate to the kitchen staff which adaptive utensil(s) are to be provided to each resident.	[redacted]

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F 369	Continued From page 35 During an observation of Resident #87 on [redacted] at 8:50 AM it was noted that the resident received her breakfast meal in the [redacted] once again the Rocker Knife was not included on the breakfast tray. The resident again was observed having difficulty cutting breakfast foods with the fork. The alert and oriented resident again stated that the Rocker Knife is not being included with meals "all of the time" and "needs the Rocker Knife with meal to be able to cut foods." The resident also stated that she keeps informing the staff that she is not receiving the Rocker Knife with meals. The Administrator was summoned to the residents [redacted] confirmed that the resident's Rocker Knife was not included on the breakfast tray. The resident also stated to the Administrator that the Rocker Knife is not included with most of the meals and keeps informing staff that she is not receiving the Rocker Knife. On [redacted] an interview was conducted with the Director of Skilled Therapy and it was revealed through documentation provided that the resident had a current order for a Built-up Fork & Spoon and Rocker Knife with meals and was ordered by the physician on [redacted].	F 369	An inventory was taken of all adaptive eating utensils to ensure that any utensil that is currently ordered is available for use. The Dietary staff was in serviced on reading the trays tickets properly with emphasis on adaptive eating utensils. Daily monitor by the FSD or designee will be conducted to ensure all residents with an order for adaptive eating utensils are provided to them as ordered. A consultant Dietitian and new CDM were hired to assist with plan of correction and implement systems issues to ensure compliance.	[redacted]
F 372 SS=F	[redacted](i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to dispose of garbage and refuse properly.	F 372	Facility disposes of garbage and refuse properly. Dumpster area and surrounding ground area leading to the dumpster were cleaned. An ongoing cleaning schedule was developed to maintain compliance.	

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F 372	Continued From page 36 The findings include: During the kitchen sanitation tour conducted on [redacted], accompanied with the Food Service Manager the following concerns were noted 1) The ground area leading to the dumpster and around the dumpster was noted to have numerous [redacted] areas of foul smelling standing water. 2) Other ground areas leading to the dumpster and around the dumpster were noted to have a build-up of green algae type [redacted] and black [redacted] type [redacted]. 3) The ground area around the dumpster was noted to be littered with garbage and trash. 4) The dumpster was noted to be so full that the containers of trash were hanging out over the sides, in the front of the dumpster and the 2 [redacted] lids were not able to be closed. 5) Interview with the Food Service Manager at the time of the observation revealed that the ground area around the dumpster is always in this condition and that the dumpster capacity is too [redacted] to handle the amount of trash/garbage that the facility generates per day.	F 372	2. All the ground areas leading to the dumpsters and around the dumpsters were cleaned. 3. The ground area around the dumpsters was cleaned. 4. The Company that provides garbage pick up was contacted to review agreement of daily garbage schedule to make sure garbage is picked up daily and ensure that the dumpsters do not overflow. Larger dumpsters were ordered to avoid overflow. Ongoing evaluation by the housekeeping, maintenance and Food Services Director will be conducted for compliance to maintain proper disposal of garbage and refuse properly. The Administrator will also conduct random rounds to ensure compliance.	3/18/16
F 431 SS=E	[redacted](b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	1-Staff was in serviced on proper storage drugs and biologicals to include [redacted] feeding and medications.	3/18/16

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F 431	Continued From page 37 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug [redacted] and Control Act of 1976 and other drugs subject to [redacted], except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the safe and secure storage of medication and resident [redacted] feedings and supplies. The findings include:	F 431	2-All closets containing [redacted] feedings were locked and secured for proper storage. 3-Daily rounds made by DON or designee to ensure all doors are locked and all supplies are kept in safe storage. 4 - Storage [redacted] #[redacted] (1 East) has been locked and appropiate staff given a key. (b) Storage [redacted] #[redacted] (2 West) has been locked and appropiate staff given a key.	[redacted]

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F 431	Continued From page 38 observation on [redacted] at 8:23 AM, Staff C was noted to be standing at the medication cart reviewing a [redacted] packaging when she was interrupted by the DON (Director of Nursing) and 1 East Desk Manager. They instructed her to enter the [redacted] Resident #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 than 10 [redacted] packages for Resident #264 in her medication book on top of the medication cart and closing it. She then walked into the [redacted] the medication in 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 [redacted], she stated that she acknowledged she had interrupted Staff C ' s process by asking her to step into the resident ' s [redacted] by doing so, Staff C did not follow the policy and procedure for securing medications. 2) During the [redacted] observation tours conducted of the facility on [redacted] at 10 AM and 1 PM, accompanied with the Administrator, Director of Nursing, Director of Housekeeping, and Director of Maintenance, the following concerns were noted: a. Storage [redacted] #[redacted] (1 East) - An unlocked/non-secured supply [redacted] in the	F 431		

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F 431	Continued From page 39 main hallway contained 10 cases of [redacted] feedings ([redacted] and Fibersource), as well as 10 cases at [redacted] feeding kits. The supply [redacted] located along the hallway of 1 East and the entry door to the [redacted] not equipped with a locking mechanism. Numerous mobile [redacted] residents are located within close proximity of the [redacted]. b. Storage [redacted] #[redacted] (2 West) - An unlocked/non-secured [redacted] in the main hallway contained approximately 20 cases of [redacted] feedings (Isosource, Protamin, Diabetasource, Nutren, and Med Pass). There were also 3 cases at [redacted] feed supplies kits. This storage [redacted] located in proximity of numerous [redacted] where mobile [redacted] residents reside. Interview with the Director of Nursing and Administrator at the time of observation revealed that they were unaware that these storage [redacted] were unlocked/non-secured and that they were required to be secured at all times.	F 431		
F 441 SS=F	[redacted] CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an [redacted] Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and [redacted] of [redacted] and [redacted]. (a) [redacted] Control Program The facility must establish an [redacted] Control Program under which it - (1) Investigates, controls, and prevents [redacted] in the facility; (2) Decides what procedures, such as isolation,	F 441	Facility has established and maintains an effective [redacted] 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 [redacted] keep them off of the floor.	[redacted]

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F 441	Continued From page 40 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to [redacted]. (b) Preventing Spread of [redacted] (1) When the [redacted] Control Program determines that a resident needs isolation to prevent the spread of [redacted], the facility must [redacted] the resident. (2) The facility must prohibit employees with a [redacted] or [redacted] from direct contact with residents or their food, if direct contact will [redacted] the [redacted]. (3) The facility must require staff to wash their [redacted] after each direct resident contact for which [redacted] washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of [redacted]. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain an [redacted] control program in the facility's laundry area and failed to ensure that medical equipment was properly sanitized after utilization. The findings included: 1) During observation of the [redacted] tour of the facility laundry service area on [redacted] at 10:30 AM, accompanied by the [redacted] Director, the following [redacted] control issues	F 441	(b)The ceiling area of the clean wash [redacted] dryer [redacted] 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/PM by supervisor to assure proper cleaning and logging. Administrator randomly is checking the dryers for lint buildup.	[redacted]

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F 441	Continued From page 41 were noted: (a) Soiled [redacted] (2) were noted to be stored in the clean wash [redacted]. (b) Numerous [redacted] areas of paint was noted to be peeling from the ceiling surface of the clean wash [redacted] dryer [redacted]. There was a potential that the peeling paint could [redacted] on resident clean linen. (c) Three of three laundry carts used to transport clean linens were noted to have a heavy build up of trash on the bottom of each cart. Upon interview during the tour, the laundry staff stated that they are not cleaning the carts after each use. (d) Observation of the lint compartment of five of five commercial dryers was noted to have an excessive build up of lint/trash. The Director states that the lint traps are to be cleaned and provided documentation of cleaning a minimum of three times a day. Review of the dryer cleaning documentation sheet revealed the last cleaning was initialed for 8:00 AM on [redacted]. During the tour, interview with laundry personnel confirmed that she initialed without cleaning. (e) Observation of the clean linen folding area revealed that the trash container was full and overflowing. Further observation revealed that the overflowing trash was coming into direct contact of stored clean linen. (f) Observation of the ceiling [redacted] located in the clean linen storage area noted that the vent and surrounding ceiling area had a build up of a black [redacted] like [redacted] and build up of condensation that could possibly drip down and contaminate clean linen that was stored underneath. (g) Observation of the clean linen storage area revealed a personal jacket stored on a rack	F 441	(e)All trash cans have been replaced with new trash can step- on type with closing lid. (f)Vent sorrounding clean linen area was cleaned and condensation was corrected. (g) No personal items are allowed in clean linen area all personal items must be stored in lockers. Staff informed and Housekeeping Supervisor will enforce.	[redacted]

3/18/16

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

PRINTED: [redacted]
FORM APPROVED
OMB NO. [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105021	A. BUILDING _____ 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

(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
F 441	Continued From page 42 housing clean linen. (h) Observation of the door leading outside the clean linen storage area revealed a [redacted] gap under the door. There was potential for rodents/animal entry as well as debris blown from the outside inside. 2) During a medication pass observation on [redacted] at 8:18 AM, Staff C was observed to clean [redacted] cuff with a Clorox Bleach [redacted] wipe sparsely for 10 seconds and discard the wipe while she allowed the [redacted] cuff dry. In addition, following resident use of the stethescope and [redacted] cuff with Resident #109, the reusable resident care equipment was not decontaminated and/or sterilized between residents, as per the facility policy titled, "Cleaning and [redacted] of 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 441	(h) Door leading to outside door of clean linen storage has been repaired . 2) Staff was provided with an in-service on the proper decontamination of reusable equipment. (see signing sheet attached) Daily rounds to be completed by the [redacted] Control Nurse to ensure that staff is following proper procedure for [redacted] equipment.	
F 464 SS=E	[redacted](g) REQUIREMENTS FOR DINING & ACTIVITY [redacted] The facility must provide one or more [redacted] designated for resident dining and activities. These [redacted] must be well lighted; be well [redacted], with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by:	F 464	The lunch schedule has been changed for the 2nd floor West wing and East wing so that 2 East cart comes out first. The carts with the east wing trays will be brought up one after the other so that residents in that area can be served 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.	[redacted]

ADMINISTRATOR 3/18/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC	1200 N 36TH AVE HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	Continued From page 43 Based on observation and interview, the facility failed to ensure residents had adequate space during dining to accommodate them comfortably without [redacted] during the lunch meal, as evidenced by observations of crowded dining [redacted] in the second floor East and West Wings. The findings include: On [redacted] at 11:57 AM observations in the dining [redacted] behind the nurse ' s station on the second floor West Wing, revealed 18 residents in the dining [redacted] 15 of those 18 residents seated in wheelchairs. The dining [redacted] observed to have five 36 x 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 [redacted]) table and 3 residents seated (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 [redacted] 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 window [redacted] of the elevator. A resident was seated in a wheelchair was observed in front of the elevator and two other Residents were seated in wheelchairs facing the dining [redacted], there was not enough [redacted] accommodate these residents in the dining area.	F 464	A new rehab dining program has been implemented in order to assist up to 7 residents with their meals in a separate area. Staff educated on meal times and assisting residents to their assigned dining area prior to food carts arriving.	3/18/16

Jorge Castallo MDMin 3/18/16

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

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F 464	Continued From page 44	F 464		

At 12:33 PM observations revealed as the dietary employee pulled the tray cart out of the elevator on the second floor, he asked an aide to move Resident #107 who was seated in front of the elevator, out of the way for him to be able to get the next tray cart out of the elevator safely. The Unit Supervisor was observed to be standing by the elevator near the tray cart as it was pulled out of the elevator. The dietary employee parked the tray cart in front of the nurses station towards the East wing. The first tray cart was delivered to the West wing.

At 12:39 PM an observation was made of the Unit Supervisor moving Resident #107 next to the West Unit double door, away from the dining area.

At 12:40 PM a resident was observed wheeling himself into the dining [redacted] parking himself at the first table. It was noted that after the resident parked at the first table, there was a 2 [redacted] distance between the resident ' s wheelchair and the nurses station counter. Observation was made throughout the dining time that the staff had to stop and wait for others (residents and staff) before moving into another task or serving another resident due to the crowded [redacted].

At 12:42 PM an aide was observed pushing another resident in a wheelchair into the dining [redacted], and as she was wheeling the resident into the dining [redacted] asked the resident, who had parked himself at the first table, to move for her so she could wheel another resident into the dining [redacted]. The resident refused and another resident seated at the table was wheeled out of the dining [redacted] accommodate the resident's request to stay at that table.

3/18/14

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

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F 464	Continued From page 45 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 [redacted]. At 12:45 PM observations revealed aides were moving residents that had not had their lunch tray from the crowded dining [redacted] 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 [redacted] [redacted] the fourth and fifth tables garbling and mumbling out loud. The Resident was observed to be removed from the dining [redacted] 1:55 PM without eating or being fed. At 1:11 PM observations revealed 9 residents seated in wheelchairs by the space to the [redacted] of the elevator and in front of the elevator waiting for their meal trays to arrive. Residents in the dining [redacted] 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 [redacted] 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 464		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469	A new exit door has been purchased and the existing air curtain that is in working order will be maintained on at all times to minimize any potential pests from entering the kitchen.	[redacted]

ADMINISTRATOR 3/18/16

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F 469	Continued From page 46 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain an effective pest control program in the main kitchen to ensure that the area was free of pests. The findings include: During the kitchen/food service sanitation tour conducted on [redacted] at 8:52 AM, accompanied with the Food Service Manager, it was noted that numerous flying insects were observed in food production, food serving areas, food storage areas (dry storage and walk-in refrigerator), 3 compartment sink area, and dish machine area. Approximately 15 - 20 individual observations were made in these areas. It was noted during the tour that exit door located near the 3-compartment sink area was wide [redacted] and covered with [redacted] plastic sheets that did not fit the door [redacted] properly. There were numerous gaps in the door opening the would allow pests to enter the kitchen area. The Food Service Manager stated that the pest control in the main kitchen is an on-going problem. Interview with the Director of Maintenance and review of the last 6 month service by the contracted pest control company revealed that the kitchen areas are serviced on a regular basis, but there was no documentation of on-going issues in the main kitchen.	F 469	A Pest Control company conducted an on-site visit [redacted] to service the entire kitchen for any existing pests. The schedule was changed from monthly to twice a month and as needed if more visits are needed. At a minimum, a bi-monthly schedule will be maintained by the Pest control company to ensure the kitchen will be free from pests. A daily check will be conducted by the Food Service Director or designee to monitor for pests in the kitchen area. The Maintenance Director and Administrator will incorporate kitchen rounds in to their rounds schedule. Two blue lights designed to attract flyes were added to the kitchen area.	[redacted]

Jorge Caballo ADMINISTRATOR 3/18/16

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F 514	Continued From page 47	F 514		
F 514 SS=D	[redacted](i)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate and complete clinical records as evidenced by failing to reconcile [redacted] medication with the Controlled Drug Record for 1 of 5 sampled residents (Resident # 269) reviewed for Unnecessary Medications. The findings included: Review of the Controlled Record form for Resident #269 revealed "Each dose signed for here requires charting on the medication record". Review of the clinical record for Resident #269 revealed a Physician's order dated [redacted] for [redacted] 5 milligrams (mg); one tablet (tab) by [redacted] every 4 hours (hrs) as needed for [redacted]. Review of Resident #269 ' s [redacted] 2016 Medication Administration Record ([redacted]) revealed [redacted] 5 mg one tab was	F 514	1-Staff was provided with education on proper documentation of [redacted] medications. (see attendance attached) 2-A weekly audit tool was created to ensure accuracy of all [redacted] medication documentation, audit to be conducted on a daily basis by nurse coordinators for three months and to be turned in weekly to DON or designee. (see sample attached) 3-Reports of all inaccuracies to be discussed in monthly Q.A. meetings with appropiate follow-up needed	[redacted]

ADMINISTRATOR

3/18/16

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F 514	Continued From page 48 documented as administered twice on [redacted] and once on [redacted] for a total of three doses of [redacted] documented as administered. Review of Resident #269's Controlled Drug Record for the [redacted] 5 mg tab revealed one tab was documented as administered on [redacted] at 4:00 PM; one tab on [redacted] at 4:15 PM; one tab on [redacted] at 8:45 PM; one tab on [redacted] at 10 PM; one tab on [redacted] at 6:00 AM; one tab on [redacted] at 11 AM; one tab on [redacted] at 3:15 PM; and one tab on [redacted] at 4:40 PM for a total of eight doses of [redacted] documented as administered, of which 6 were not documented on the [redacted] 2016 [redacted]. During an interview with the Director of Nursing (DON) on [redacted] at 12:41 PM, the DON was apprised of the inaccuracy of the [redacted] medication reconciliation between the [redacted] and Controlled Drug Record for Resident #269. The DON confirmed that the nurses are to document all [redacted] drugs given on the Controlled Drug Record as well as on the resident's [redacted].	F 514		

Jorge Valadez ADMINISTRATOR 3/18/16

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	100611	A. BUILDING: _____ B. WING _____	02/18/2016

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

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N 000	INITIAL COMMENTS An unannounced Re-licensure survey was conducted on [redacted] to [redacted] at Rehabilitation Center at Hollywood Hills. The facility had deficiencies at the time of the visit.	N 000	This plan of correction constitutes our written allegation for compliance for the deficiencies cited. Our submission of the Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This plan of corrections submitted to meet requirements established by state and federal laws.	
N 054 SS=D	59A-[redacted](5), FAC Follow Physician Orders 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. 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 25.9 percent. 7 medication errors were identified while observing a total of 27 opportunities, affecting Resident #268 and Resident #264. The findings include: 1) On [redacted] 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 [redacted] drops ordered. After reviewing the Medication Administration Record ([redacted]) for Resident #268, Staff B prepared the medications and placed an [redacted] pill and [redacted] pill into the medication cup and stated 'it looks like this is all the resident gets 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	N 054	1-LPN Staff B was provided with 1:1 education on med pass. (see attached) RECEIVED [redacted] 18 2016 BY:	3/18/16

[redacted]CA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jorge Caballe — TITLE: ADMINISTRA[redacted] — (X6) DATE: 3/18/16

STATE FORM [redacted] S4XQ11 If continuation sheet 1 of 42

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N 054	Continued From page 1	N 054		

Included in the number of opportunities required to be observed. Staff B then proceeded into Resident #268's [redacted] stated to the resident she had the [redacted] pill and [redacted] pill for her to take.

On [redacted] medication reconciliation was conducted by reviewing the physician orders and MARs. The physician orders included [redacted] 325 mg due at 8:30 a.m., [redacted] 325 mg due at 8:30 a.m., [redacted] C 500 mg twice daily due at 8:30 a.m., [redacted] 10 ml liquid daily due at 8:30 a.m. and [redacted] one drop to right [redacted] every hour for dry [redacted] which would have been due at 10:00 a.m. as the medication pass observation was conducted at 9:40 a.m. With reconciliation of the medications it was noted Staff B did not administer the [redacted] C, [redacted] or [redacted] during the medication pass observation on [redacted]. Further review of the MARs for [redacted] revealed Staff B had initialed/signed off on the 3 medications that were not administered.

Resident #268 was not available for interview until [redacted] at 3:40 p.m. and when asked how many pills she received during the medication pass observation on [redacted] she confirmed she only received 2 pills, the [redacted] and the [redacted] pill.

On [redacted] at approximately 4:00 p.m. an interview was conducted with the pharmacy consultant who was apprised of the medication pass observation conducted on [redacted] 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.

ADMIN

3/18/16

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N 054	Continued From page 2	N 054		

2) During a medication administration pass observation on [redacted] at 9:04 AM, Staff C prepared Resident #264's medication as prescribed. The medication included: [redacted] 0.4mg/24 hour 1 [redacted] QD. Staff C stated as she was getting ready to apply the newly opened [redacted], that the previous [redacted] had been removed at 7:55 AM for morning care. She then proceeded to apply the new [redacted] to the resident's right [redacted] at 9:17AM and then dated and initialed the [redacted].

Upon interview with Staff C at 10:00 AM she stated that she had not waited to remove the [redacted] until the new one was being placed because she misjudged the time and figured she was getting ready to give the resident ' s mediations, but that it took much longer than expected and that the resident did go without the medication during that time.

Upon interview with the Pharmacist, on [redacted] at 11:12 AM he states that based on the current Nitroglycerin order, the old [redacted] should have been removed just prior to the new [redacted] being placed.

3) During a medication administration pass observation on [redacted] at 9:04 AM with Resident #264, Staff C was observed to administer three [redacted] inhalants [redacted] to [redacted], in the following order with less than 35 seconds between each to include: Spiriva Handheld 18mcg capsule 1 capsule; [redacted]

2-Staff C was provided with 1:1 education on med pass to include administration of different types of inhalant medications. (see attached) [redacted]

3-All nurses were re-inserviced and provided with education on med pass. [redacted]

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N 054	Continued From page 3 Diskus Aer 1 puff [redacted] and Combinvent [redacted] 1 puff [redacted]. Staff C failed to shake the [redacted] and [redacted] Inhalants before administering. In an interview with the Pharmacist at [redacted] at 11:15 AM he stated that all of the medication inhalants should be shaken before used because they are in [redacted] form and the ingredients must be uniform throughout, before administering. This ensures the resident receives the appropriate mixture and dose of the medication. In addition, upon review of Resident #264's Medication Record, he stated that the resident is on three types of inhaler medications which should be delivered in a specific order. He stated that the first type to be given is the [redacted] Agonist, the [redacted]; the second inhalant to be administered is the Anti Cholinergic, the [redacted] and third medication to be administered is the [redacted] inhaler, the Advair. He also stated that after the [redacted] Inhaler the nurse should have the resident rinse their [redacted] and spit it out after the [redacted]. He stated that there needs to be a 2-5 minute pause between each inhalant medication. Lastly, in the Metered Dose Inhaler's (MDI'S) form provided to the surveyor by the Pharmacist and inserviced to the staff after the surveyor's interview with the Pharmacists states to shake canister six times before each Inhalation; give MDI's in this sequence: [redacted] dilators first and Steriods last; after Steriod, rinse [redacted]; and to wait one minute between puffs of the same medication and 5 minutes between different medications.	N 054	4-Observations on med pass being conducted three times a week by DON or designee 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 no adverse reactions from cited incorrect administration of medication.	[redacted]

ADMINISTRATOR

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 054	Continued From page 4 Class III	N 054		
N 082 SS=D	59A-[redacted](3), FAC Dietary Serv - Supervisor Qualifications A Dietary Services Supervisor shall be a person who: (a) Is a qualified dietitian as defined in paragraphs 59A-4.110(2)(a), (b), F.A.C.; or (b) Has successfully completed an associate degree program which meets the education standard established by the American Dietetic Association; or (c) Has successfully completed a Dietetic Assistant correspondence or class [redacted] program, approved by the American Dietetic Association; or (d) Has successfully completed a course offered by an accredited college or university that provided 90 or more hours of correspondence or [redacted] in food service supervision, and has prior work experience as a Dietary Supervisor in a health care institution with consultation from a qualified dietitian; or (e) Has training and experience in food service supervision and management in the military service equivalent in content to the program in paragraph (3)(b), (c) or (d); or (f) Is a certified dietary manager who has successfully completed the Dietary Manager ' s Course and is certified through the Certifying Board for Dietary Managers and is maintaining their certification with continuing clock hours at 45 CEU ' s per three year period. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the individual designated by the	N 082	The Facility's Full-time Registered Dietitian was appointed in writing as the Director of Food and Nutrition Services effective [redacted]. A consultant Dietician and CDM were hired to provide support. Ongoing evaluation will be conducted by the Facility Administrator to ensure a Qualified Dietary Services Supervisor is maintained as defined by regulatory guidelines.	[redacted]

Jose Castallo ADM Investigation 3/18/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100511	A. BUILDING: _____ B. WING _____	02/18/2016

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

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N 082	Continued From page 5 facility, as the Dietary Services Supervisor, failed to meet the requirements as a Certified Dietary Manager, who has successfully completed the Dietary Manager's Course and certified through the Certifying Board for Dietary Managers and maintain certification with the clock hours at 45 CEU's (Continuing Education Units). The finding include: During the review of the employee file of the facility's designated Dietary Services Supervisor it was revealed that the file did not contain a current valid certificate of completion of the Dietary Manager's Course and certification by the Board for Dietary Managers. Further review of the file revealed the facility's job description for the Dietary Services Supervisor required a Certified Dietary Manager. Following the employee file review, an interview conducted with the Administrator revealed that the facility's Dietary Services Supervisor allowed his dietary managers license expire and had not renewed the license. Further interview with the Administrator revealed that once the issues were revealed, the facility's full time Registered Dietitian was appointed in writing of her promotion to Director of Food Services And Nutrition, effective [redacted]. Class III	N 082	The Facility's Full-time Registered Dietitian was appointed in writing as the Director of Food and Nutrition Services effective [redacted]. A consultant Dietitian and CDM were hired to provide support in the kitchen. Ongoing evaluation will be conducted by the Facility Administrator to ensure a Qualified Dietary Services Supervisor is maintained as defined by regulatory guidelines.	
N 101 SS=D	[redacted] (1)(j), FS; 59A-[redacted](2), FAC Resident Medical Records [redacted] (1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or	N 101	1-Staff was provided with education on proper documentation of [redacted] medications. (see attendance attached)	[redacted]

[redacted] S4XQ11
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3/18/16

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N 101	Continued From page 6 other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be [redacted] to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-[redacted](2) FAC Each medical record shall contain sufficient information to clearly identify the resident, his [redacted] and treatment, and results. Medical records shall be complete, accurate, accessible and systematically organized. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate and complete clinical records as evidenced by failing to reconcile [redacted] medication with the Controlled Drug Record for 1 of 5 sampled residents (Resident # 269) reviewed for Unnecessary Medications. The findings included: Review of the Controlled Record form for Resident #269 revealed "Each dose signed for here requires charting on the medication record". Review of the clinical record for Resident #269 revealed a Physician's order dated [redacted] for [redacted] 5 milligrams (mg); one tablet (tab) by [redacted] every 4 hours (hrs) as needed for pain. Review of Resident #269 ' s [redacted] 2016 Medication Administration Record ([redacted]) revealed [redacted] 5 mg one tab was documented as administered twice on [redacted]	N 101	2-A weekly audit tool was created to ensure accuracy of all [redacted] medication documentation, audit to be conducted on a daily basis by nurse coordinators for three months and to be turned in weekly to DON or designee. (see sample attached) 3-Reports of all inaccuracies to be discussed in monthly QA meeting with appropiate follow up as needed.	[redacted]

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N 101	Continued From page 7 and once on [redacted] for a total of three doses of [redacted] documented as administered. Review of Resident #269 ' s Controlled Drug Record for the [redacted] 5 mg tab revealed one tab was documented as administered on [redacted] at 4:00 PM; one tab on [redacted] at 4:15 PM; one tab on [redacted] at 8:45 PM; one tab on [redacted] at 10 PM; one tab on [redacted] at 6:00 AM; one tab on [redacted] at 11 AM; one tab on [redacted] at 3:15 PM; and one tab on [redacted] at 4:40 PM for a total of eight doses of [redacted] documented as administered, of which 6 were not documented on the [redacted] 2016 [redacted]. During an interview with the Director of Nursing (DON) on [redacted] at 12:41 PM, the DON was apprised of the inaccuracy of the [redacted] medication reconciliation between the [redacted] and Controlled Drug Record for Resident #269. The DON confirmed that the nurses are to document all [redacted] drugs given on the Controlled Drug Record as well as on the resident ' s [redacted]. Class III	N 101		
N 110 SS=D	400.141(1)(h) FS; 59A-[redacted](1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-[redacted](1) FAC The facility shall provide a safe, clean, comfortable, and homelike environment, which	N 110	A Pest Control company conducted an on-site visit [redacted] to service the entire kitchen for any existing pests. The schedule was changed from monthly to twice a month and as needed if more visits are needed.	[redacted]

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N 110	Continued From page 8 allows the resident to use his or her personal belongings to the extent possible. This Statute or Rule is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain an effective pest control program in the main kitchen to ensure that the area was free of pests. The findings include: During the kitchen/food service sanitation tour conducted on [redacted] at 8:52 AM, accompanied with the Food Service Manager, it was noted that numerous flying insects were observed in food production, food serving areas, food storage areas (dry storage and walk-in refrigerator), 3 compartment sink area, and dish machine area. Approximately 15 - 20 individual observations were made in these areas. It was noted during the tour that exit door located near the 3-compartment sink area was wide [redacted] and covered with [redacted] plastic sheets that did not fit the door [redacted] properly. There were numerous gaps in the door opening the would allow pests to enter the kitchen area. The Food Service Manager stated that the pest control in the main kitchen is an on-going problem. Interview with the Director of Maintenance and review of the last 6 month service by the contracted pest control company revealed that the kitchen areas are serviced on a regular basis, but there was no documentation of on-going issues in the main kitchen. Class III	N 110	At a minimum, a bi-monthly schedule will be maintained by the Pest control company to ensure the kitchen will be free from pests. A daily check will be conducted by the Food Service Director or designee to monitor for pests in the kitchen area. The Maintenace Director and Administrator will incorporate kitchen rounds in to their rounds schedule. Two blue lights designed to attract flyes were added to the kitchen area.	[redacted]

3/18/16

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N 111	Continued From page 9	N 111		
N 111 SS=E	[redacted](2), FAC Physical Environment - Specifics The facility shall provide: (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (b) Clean bed 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 [redacted] belonging to the resident will 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 [redacted] it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior in 4 (1 East, 1 West, 2 East, and 2 West) of 4 Resident Units. The findings included: During an [redacted] tour conducted on [redacted] at 10:05 AM and 1:00 PM accompanied with the Administrator, Engineer Director, Director of Nursing and [redacted] Director, the following concerns were noted: 1.) 1 East Wing: a. [redacted]- The wooden [redacted] was scratched and chipped.	N 111	(a) [redacted] entrance [redacted] has been fixed.	3/18/16

AHCA Form 3020-0001
STATE FORM

Jorge Caballero

6899 S4XQ11
AOHCA

3/18/16

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N 111	Continued From page 10 b. [redacted] - The area on the floor around the sink had missing and cracked tile. There was a hole in the floor near the sink. c. [redacted] - The paint on the [redacted] was peeling. There was not a trash can in the [redacted]. The second bed ' s dresser/night stand was scratched and worn. d. [redacted] - The mirror above the sink was desilvering, black spots. The wall under the television had paint peeling and was scratched. The bottom of the [redacted] was rusted. e. [redacted] - The tiles on the floor near the [redacted] were cracked. The [redacted] was in disrepair with scratches and gauges out of the wooden door. The only existing mirror at the sink was desilverizing, black spots. The tile on the [redacted] was uneven, slightly higher than the tile on the floor of the [redacted] the doorway to the [redacted]. f. Corridor [redacted] Rails- The wooden wall railing throughout the 1 East Wing was in disrepair with deep scratches and scuffs. g. Storage [redacted] #[redacted]- An unlocked supply [redacted] the hallway contained 10 cases of [redacted] feedings ([redacted] and fibersource), as well as [redacted] feeding supplies. h. Soiled utility [redacted]- contained overflowing trash in bins and trash on the floor. i. Community shower- displayed a call bell [redacted] wrapped around the [redacted] rail.	N 111	(b) [redacted] sink has been repaired and cracked tile replaced. (c) [redacted] has been painted and a trash can has been placed in the bath [redacted]. The bed dresser has been replaced. (d)Room 119 mirror above the sink has been replaced. Wall area under the television has been fixed and painted. (e) [redacted] floor tiles near the [redacted] been replaced, bath room door has been fixed. The mirror by the sink has been replaced. (f) Corridor [redacted] rails in 1 East Wing have been painted. (g) Storage [redacted] #[redacted] has been locked and appropriate staff given a key. (h)Building Service Staff and Clinical Staff have been in serviced in proper trash disposal in Soiled Utility. (i) All [redacted] were loosened and or replaced to be hanging by the floor Staff [redacted] in-serviced.	

ADM

3/18/16

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N 111	Continued From page 11 j. Kitchen Pantry- four dirty " wet floor " signs were stored on the floor next to the countertop. The refrigerator and freezer gaskets were full of dirt and debris. k. 1East Activity [redacted]-The wooden entry doors were in disrepair with deep scrapes and scuffs. The [redacted] walls had peeling paint. l. Storage [redacted]- had a loose door knob and dirty floor. 2.) 1 West Wing: a. [redacted]- The door jam ' s paint was chipped, and the floor at the door was chipped. The railing/bumper guard displayed the [redacted] outside of [redacted]. b. Shower [redacted]- contained [redacted] bottles of shampoo (2), mouthwash, lotion and wet paper towels. c. [redacted]- The entry door was scraped. The wall of bed 2 displayed 2 [redacted] picture hangers and scrapped walls. There was a chair with torn cushions. The air conditioner vent was rusty. d. Medication carts- 3 of 3 trash cans were observed full of waste products with no cover. 3.) 2 East: Hallway Corridors- The corridor handrails throughoutwere worn. a. [redacted]- The wooden [redacted] board and [redacted] board of beds B and C were in disrepair with scratches and scrapes. A hole was noted in the wall in the [redacted]. The night table of bed 1 is in disrepair.	N 111	(j) Wet floor signs have been removed from Pantry. House Keeping staff inserviced. Signs moved to Janitors closet. (k) 1 East Activity [redacted] have been repaired. (l) Lock has been replaced and floor cleaned. (a) [redacted] door jam's was filled and painted. The rail bumper guard has been fixed. (b)[redacted] shampoo bottles removed, mouthwash removed, wet paper towels removed staff in-serviced to discard all items from shower when finished bathing a resident (c) [redacted] entry door has been fixed, the wall of the bed has been repaired and painted, [redacted] picture hangers removed and wall fixed, cushions discarded and A/C vent rust fixed. (d) Medication waste covers purchased and installed. Staff in serviced on waste level and disposal. (a)[redacted] Wooden [redacted] boards B and C have been replaced. The hole in the [redacted] been fixed. The night table of bed 1 has been replaced.	[redacted]

Jorge Carballo ADM 3/16/16

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N 111	Continued From page 12	N 111		
	b. [redacted]- The entry door was scrapped. The baseboard behind bed B was dirty and chipped. The night table for bed C was dirty.		(b) [redacted] door has been fixed baseboard behind bed B cleaned and painted. Night table for bed C has been cleaned.	
	c. [redacted]- There were staples and nails in the walls. The baseboard under the window had black stains. There were numerous [redacted] holes in the floor tile in the [redacted].		(c) [redacted] staples and nails removed the wall was painted. Floor tiles in the [redacted] been replaced.	
	d. [redacted]- The [redacted] door is chipped and the wall behind bed B is scratched. The corner guard is [redacted].		(d) [redacted] Entry door fixed, wall behind bed B fixed, corner guard fixed.	
	e. [redacted]- The walls had paint peeling. The night table of bed A was in disrepair.		e) [redacted] Walls fixed and painted, night table bed A has been replaced.	
	f. [redacted]- The overbed table ' s [redacted] were peeling paint.		f) [redacted] The overbed table was replaced.	
	g. [redacted]-The [redacted] ' s door frame was rusted. The tub was soiled.		(g) [redacted] [redacted] frame was fixed and painted. The bath tub was cleaned.	
	h. [redacted]- The wall behind bed A had paint peeling.		(h) [redacted] wall behind bed A was fixed and painted.	
	i. Clean Linen Doors- were in disrepair and the handle was falling off.		(i) Clean Linen doors handle fixed, doors fixed.	
	j. 2 East Dining [redacted]/Activity [redacted]-The entry door to the [redacted] chipped.The air vents were dusty, and the walls paint was peeling.		j) 2 East Dining [redacted] [redacted] entry fixed and painted, air vents cleaned and walls painted.	
	4.) 2 West Wing:			
	a. [redacted]- The [redacted] has missing tile.		(a) [redacted] [redacted] tiles fixed.	
	b. [redacted]- The [redacted] has missing/broken tile. The [redacted] was		(b) [redacted] [redacted] fixed, tiles replaced. Baseboard was fixed. Soiled wheelchair removed and cleaned.	[redacted]

Jorge Caballero ADM 3/18/16

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N 111	Continued From page 13 uneven with the [redacted]. A soiled wheelchair was observed in the [redacted]. The baseboard was loose. c. [redacted]- baseboard outside of [redacted] exposed. d. Shower [redacted]- toilet seat was loose. The shower [redacted] call light was too short. e. Pantry [redacted]- had personal belongings, a jacket, and more than 4 purses. f. 2 West Activity [redacted]- wall paper was bubbled. The window sills were stained. During an interview directly following the [redacted] tour on [redacted] at 2:00 PM with the Administrator, Engineer Director, [redacted] Director, all of the findings above were acknowledged. Further interview 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 course/in service on how to report housekeeping/maintenance. The Administrator stated that only recently was a quality assurance tool developed and implemented for housekeeping/maintenance. Class III	N 111	(c)[redacted] baseboard outside [redacted] repaired. (d)Shower [redacted] seat was fixed, call light [redacted] was replaced. (e)Staff in-serviced in all floors not to place personal belongings in Pantry [redacted]. (See in-service) (f)2 West Activity [redacted] paper has been fixed window sills replaced. All other facility [redacted] in common areas have been assessed and all nessesary repairs have been completed. To ensure continued compliance, the Director of Maintenancewill maintain a preventative maintenance manual with a log for daily rounds. In addition the ADM will make weekly rounds to observe Maintenance and Housekeeping provided.	3/18/16
N 201 SS=D	[redacted](1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate	N 201	1- Resident #269 went to a urologist appointment on [redacted] and came [redacted] with orders to remove [redacted].	

ADMINISTRATOR

3/18/21

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N 201	Continued From page 14 health care and protective and support services, including social services; [redacted] health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the appropriate provision of [redacted] care for 1 of 1 residents reviewed for [redacted] wounds. (Residents #46), as evidenced by failing to perform [redacted] care in a manner to prevent the potential for contamination of the wounds for Resident #46; and failure to reassess the need for a [redacted] and [redacted] consult for 1 of 1 sampled residents (Resident #269), reviewed for [redacted] Use. The findings included: Review of the facility policy for Handwashing/Hand Hygiene states in part, 'Employees must wash their [redacted] for at least fifteen (15) seconds using [redacted] or non-antimicrobial soap and water under the following conditions: Before and after changing a dressing'. The Procedure states: 'Vigorously lather [redacted] with soap and rub them together, creating [redacted] to all surfaces, for at least fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature'. Review of the facility policy for [redacted] Care documents the Steps in the Procedure for non-disposable supplies to include: Wipe reusable supplies with [redacted] as indicated (i.e.	N 201	Continue from page 14 [redacted] was discontinued on [redacted]. (see order and progress note attached) 2- Staff was educated on ensuring that residents who enter the facility without an indwelling [redacted] are not catherized unless the resident's condition demonstrates that catherization is necessary. (see attendance signing sheet attached) 3- Restorative assessment form was updated to reflect residents that are admitted with [redacted] and the [redacted] with proper follow up. Restorative Nurse educated on the need for assessment of all residents that are admitted to the facility with an indwelling [redacted] for proper follow up and care plan. 4- An audit was conducted of all current residents in the facility to ensure proper follow up appointments have been scheduled for the residents without a [redacted] to support an indwelling [redacted]. (See attached)	

3/18/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	A. BUILDING: _____ B. WING _____	02/18/2016

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

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N 201	Continued From page 15 outsides of containers that were touched by unclean [redacted], scissor blades etc.) 1) Resident #46 was admitted to the facility on [redacted] with hospital admissions on [redacted] through [redacted] and [redacted] with a readmission [redacted] to the facility on [redacted]. Review of the clinical record revealed Resident #46 was admitted with a [redacted] to the sacral area, an unstageable [redacted] heel [redacted] and a suspected deep [redacted] to the right heel. On [redacted] at 10;30 a.m., with the consent of the resident, observation of [redacted] care was commenced with [redacted] Care Registered Nurse, Staff A. With the assistance of an aide, the resident was repositioned to his [redacted] side and the adult brief was removed. It was observed there was no dressing on the sacral [redacted]. The [redacted] was noted to be the size of 2 quarters placed side by side with a smaller [redacted] the approximate size of a dime below and to the right of the larger [redacted]. The wounds were observed to be draining a [redacted] amount of [redacted]. Staff A removed her gloves, washed her [redacted] for 10 seconds and donned new gloves. She then poured sterile normal saline on a wad of gauze and proceeded to cleanse the wounds with initially a dabbing motion and then a swiping motion over the entire wounds. She dabbed the wounds with dry gauze. She then removed her gloves, washed her [redacted] for 4 seconds and donned new gloves. She squeezed [redacted] wound care ointment in a medication cup and with a [redacted] depressor placed the ointment on the wounds in a swiping motion. She then picked up another wad of gauze and with her gloved [redacted] touching the side of the gauze that was going to be in contact with the [redacted], she placed the	N 201	Continue from page 15 5-A weekly audit will be conducted by DON or designee of all residents with a [redacted] to ensure the proper [redacted] are in place for the use of [redacted] and orders for attempts of removal from MD are in place for those that are not necessary. 1-[redacted] care nurse was provided with 1:1 education on proper [redacted] care procedure to prevent [redacted] and avoid cross contamination to include proper handwashing with return demonstration. (see attendance sheet attached) 2-Competency validation of dressing changes was performed on both [redacted] care nurses to ensure compliance. (see competencies attached) 3-Weekly [redacted] observations to be done by DON or designee for the next three months to ensure proper [redacted] care procedure is being followed, reports will be taken to QA monthly. (see sample observation attached)	[redacted]

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N 201	Continued From page 16	N 201		

gauze over the wounds and secured with an Omni fix dressing. She then removed her gloves, did not wash her [redacted], and dated the outside of the dressing. She then donned new gloves without washing her [redacted] and repositioned the resident's [redacted] on a pillow to have access to the [redacted] heel. She removed her gloves, washed her [redacted] for 6 seconds, donned new gloves and with scissors cut off the Kling wrap dressing over the [redacted] heel. The [redacted] heel [redacted] was observed to be an unstageable [redacted]. She placed the used scissors on the clean [redacted] care supply field and without removing her gloves, washing her [redacted] and donning new gloves, she cleansed the [redacted] heel [redacted] with sterile normal [redacted] and dried the area with dry gauze. In reaching for the dry gauze, the plastic bag containing [redacted] ointment sitting on the clean field, fell on the floor. She proceeded to pick up the plastic bag off the floor and placed it [redacted] on the clean [redacted] care supply field. She then took a box of gloves sitting on the clean [redacted] supply field and placed the box on the resident's bed next to the [redacted]. She then removed her gloves, washed her [redacted] for 4 seconds and donned new gloves. She placed the [redacted] ointment 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 [redacted] on the clean field and with a [redacted] depressor placed the [redacted] ointment on the [redacted], covered the [redacted] with a wad of gauze and secured with Kling wrap. She then removed her gloves, dated the outside of the dressing and washed her [redacted] for 5 seconds. She then proceeded to place the box of gloves sitting on the bed next to the resident's [redacted], on the [redacted] supply clean field. She donned new gloves and with the same scissors she used to remove the dressing from the [redacted] heel, cut off the

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dressing on the right heel and placed the scissors [redacted] on the clean field next to a clean wad of gauze. She then placed the [redacted] ointment on the right heel [redacted] with a [redacted] depressor however did not cleanse the [redacted] first. She removed her gloves, washed her [redacted] for 3 seconds, donned new gloves and picking up the wad of gauze sitting next to the used scissors on the clean field, placed the gauze over the right heel [redacted] and secured with Kling wrap. Using the same scissors she cut a piece of the Omni fix dressing and secured the Kling, placed the previously used scissors [redacted] on the clean field, placed the Omni fix dressing over the Kling wrap and dated the dressing. She closed up the red biohazard garbage bag, took her gloves off and washed her [redacted] for 6 seconds. She took the bag out of the [redacted], came [redacted] in, washed her [redacted] for 5 seconds and proceeded to pick up the paper package of clean gauze and box of Omni fix tape holding them to her body then put them [redacted] on the clean field. She then went out of the [redacted] returned with another red biohazard bag and placed some of the used supplies in the bag then picked up the paper package of gauze, Omni fix tape, and ointments, placed them on a white foam tray and placed the box of gloves that had been sitting on the resident's bed, on top of the supplies and took the biohazard bag out of the [redacted]. She then returned [redacted] to the [redacted], removed her gloves and washed her [redacted] for 5 seconds. She then took the box of gloves now sitting on top of the supplies and put it in the rack above the sink, picked up the ointments, paper package of gauze and Omni fix tape, went to the [redacted] care treatment cart, and placed the supplies [redacted] into the cart. Returning [redacted] to the [redacted] went to the sink and rinsed the scissors for 4 seconds under running wate[redacted] them in a paper

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towel, returned to the [redacted] 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 [redacted] care had been rendered in the Treatment Record.

On [redacted] at approximately 4:00 p.m. the Director of Nurses was apprised of the [redacted] 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 [redacted] care in the past, with no issues identified.

2. Record review revealed Resident #269 was admitted to the facility on [redacted] with an indwelling [redacted] with the indication of "[redacted] retention" noted in the Physician Orders. A follow up Physician's progress note does not address the resident's [redacted] status, a [redacted]/plan nor if the resident has an indwelling [redacted] present. The Nursing note entry's only mention the indwelling foley [redacted] twice; once in the admission note and the second time in a nursing entry dated [redacted]. No nursing entries show that the physician was contacted to discuss the follow up care or plan related to the resident's indwelling [redacted]. No [redacted] consults had been made to address the resident ' s urological status

The Minimum Data Set (MDS) reveals that the resident has a [redacted] (BIMS) summary score of 15, which indicates Resident #269 as able to be interviewed and [redacted] intact. In addition, the [redacted] and [redacted] shows an indwelling [redacted] catheter is present.

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N 201	Continued From page 19 Record review revealed two care plans addressing [redacted] status were initiated, however, a plan, other than to keep [redacted] bag below [redacted] level, is not indicated. On [redacted] at 1:43 PM, the ADON (Assistant Director of Nursing) stated that the reason for [redacted] is [redacted] Retention and that this is an acceptable [redacted]. She stated that there should be follow-up regarding the [redacted] in the chart but was unable to find any indication regarding the plan to assist the resident in the [redacted] of her [redacted] function. She stated that they have morning meetings and clinical meetings regarding residents to discuss care and concerns; however, this was not identified. The ADON stated that they need to contact the doctor and make a follow up [redacted] appointment and if indicated, attempt to remove the [redacted]. The ADON acknowledged the lack of documentation throughout the chart and that she too could not see a clear picture of the plan of care. On [redacted] at 2:53 PM in an interview with the 1 East Desk Nurse stated that the resident has the [redacted] for [redacted] retention and thinks the resident may have a doctors appointment but is not sure and could not locate any additional information. She stated that she was not sure as to what the Physician ' s plan is for the resident. In an interview on [redacted] at 2:47 PM with Staff C, she stated she is not sure why the resident has an indwelling [redacted] [redacted] and does not know what the plan is, if any. On [redacted] the Resident #269 was observed several times during the day at Physical Therapy and in her room with the indwelling [redacted] [redacted]. At 2:58 PM the resident stated she had a good	N 201		[redacted]

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N 201	Continued From page 20 day and upon surveyor inquiry regarding the Indwelling [redacted] she stated they put it in in the hospital because she was having difficulty [redacted]. However, she is not sure what they are doing about it now and has not seen the doctor or a [redacted] regarding it since she has been discharged from the hospital. On [redacted] at 4:18 PM, the ADON confirmed that a follow up appointment had been made which was confirmed by the surveyor in calling the Physician's office to verify. The resident had been scheduled on [redacted] and the receptionist stated upon surveyor inquiry that the resident would be seen on [redacted] if the facility were willing to pay for the visit. She was going to contact them [redacted] and make them aware. The DON was notified. On [redacted] at 10:30 PM in an interview with the DON, Administrator and Corporate Consultant, they acknowledged that Resident #269 should have had the Indwelling [redacted] looked into and its necessity evaluated. The Administrator stated that they were keeping the [redacted] appointment and paying for it through the facility. The DON acknowledged that best practice would have been to follow up with the MD and do a trial, if indicated or set up an appointment with the Urologist earlier if indicated but understood that a plan for the continued use of the [redacted] was not in place. Class III	N 201		
N 203 SS=E	[redacted](1)(n), FS Right to be Treated with Dignity The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive	N 203		

Jorge Caballero ADM 3/18/16

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N 203	Continued From page 21 a written statement and an [redacted] explanation of the services provided by the licensee, including those required to be offered on an as-needed basis. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were treated with dignity with respect for their individuality and preferences for 1 out of 1 sampled residents (Resident #265) as evidenced by failure to include Resident #265 in preferred activities, as assessed upon admission; failure to provide activities of daily living (ADL) to include nail care and shaving for 1 out of 1 residents (Resident #46), reviewed for ADL care; and failure to address residents in a respectful manner on the second floor east wing during dining observation. The findings include: Review of the facility policy titled Quality of Life - Dignity, states, 'Residents shall be assisted in attending the activities of their choice...' Resident #265 was admitted to the facility on 01/20/16 with diagnoses to include [redacted] and Dysphagia, requiring a [redacted] feeding [redacted] for nutrition and hydration. 1. Review of the initial Activity Assessment dated [redacted] completed by an Activity Assistant, documents the current activity interests of Resident #265 include Exercise, Being Outdoors, Watching TV, Movies and Music. The Summary/Program includes, Resident will receive appropriate structured group programming to enhance and/or maintain his or her level of socialization and interaction with others. Resident will be escorted to and from activities as needed.	N 203	1)Resident was assigned to a sensory stimulation program in a [redacted] group of 5 to 8 residents and in smaller time increments to better meet the residents [redacted] needs.	[redacted]

Admin

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N 203	Continued From page 22 On [redacted] between 11:00 a.m. through 2:00 p.m. multiple observations were made of Resident #265. On each observation, the resident was observed in her [redacted] in bed with her night gown on, facing the overhead TV which was not turned on. The [redacted] were turned off and the window drapes were pulled closed. At 2:30 p.m. the resident was observed in her [redacted], in bed, having [redacted] feedings [redacted] via [redacted], next to the bed. She remained in her nightgown facing the TV which was not turned on and the [redacted] remained off and window drapes closed. Review of the resident's clinical record revealed she receives [redacted] feedings via feeding [redacted] starting at 2 PM and concluding at 6 AM for a total of 16 hours per day. Review of the 1st Floor Activity Calendar revealed the scheduled activities on [redacted], which Resident #265 was assessed as having interest in, to include at 10:45 a.m. Move & Groove Your Body Exercise; at 2:30 p.m. Creative Art; and at 4:00 p.m. a group watching of a TV show. Review of the Sensory Stimulation Attendance record received from the Activity Director on [redacted] documents on [redacted] the resident participated in Group activity (no time was documented), however Resident #265 was observed to be in bed as noted during observations, in her nightgown facing the overhead TV which was not turned on. Review of the Activity Participation record documented on [redacted] the resident was watching TV. On [redacted] at 10:00 a.m. Resident #265 was observed to be up in a wheelchair in street clothes parked between the 2 beds opposite her	N 203	2) Audit was conducted of all active residents to insure that the activities that are being provided are adequate with their cognition and functional status in order to improve their quality of life. (Audit form attached) 3) To ensure that all resident are attending the proper activities based on their evaluation Staff was in-service on new activity calendar and a list of residents with their assign activities area will be provided weekly to nurse coordinator. (staff in-service attached) 4) Daily rounds will be conducted by activities director or designee to ensure attendance and any absenteeism will be communicated immediately to IDT for further intervention. If any resident doesn't wish to participate on any [redacted] day their assigned activities an activity staff member will provide appropriate activities in [redacted].	[redacted]

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N 203	Continued From page 23 bed. She was observed to be facing the over [redacted] TV however, the TV was not on. The lights were out and the window curtains were closed. On [redacted] at 11:19 a.m. Resident #265 was observed sitting in the same spot, with the TV still not on. The lights were out and the window curtains were closed. On [redacted] at 1:30 p.m. Resident #265 was observed in her [redacted] in the same spot with 2 nurses at her side working on connecting the [redacted] feeding. On [redacted] at 3:11 p.m. Resident #265 was observed in her [redacted] in the same spot. The TV was on for the resident in the next bed however Resident #265 could not see it from her vantage point. The overhead TV above Resident #265 remained off. Review of the Sensory Stimulation Attendance record received from the Activity Director on [redacted], documents on [redacted] the resident was in her [redacted] no activity indicated. Review of the Activity Participation record documented on [redacted] the resident received sensory stimulation, listened to music, and was read to. Resident #265 was not observed to have moved from the spot between the 2 beds opposite her bed. On [redacted] at 10:00 a.m. Resident #265 was observed in her [redacted] bed in her nightgown. The lights were out and the window curtains were closed. On [redacted] at 11:00 a.m. Resident #265 was observed in her [redacted] bed in her nightgown. The overhead TV was not on. The lights were out and the window curtains were closed. On [redacted] at 12:15 p.m. Resident #265 was observed remaining in bed, in her nightgown with the TV not on. The lights were out and the	N 203		

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window curtains were closed.
On [redacted] at 2:15 p.m. Resident #265 was observed remaining in bed in her nightgown with the TV not on. The lights were out and the window curtains were closed.
Further, observation was made on [redacted] at 2:20 p.m. of the Activities Director walking down the first floor hall recruiting residents to participate in an interactive singing activity on the first floor outside patio.
On [redacted] at 3:00 p.m. Resident #265 was observed remaining in bed, in her nightgown with the TV not on. Resident #265 was not included in the singing activity on the outside patio.

Review of the Sensory Stimulation Attendance record received from the Activity Director on [redacted] at 3:20 p.m., documents on [redacted] no interaction. Review of the Participation record on [redacted] documents no interaction.

Review of the 1st Floor Activity Calendar revealed the days activities on [redacted], which Resident #265 was assessed as having interest in, to include, 10:45 a.m. Morning Stretch; at 2:30 p.m. Sing-A-Long and at 4:00 p.m. a group watching of a TV show.

On [redacted] at 10:00 a.m. Resident #265 was observed in bed in her nightgown. The TV was not on and the lights were off and window curtains closed.
On [redacted] at 10:45 a.m. Resident #265 was observed in her [redacted] in a wheelchair next to her bed. The TV was not on, the lights were out and the window curtains drawn.
On [redacted] at 1:27 p.m. Resident #265 was observed in her [redacted] in a wheelchair next to her bed. The TV was off and facing the other way; the lights were out and the window curtains

Jorge Carballo ADMIN 3/18/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	A. BUILDING: _____ B. WING _____	02/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 203	Continued From page 25	N 203		

drawn. A nurse and an aide were observed in the [redacted] the resident of the door bed [redacted] into her bed. The nurse stated they are getting the resident [redacted] to bed so she can start the [redacted] feeding.

Review of the 1st Floor Activity Calendar revealed the days activities on [redacted], which Resident #265 was assessed as having interest in, to include at 10:45 a.m. Sit & Fit Exercise.

On [redacted] at 3:20 p.m. an interview was conducted with the Activity Director who stated they have a "Stim" 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 [redacted] are visited in their [redacted] at least 3 times a week and they will turn on the TV for them if they can't get out of the [redacted]. She stated they target people that really need it because they can't participate themselves so they take them to entertainment, take them outside and do word games with them. She stated residents with [redacted] are not eliminated from group activities. She stated Resident #265 has "something" done every day however, Resident #265 was not observed from [redacted] through [redacted] to be out of her [redacted], participating in any group exercise or music activities that were observed to be attended by other [redacted] residents that did not have [redacted] feeding [redacted] and who did not have the [redacted] feedings commencing at 2 PM in the afternoon.

2) On [redacted] at 11:30 a.m. Resident #46 was observed in his [redacted] bed. His fingernails on both of his [redacted] were observed to be long with the right [redacted] worse, with long jagged sharp edges and a black unknown [redacted] observed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 203	Continued From page 26 under the nails of his right [redacted] and a thick yellowish spongy [redacted] under the [redacted]. Additionally, the resident looked like he had not been shaven for a few days. The [redacted] on his [redacted] was noted to be very fragile with multiple [redacted] and scratches on both [redacted]. An inquiry was made if he had [redacted] scratched himself with his long [redacted] and he stated his [redacted] 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 [redacted]. Review of the clinical record revealed Resident #46 was initially admitted to the facility on [redacted] with hospital admissions on [redacted] through [redacted]; and [redacted] with a readmission [redacted] to the facility on [redacted]. On [redacted] at 9:51 a.m. the resident ' s [redacted] on both [redacted] remained long and jagged with the black [redacted] remaining under the right [redacted] and the thick yellowish spongy [redacted] under the [redacted]. He remained unshaven. On [redacted] at 3:15 p.m. the resident was observed in his [redacted] bed. He stated the last time he had a shave was last Thursday while in the hospital and he is waiting for a [redacted] aide (name of aide) to come tomorrow and he knows that she will shave him and cut his [redacted]. His nails were observed to still be long, jagged with the blackish [redacted] under the right [redacted] and his [redacted] with the thick spongy [redacted] under his nails. The resident stated (name of aide) will help him tomorrow. Review of the Certified Nursing Assistant	N 203		

Jorge Castillo
ADMin
3/16/16

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N 203	Continued From page 27 Tracking Form for [redacted] 2016 and [redacted] 2016 revealed under 'Personal Hygiene' documentation the resident was receiving assistance with ADLs (activities of daily living) to include shaving every shift. Additionally under Nail Care there was no documentation the resident's long [redacted] nails were being addressed. On [redacted] at 11:15 a.m. during an interview with Resident #46, observation was made of his [redacted] which had now been manicured and his [redacted] had been shaven. The resident stated an aide cut his [redacted] and gave him a shave yesterday as he held out his right [redacted] stating 'They look pretty good don't they?' 3) Upon dining observations in the 2E dining [redacted] [redacted] at 12:38 PM during tray delivery, it was noted that residents were being referred to by the staff as "feeders" and identified according to their [redacted], not their name. For example, Staff J was heard announcing out loud from inside the 2E dining [redacted] Staff K, who was out in the hallway next to the tray cart, "she is [redacted]" as she pointed to a resident. In return, Staff K stated loudly [redacted] 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 [redacted] those who were listening, "who are the other feeders?" On [redacted] at 1:18 PM, Staff K was observed delivering a tray into [redacted] tray. As she exited, she was heard asking loudly, "Is 201A is a feeder?, as the Certified Nursing Assistant (CNA) entered the [redacted] her. At 1:22 PM she was heard in the hallway saying, "202B is a feeder".	N 203		

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N 203	Continued From page 28 In an interview on [redacted] at 12:52 PM, Staff K stated that a feeder is someone who needs 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." Class III	N 203		
N 407	400.141(1)(i), FS Dietary Services Every licensed facility shall comply with all applicable standards and rules of the agency and shall: (i) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by attending physicians. In making rules to implement this paragraph, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined that the resident approved menu was not being followed. The findings include: During the observation of the lunch meal service in the main kitchen on [redacted] at 11:30 AM accompanied with the Administrator it was revealed that the approved menu was not being as evidenced by the following:	N 407	The dinner menu was adjusted for [redacted] to ensure the residents received adequate [redacted] 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. A consultant Dietitian and new CDM were hired to assist with plan of correction and implement systems issues to ensure compliance.	[redacted]

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N 407	Continued From page 29 1) Observation of the Chicken Enchilada revealed that it appeared to be an egg roll appetizer (2 rolls per serving). Further review revealed that the packaging box was labeled "Chicken Egg Rolls". Further investigation of the box revealed documented Nutrition Facts that 1 egg roll contained only 8 grams of [redacted] which [redacted] at 1.6 grams of [redacted] per resident serving. Interview with the Food Service Manager at the time of the observation revealed that he was unaware that the approved menu entree [redacted] serving to the residents did not meet the 4 ounce (28 gram) portion and only 16 grams (2 ounce) of entree [redacted] was being served. Interview with the Administrator at the time of the observation revealed that the entree being served was not a chicken enchilada. 2) Observation of the lunch tray line revealed that the 4 ounce of salad was not prepared for all 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	N 407	The Dietary staff was in-serviced on following the menu with proper portions and menu extensions. Daily monitor by the Food Service Director or designee will be conducted to ensure the approved menus are followed each day.	3/18/16

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N 407	Continued From page 30 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. Class III	N 407		
NZ815 SS=C	[redacted]; [redacted](2); [redacted] FS Background screening; prohibited offenses [redacted] Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and	NZ815	The RCHH policy was reviewed with the HR Manager and Department Heads. All employees are required to have an AHCA Level II. A reference check will also be obtained. If a former employer is not willing to comply with a reference check request, this information will be added in the employee file.	[redacted]

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NZ815	Continued From page 31	NZ815		

explanation of the conviction at the time of license application.
(e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor screening may be retained by the contractor ' s employer or the licensee.

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under [redacted] (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person ' s [redacted] to the Federal Bureau of Investigation for a national criminal history record check unless the person ' s [redacted] are enrolled in the Federal Bureau of Investigation ' s national retained print [redacted] notification program. If the [redacted] of such a person are not retained by the Department of Law Enforcement under s. [redacted] (2)(e) and (h), the person must submit [redacted] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [redacted] to the Federal Bureau of Investigation for a national criminal history record

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check. The [redacted] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print [redacted] 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 [redacted]. Until a specified agency is fully implemented in the clearinghouse created under s. [redacted], the agency may accept as satisfying the requirements of this [redacted] 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 [redacted], the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. [redacted] and this [redacted];
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this [redacted] using forms provided by the agency.

(3) All [redacted] must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. [redacted] and this [redacted], and the qualifying or

ADM
3/8/16

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disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee ' s behalf.

(4) In addition to the offenses listed in s. [redacted], all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an [redacted] awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo [redacted] or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) [redacted] 409.920, relating to Medicaid provider fraud.
(d) [redacted], relating to Medicaid fraud.
(e) [redacted] 741.28, relating to domestic violence.
(f) [redacted], relating to attempts, solicitation, and conspiracy to commit an offense listed in this [redacted].
(g) [redacted], relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(h) [redacted], relating to false and fraudulent insurance claims.
(i) [redacted], relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(j) [redacted], relating to fraudulently obtaining goods or services from a health care provider.

Jorge Caballero
AHCA
3/17/16

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(k) [redacted] 817.505, relating to patient brokering.
(l) [redacted] 817.568, relating to criminal use of personal identification information.
(m) [redacted], relating to obtaining a credit card through fraudulent means.
(n) [redacted] 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
(o) [redacted], relating to forgery.
(p) [redacted], relating to uttering forged instruments.
(q) [redacted] 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
(r) [redacted], relating to uttering forged bank bills, checks, drafts, or promissory notes.
(s) [redacted], relating to fraud in obtaining medicinal drugs.
(t) [redacted] 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled [redacted], if the offense was a felony.
(u) [redacted], relating to racketeering and collection of unlawful debts.
(v) [redacted], relating to the Florida Money Laundering Act.

If, upon rescreening, a person who is currently employed or contracted with a licensee as of [redacted], 2014, and was screened and qualified under ss. [redacted] and [redacted], has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received

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by the agency no later than 30 days after receipt of the rescreening results by the person.

(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on [redacted], 2010, who has been screened and qualified according to standards specified in s. [redacted] or s. [redacted] must be rescreened by [redacted] 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:
(a) Individuals for whom the last screening was conducted on or before [redacted], 2004, must be rescreened by [redacted], 2013.
(b) Individuals for whom the last screening conducted was between [redacted], 2005, and [redacted], 2006, must be rescreened by [redacted] 31, 2014.
(c) Individuals for whom the last screening conducted was between [redacted], 2009, through [redacted], 2011, must be rescreened by [redacted], 2015.

(6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees

Jorge Carballo ADMIN 3/18/16

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may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.

(7)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this [redacted] and who:
1. Does not have an active professional license or certification from the Department of Health; or
2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification.
(b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this [redacted] and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.

(8) The agency and the Department of Health may adopt rules pursuant to ss. [redacted](1) and 120.54 to implement this [redacted], chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [redacted] pursuant to s. [redacted](2).

(9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this [redacted], terminates the

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FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100811	A. BUILDING: _____ B. WING _____	[redacted]

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
NZ815	Continued From page 37 person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. [redacted] 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 notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any [redacted] person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any [redacted] person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. [redacted]. (b) If an employer becomes aware that an employee has been [redacted] for a disqualifying offense, the employer must remove the employee from contact with any [redacted] person that places the employee in a role that requires	NZ815		

3/18/16

PRINTED: [redacted]
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	A. BUILDING: _____ B. WING _____	02/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
NZ815	Continued From page 38 background screening until the [redacted] is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. [redacted]. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with [redacted] persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including [redacted] if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or [redacted] for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was [redacted], regardless of whether or not that person has filed for an exemption pursuant to this chapter. [redacted] Definitions.-For the purposes of this	NZ815		

3/18/16

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	A. BUILDING. _____ B. WING _____	02/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
NZ815	Continued From page 39 chapter, the term: (2) " Employee " means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on interview and employee record review, the facility failed to ensure the Human Resources Personnel conducted employment reference checks and/or initiated a new Agency for Health Care (AHCA) Level II background screening pursuant to chapter 435 that must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under Chapter 435, for 4 out of 10 employee records reviewed (Staff E, F, G, and H);Whose responsibilities may require him or her to, provide personal care or services directly to residents. The findings include: On [redacted] at 11 AM employee record reviews revealed the following documentation: 1) Staff E, a Licensed Practical Nurse, hire date- [redacted] and an AHCA Level II background screening eligibility determination date as [redacted]. 2) Staff F, a Certified Nurse Assistant, hire date- [redacted] and an AHCA Level II background screening eligibility determination date as [redacted]. 3) Staff G, a Registered Nurse, hire date- [redacted] an AHCA Level II background screening eligibility determination date as [redacted]. 4) Staff H, a Certified Nurse Assistant, hire	NZ815		

Jose Castillo ADN 3/18/16

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100511	A. BUILDING: _____ B. WING _____	02/18/2016

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

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NZ815	Continued From page 40 date- [redacted] and an AHCA Level II background screening eligibility determination date as [redacted]. On [redacted] at 11:15 AM employee record review revealed Staff E, F, G, and H's job applications each documented a list of previous employers whom they worked for between the dates of their AHCA Level II background screenings and their hiring date the facility. A review of the facility's Purpose and Policy for Reference Checks issued by Human Resources and effective as of [redacted] indicates "RCHH obtain additional applicant-related information that helps determine the applicant's overall employability, ensuring the protection of the current people, property, and information of the organization." Further review of the facility's policy on Reference Checks indicates "Effective immediately, reference checks are to be conducted on every job applicant and the Reference Check template must be utilized." (Copies of policy obtained). On [redacted], the employee record review of Staff E, F, G,and H's files found no documentation that indicates verification of reference checks conducted on their former places employment. In an interview with the Director of Human Resource on [redacted] at 11:30 AM she confirmed there were no reference checks conducted for Staff E, F, G and H. On [redacted] at 11:45 AM, an interview was conducted with the Administrator and the Director of Human Resource. They acknowledged the error of failing to not follow their policy on job reference checks and not initiating a new AHCA Level II background screening for employees who	NZ815	The RCHH policy was reviewed with the two HR Managers. All employees have had a reference check and are on their file.	[redacted]

3/18/16

PRINTED: [redacted]
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	A. BUILDING: _____ B. WING _____	02/19/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
NZ815	Continued From page 41 have had a 90-day gap between employment. Unclassified	NZ815		

AHCA Form 3020-0001
STATE FORM [redacted] S4XQ11 If continuation sheet 42 of 42

3/18/16

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

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

RE: Recertification & Relicensure Surveys

Dear Administrator:

On [redacted], 2016 through [redacted], 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 only receive this faxed report.**

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than [redacted], 2016.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL [redacted]
Phone:(561) [redacted]; Fax:(561) [redacted]
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
[redacted].com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed [redacted], **2016** if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on [redacted], **2016** if substantial compliance is not achieved by that time.

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

Informal Dispute Resolution:

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

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

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

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

Thank you for the assistance provided to the representative. If you have questions, please contact this office at (561) [redacted].

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

R6WB