To:15614965924 :9549817229 # 2/2

#666 P ----

15:30 PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING 105021 02/18/2016 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC 1200 N 35TH AVE HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION F 000 INITIAL COMMENTS F 000; This plan of correction constitutes our written allegation for compliance for An unannounced Recertification survey was the deficiencies cited. Our submission conducted on the state of the s of the Plan of Correction is not an admission that the deficiency exists or Requirements for Long Term Care Facilities. that one was cited correctly. This plan (a) DIGNITY AND RESPECT OF F 241; of corrections submitted to meet SS=E INDIVIDUALITY requirements established by state and The facility must promote care for residents in a federal laws. 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 falled to ensure residents were treated with dignity with respect for their individuality and preferences for 1 out of 1 1)Resident #265 was assigned to a sampled residents (Resident #265) as evidenced by failure to include Resident #265 in preferred sensory stimulation program in a activities, as assessed upon admission; failure to group of 5 to 8 residents and in smaller provide activities of daily living (ADL) to include time increments to better meet the nail care and shaving for 1 out of 1 residents residents needs. (Resident #46), reviewed for ADL care; and fallure to address residents in a respectful Resident #46 was provided with nail care manner on the second floor east wing during dining observation. and was shaved, Staff provided with education on ADL including nail care The findings Include: and shaving (see signing sheet attached) Review of the facility policy titled Quality of Life -Dignity, states, 'Residents shall be assisted in attending the activities of their choice...' Staff was provided with education on addressing residents with dignity and respect, (see attendance sheet attached) Resident #265 was admitted to the facility on LABORATORY DIRECTORS OR PRODUPERISUPPLIES REPRESENTATIVES SIGNATURE

AD H

AD H

5614965925

ADMINISTRATOR Any deficiency statement ending with an astraix (1) denotes a deficiency which the institution may be excusted from correcting providing it is determined that other safequards provides sufficient protection to the patients. (See instructions.) Except for cursing homes, the findings stated above are deliciosable bit described by days following the date of survey whether or not a plant of correction is provided. For running homes, the above findings and plants of correction are deliciosable to the facility. It deficiencies are closed, an approved plant of correction is revokable to the facility. It deficiencies are closed, an approved plant of correction is revokable to the facility. It deficiencies are closed, an approved plant of correction is revokable to the facility. It deficiencies are closed, an approved plant of correction is revokable to confinued

FORM CMS-2567(02-99) Previous Versions Obsoleto

Event ID: S4XQ11

Facility ID: 100811

If continuation sheet Page 1 of 49

18/16

(XB) DATE

2/1

#668 P.

From:FLORDA AGENCY HEALTH

6614965925 15:30

DEPARTMENT OF HEALTH					APPROVED
CENTERS FOR MEDICARE				OMB NO).
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DAT	TÉ SURVEY MPLETED
	105021	B. WING			/18/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HILLS, LLC	1	1200 N 35TH AVE HOLLYWOOD, FL 33021		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
nutrition and hydratic 1. Review of the hill completed documents the curre Resident #265 inclut Watching TV, Movie Summary/Program in appropriate structure enhance and/or maila socialization and hill will be escorted to ar On bubble to be the social control of t	ses to include and a late (leeding of or on one of the control of or one of	F2		ed of all active t the activities d are adequate d functional ove their quality ttached) sidents are ctivities based on vere in-service on far and a list of igned activities service attached) a education on ith dignity and	

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Event ID: \$4XQ11

Facility ID: 100811

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

ADHINISTEATON

From:FLORDA AGENCY HEALTH M/M/MM 15:30 #666 P. PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. A RISEDING B. WING 105021 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES
[EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION] PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX TAG PREFIX F 241 Continued From page 2 F 241 Review of the Sensory Stimulation Attendance record received from the Activity Director on 4) Daily rounds will be conducted by activities director or designee to ensure documents on the resident attendance and any absenteeism will be participated in Group activity (no time was communicated immediately to IDT for documented), however Resident #265 was further intervention. observed to be in bed as noted during observations, in her nightgown facing the overhead TV which was not turned on. Review of If any resident doesn't wish to the Activity Participation record documented on day their participate on any the resident was watching TV. assigned activities an activity staff at 10:00 a.m. Resident #265 was member will provide appropriate On the at 10:00 a.m. Resident #265 was observed to be up in a wheelchair in street activities in clothes parked between the 2 beds opposite her bed. She was observed to be facing the over In adition, DON, designee, Nurse TV however, the TV was not on. The lights Supevisor and Administrator or were out and the window curtains were closed. designee will observe during daily at 11:19 a.m. Resident #265 was On I observed sitting in the same spot, with the TV still rounds, all residents remaining in their not on. The lights were out and the window lengthly periods without curtains were closed.
On at 1:30 p.m. Resident #265 was observed in her in the same spot with 2 nurses at her side working on connecting the receiving stimulation activities. Any findings will be reported to the Activities Director. On and at 3:11 p.m. Resident #265 was observed in her in the same spot, The TV was on for the resident in the next bed however Resident #265 could not see it from her

documented on the resident received proficus versigna Obsoleis
for glaballe FORM CMS.2587/

In her

vantage point. The overhead TV above Resident #265 remained off. Review of the Sensory Stimulation Attendance record received from the Activity Director on , documents on the resident was no activity indicated.

Review of the Activity Participation record

Event ID: \$4XQ11

ADMU

. Facility ID: 100811

et Page 3 of 49

11/11

:9549817229

To:15614965924 :9549817229

11/11

From:FLORDA AGENCY HEALTH 5614965925 ME/M/MMM 15:30 #668 P. PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: A. BUILDING _ 02/18/2016 105021 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 241 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 at at a.m. Resident #265 was observed in her at 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 bed in her nightgown.
The overhead TV was not on. The lights were out and the window curtains were closed. On 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. 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 the 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. at 3:00 p.m. Resident #265 was On I 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 Attendence record received from the Activity Director on at 3:20 p.m., documents on no interaction. Review of the Participation record on

Review of the 1st Floor Activity Calendar revealed the days activities on which Resident FORM CMS-2587(02-48) #10 forse Carballo

documents no interaction.

Facility ID: 100811 ADHU

EVENT ID: S4X011

sheet Page 4 of 49

3/18/16

11/11

From:FLORDA AGENCY HEALTH 5614965926 16:31 #668 P. PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING _ 105021 B. WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INPORMATION) (XS) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 241 . Continued From page 4 F 241 #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. 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. at 10:45 a.m. Resident #265 was observed in her to her bed. The TV was not on, the lights were out and the window curtains drawn, On I at 1:27 p.m. Resident #265 was observed in her to be in a wheelchair next her bed. The TV was off and facing the other In a wheelchair next to way; the lights were out and the window curtains drawn. A nurse and an alde were observed in the the resident of the door bed into her bed. The nurse stated they are getting the resident to bed so she can start the feeding. Review of the 1st Floor Activity Calendar revealed the days activities on which Resident #265 was assessed as having interest in, to include at 10:45 a.m. Sit & Fit Exercise. On tale 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 stated are visited in their seeds at least 3 times

Facility ID. 100811

If continuation sheet Page 6 of 48

To:15614965924 ;9549817229

From:FLORDA AGENCY HEALTH

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#688 P./

PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 105021 B. WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX YAG COMPLETION F 241 Continued From page 5 F 241 entertainment, take them outside and do word games with them. She stated residents with are not eliminated from group activities. She stated Resident #265 has "something" done every day however, Resident #265 was not observed from through to be out observed from through to be out of her participating in any group exercise or music activities that were observed to be attended by other residents. The did not have the feedings and who did not have the feedings commencing at 2 PM in the attemporer. 2) On at 11:30 a.m. Resident #46 was observed in his were observed to be long with both of his worse, with long Jagged sharp the right observed to be long. edges and a black unknown I observed under the nalls of his right and a thick yellowish spongy under the last a Additionally, the resident looked like he had not been shaven for a few days. The observed multiple and screening scratched inquiry was made if he had and he stated his black and he stated his scratched 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 resident stated he thinks he is going to get shaved 'lodgy' and maybe in a day or two they will cut his "A eview of the clinical record revealed Resident 446 was initially admitted to the facility on "A with hospital admissions on "A with a readmission to the facility on with a readmission to the facility on the facility on the same with a readmission to the facility on the facility of the facility on the facility of the facility on the facility of the facil On and at 9:51 a.m. the resident's on John remained long and remai

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Event ID: S4XQ11 ADMIL

, Facility ID: 100811

sheet Page 6 of 49

15:31 #668 P.MM/

ATEMENT D PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS A. BUILDINI	PLE CONSTRUCTION	(X3) DA	TE BURYEY
		105021	8. WING			
	PROVIDER OR SUPPLIER LITATION CENTER A	HOLLYWOOD HILLS, LLC	- 1	STREET ADDRESS, GITY, STATE, ZIP CI 1200 N 36TH AVE HOLLYWOOD, FL 33021	DDE	
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F 241	Continued From pa jagged with the bla the right spongy spongy He remained unsha	remaining under and the thick yellowish under the	F 24			TALLED TO SERVICE STREET, STRE
	observed in his time he had a shav the hospital and he (name of aide) to c that she will shave nalls were observed the blackish thick spongy	ome tomorrow and he knows him and cut his second. His d to still be long, jagged with				,
	Tracking Form for 2016 revealed under documentation the assistance with ADI include shaving ever Nail Care there was	led Nursing Assistant 2016 and				
	with Resident #46, which has his had been saide cut his yesterday as he held 'They look pretty go	5 a.m. during an interview observation was made of his d now been manicured and haven. The resident stated an all and gave him a shave d out his right stating od don't they?				;
	delivery, it was note referred to by the st according to their re	t 12:38 PM during tray d that residents were being aff as "feeders" and identified om number, not their name.				!
M CMS-26	37(Provibus Versighs) Min Fo	cilly ID: 100611 If o	cominuation short	st Page 7 of

15:31 #668 P.

		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED FORM OMB NO	APPROVED
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		105021	B. WING			02	18/2016
NAME OF PROVIDER OR S	UPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
		HOLLYWOOD HILLS, LLC			DLLYWOOD, FL 33021		
PREEIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	x	PROVIDER'S PLAN OF CORRECTING ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	COMPLETION DATE
loud from it is who was ou in he is who was ou in he is whose which is he is who was out in he is whose who is whose who he is whose who he is whose who he is whose whose who he is whose whose whose whose whose whose whose whose whose who is whose w	e, Staff sside the staff K sta ent name they are they are they are to were to the tray into the Cer they are they a	J was heard announcing out 226 dning Staff K, hallway next to the tray cart, as she pointed to a resident, state loudy sea at Staff J, as to include Resident \$270 c feeders'. Staff K then asked into cart into the dning staff to the dning cart into the dning cart into the dning cart into the dning staff to the dning		241			
because "I" SS=D RELATED: The facility services to practicable well-being of this RECU by: Based on in	nat is who provided in the pro	ovide medically-related social maintain the highest , maintail, and psychosocial	F:	250	A grievance was done for Resider regarding Dentures, Glasses and Hearing Aid unanswered requestions are on Examination or everage with the season of the sea	its. le m improve n both	
A		F/ 5)Hu-		(See attached Forms)	sation shee	Page 8 of 4

To:15614965924 ;9549817229

From:FLORDA AGENCY HEALTH 5614965926

16:32 #668 P.

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		AND HUMAN SERVICES			PKINIE	M APPROVED
		& MEDICAID SERVICES				0. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		105021	B. WING			2/18/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		1290 N 36TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	 (EACH DEFICIENCY 	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHA CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION CATE
	Resident #118) of 1 for social services. The findings include During an interview #118's designated h on a service #118's designated h on a service #118's designated h on a service #118's designated h on previous cocassis specific self membe socie with Staff i, in She also stated because #118's designated h one month ago socie with Staff i, in She also stated the one month ago stated because #118's designated h one month ago wanted. Resident's dentures, it was a self-was a self-w	ical services that included irring, and vision for 1 sampled residents reviewed id: conducted with Resident eath care surrogate (HCS) 17 PM, I was revealed that sting dentures, glasses, and cocial services multiple times ons, but does not recall a res name. She stated that she the business office "today", ause of the facility called approximately stated they cleaned the they cleaned the they cleaned the services are delayed. The facility called approximately that is not what the HCA to that is not what the HCA to have denoted they cleaned they cleaned they cleaned they cleaned they considered and state of the facility she facility called and plasses on the services are delayed. The services are delayed to the facility she full plasses on the services are delayed. The services are delayed to the facility she full plasses on the services are delayed to the facility she full plant that the services are delayed. The services are delayed to the facility she full plant that the services are delayed to the facility she full plant that the services are delayed. The services are delayed to the facility she full plant that the services are delayed. The services are delayed to the facility she full plant that the services are delayed. The services are delayed to the facility she full plant the services are delayed. The services are delayed to the facility she full plant the services are delayed. The services are delayed to the facility she full plant the services are delayed. The services are delayed to the services are delayed to the services are delayed. The services are delayed to the services are delayed to the services are delayed. The services are delayed to the services are delayed to the services are delayed. The services are delayed to the services are delayed to the services are delayed. The services are delayed to the	F 2:	Resident was seen by Hearing ———————————————————————————————————	d for wax	

To: 15614965924 ;9549817229

From:FLORDA AGENCY HEALTH 5614966925

15:32 #668 P.

		AND HUMAN SERVICES & MEDICAID SERVICES				03/10/2016 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE COME	SURVEY PLETED
		105021	B. WING		02/1	18/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021		
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F 250	Continued From pa	ge 9	F 250			
	did come to the bus did come to the turn about dentures, bus about dentures, bus about dentures about dentures. Social Services Dir were in the middle of th	ad that Resident #198 HCS intess office to inquire again unities office to inquire again and glasses. Staff I dident #118° LAC to see the sctor on Monday because they of a survey. with the Director of Social or of Nursing on the sctor of Social Services offices, office and the school of the sch		An audit of all active Residents was conducted by Social Service Direct ensure that no other Resident was identified with hearing, vision or without proper follow up. To ensure compliance, QA Commwill audit sample charts of resident identified with having vision hearing and without proper follow up. To ensure compliance, QA Commwill audit sample charts of resident identified with having vision hearing and with related concerns. Facility assess the need for hearing with safety for up and with the province related communicating any moted it to Social Services immediately for follow-up.	ittec is ng ty will ion,	
:		o a grievance, make a hearing ent and contact Resident				

FORM CMS-2507(

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Event (D; S4XQ11

Facility ID: 190811 ADMINISTERTOR

3/18/16

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From:FLORDA AGENCY HEALTH 5614965925 16:32 #668 P. PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 9 WING 02/18/2016 105021 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION (X4) ID PREFIX TAG F 250 F 250 Continued From page 10 examination dated that stated "patient for surgery. Glasses is not a will not improve vision..." 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 ______, ___ consult second opinion dated _____, and for a hearing appointment, on at 11:00 AM, , and a resident dated grievance/complaint for dentures, glasses, and hearing dated was When questioned about follow up with Resident #118 dentures and . When questioned vision appointment, the Director of Social Services stated there was no follow up and no appointment made at this time. She stated the 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 at 3:30 PM, the Director provided documentation of "evecare examination" dated 11/5/2015. She stated that when she called to make an appointment they informed her that revealed that glasses would not improve patients vision due to the presence of in both "Documentation also provided with

FORM CMS-2567/ Jorgantalle

services dates from a Services company with appointment dates at 11:00 AM, and at 11:00 AM. The Director of Social Services stated she

would give Resident #118 HCA a call to inform

at 11:00

ID. S4XQ11

Facility ID. 100011 MOMIN

est Page 11 of 49

3/18/14

PRINTED: 03/10/2016

RE & MEDICAID SERVICES (X1) PROVIDENSIBPLIENCIA IDENTIFICATION NUMBER: 105021 R AT HOLLYWOOD HILLS, LLC TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFICATION THE clinical record or Resident It was noted an admission that included and admission that included a	(X2) MULTI A BUILDI B. WING ID. PREFIX TAG	STREET ADDRESS, CITY, STATE, DP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021 PROVIDERS PLAN OF CORRECT (LOCH CORRECTIVE ACTION SHOUL CROSS-REFERENCE) DEFICIENCY)	ILO BE COMPLETE
AT HOLLYWOOD HILLS, LLC TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Dage 11 The clinical record or Resident If was noted an admission that included and Anorexia realed the resident is	ID PREFIX TAG	1200 N 35TH AVE HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ION (X5)
AT HOLLYWOOD HILLS, LLC TATEMENT OF DEFICIENCIES EVY MUST SEE PRECEDED BY FULL LISE DESIRT PRINCIPLES DESIRED FOR MATION) Deage 11 If he clinical record or Resident If was noted an admission that included the first of a state of a state.	PREFIX	1200 N 35TH AVE HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ION (X5)
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CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) page 11 fine clinical record or Resident it was noted an admission that included an admission that included an admission and Anorexia.	PREFIX	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILO BE COMPLETE
f he clinical record or Resident it was noted an admission that included of atus. And Anorexia realed the resident is	F 20	50	
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SEKEEPING &	F 25	53	
rovide housekeeping and ices necessary to maintain a			na
ation and interview conducted is determined that the facility busekeeping and maintenance y to maintain a sanitary, intable interior in 4 (1 East 1			
led:		į	
the Administrator, Engineer of Nursing and			
		1. (a) entrance	has
		been fixed.	i
area on the floor around the		(b) sink has been repa and cracked tile replaced.	ired
A S C S C S C S C S C S C S C S C S C S	vices necessary to maintain a and comfortable interior. ENT is not met as evidenced atton and interview conducted as determined that the facility ousskeeping and maintenance by to maintain a sanitary, ortable interior in 4 (1 East 1 12 West) of 4 Resident Units. dedc: I tour conducted on 5 AM and 1:00 PM the Administrator, Engineer of Nursing and and 1:00 PM the Administrator, Engineer of Nursing and and 1:00 PM the Administrator, Engineer of Nursing and and 1:00 PM the Administrator, Engineer of Nursing and and 1:00 PM the Administrator, Engineer of Nursing and and 1:00 PM the Administrator, Engineer of Nursing and 1:00 PM the Administrator, Engineer of Nurs	vices necessary to maintain a and comfortable interior. ENT is not met as evidenced as determined that the facility observed that the facility of the facility	ices necessary to maintain a and comfortable interior. ENT is not met as evidenced and on a substantial interior and conformable environment. ENT is not met as evidenced as determined that the facility observes play and maintenance y to maintain a sanitary, orderly and conformable environment. ENT is not met as evidenced as determined that the facility observes play and maintenance y to maintain a sanitary, orderly and conformable environment. ENT is not met as evidenced environment. Services are provided to maintains sanitary, orderly and conformable environment. ENT is not met as evidenced environment. Services are provided to maintains sanitary, orderly and conformable environment. Services are provided to maintains sanitary, orderly and conformable environment.

/ 16:93 #668 P. 16:93

		AND HUMAN SERVICES			1	NTED: FORM APPROVED
		& MEDICAID SERVICES				B NO. 0938-0391
STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION	P	COMPLETED
		105021	B. WING_			02/18/2016
NAME OF PROVIDER OR	SUPPLIER		T	STREET ADDRESS, CITY, STATE	, ZIP CODE	
REHABILITATION CE	NTER AT	HOLLYWOOD HILLS, LLC		1200 N 36TH AVE HOLLYWOOD, FL 33021		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE THE APPROPRIA	E COMPLETION TE DATE
hole in the	issing an floor nea	id cracked tile. There was a r the sink.	F 25	53		
was peelin stand was d. deslivering	g. There the second check of the second check	paint on the was not a trash can in the ond bed 's dresser/night d and worn. mirror above the sink was solution. The wall under the peeling and was cratched.		(c) has been plant trash can has been plant. The bed dresse replaced. (d) mirror been replaced. Wall a television has been fin	aced in the bat r has been above the sink rea under the	h : has
was in disre the wooder sink was de	were epair with door. The esilverizing was to	clies on the floor near the cracked. The scratches and gauges out of the only existing mirror at the garage before the one of the control of the scratches and the doorway to the cracket of the scratches and the doorway to		(e) been the been the been the by the sink has been the by the by the sink has been the by the by the sink has been the by	eplaced, bath ixed. The mire	ror
f. Corridor throughout deep scrate	the 1 Eas	ils- The wooden wall railing st Wing was in disrepair with scuffs.		(f) Corridor rails have been painted. (g) Storage have # ha	s been locked	
the hallw feedings (ay contail ding supp			and appropiate staff giv (h)Building Service Sta Staff have been inservice trash disposal in Soiled	ff and Clinical ed in proper	
trash in bins	and tras	- contained overflowing in on the floor.		attached) (i) All pull pull been loosened and Hou	sekeeping	
wrapped are	ound the			Department Director h serviced staff on keepin and untied.		
ORM CMS-2587(02-99) Previou	s yerslans O	backflay Event ID: S4XQ11	F	scilly ID; 100011	If continuation s	heet Page 13 of 49

APM -

3/18/12

15/100

■-B-B; ■: ■ : From: To:15614965924

From:FLORDA AGENCY HEALTH 5614965926 15:33 P.019/096 PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER: A RISH DING 105021 A WANG 02/18/2016 STREET ADDRESS, CITY, STATE, 2IP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE F 253; Continued From page 13 F 253 (i) Wet floor signs have been removed were stored on the floor next to the countertop from Pantry. House Keeping staff The refrigerator and freezer gaskets were full of inserviced. Signs moved to Janitors dirt and debris. closet, (Staff in-serviced) (k) 1 East Activity k. 1East Activity The wooden entry doors were in disrepair with deep scrapes and scuffs. been repaired. The walls had peeling paint. (i) Lock has been replaced and floor I. Storage #1- had a loose door knob and cleaned. dirty floor 2.) 1 West 2.) 1 West Wing:
a. The door jam's paint was chipped, and the floor at the door was chipped. The (a) door jam's was filled and painted. The rail bumper guard has been fixed. ralling/bumper guard displayed the use outside (b) shampoo bottles removed, mouthwash removed, wet paper towels b. Shower contained bottles of shampoo (2), mouthwash, lotion and wet paper removed staff in-serviced to discard all used items after residents shower. entry door has been

- The entry door was scraped. The wall of bed 2 displayed 2 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.

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

the night table of bed 1 has been replaced.

(c)

fixed

painted.

(a)

level and disposal.

fixed, the wall of the bed has been

repaired and painted, mail picture hangers removed and wall fixed,

cusheons discarded and A/C vent rust

(d) Medication waste covers purchased and installed. Staff inserviced on waste

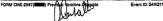
Hallway corridors have been fixed and

and C have been replaced. The hole in

Wooden wow boards B

been fixed. The

ion sheet Page 14 of 49 3/18/16



Facility ID: 100611 ■Mîn

1 / 1

#656 P.

From:FLORDA AGENCY HEALTH

6614965925

16:33

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC 1200 N 35TH AVE HOLLYWOOD, FL 33021 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) co F 253 Continued From page 14 F 263 b. The entry door was scrapped. The baseboard behind bed B was dirty and chipped. (b) door has been fixed. The baseboard behind bed B cleaned and The night table for bed C was dirty. painted. Night table for bed C has been walls. The baseboard under the window had holes in - There were staples and nails in the cleaned. (c) staples and nails removed black stains. There were numerous the wall was painted. Floor tiles in the been replaced. d. The door is chipped and the wall behind bed B is scratched. Entry door fixed wall behind bed B was fixed and corner The corner guard is guard fixed (e) Walls fixed and painted, e. The walls had paint peeling. The night table of bed A was in disrepair. night table bed A has been replaced. - The overbed table 's were (f) The overbed table was peeling paint replaced. (g) frame was g. ______-The _____ rusted. The tub was soiled. 's door frame was fixed and painted. The bath tub was - The wall behind bed A had paint (h) behind bed A was fixed and painted. (i) Clean Linen doors handle fixed doors I. Clean Linen Doors- were in disrepair and the fixed. handle was falling off. (i) 2 East Dining door entry fixed and painted, air vents cleaned and walls paitned. 4.) 2 West Wing: (a) tiles fixed - The has missing fixed, tiles replaced. Soiled wheelchair removed and cleaned. FORM CMS-2687(P) P Event ID: S4XO11 Facility (D: 100811 ation sheet Page 15 of 49 ADKIN 3/18/14

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Il continuation sheet Page 16 of 49 3/18/16

From:FLORDA AGENCY HEALTH

661496502K

	501-	05025	75:34	#668 P
DEPARTMENT OF HEALTI CENTERS FOR MEDICAR	AND HUMAN SERVICES			PRINTED: FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. (X3) DATE SURVEY COMPLETED
	105021	B. WING		
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	02/18/2016 DE
REHABILITATION CENTER A			1200 N 35TH AVE HOLLYWOOD, FL 33021	
	Yement of deficiencies I must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	
F 253: Continued From pa missing/broken tile. uneven with the was observed in the loose. c	The was	F 25	(c)Room 225 baseboard outsi was repaired.	de III
e. Pantry — ha Jacket, and more the same part of the same	- wall paper was bubbled, as slained, as slained, as slained, as slained as 2:00 PM with gineer Director, or, all of the findings above Further interview revealed is for staff reporting broken ed to be repaired, the gresponded that each box in which work orders trieves them daily. The g stated that the staff isself as the staff is staff in the staff in the staff is staff in the sta	F 314	(d)Shower was replaced. (e)Facility staff in-serviced no personal belongings in Pantry (f)2 West Activity been fixed window stills replace All other facility in in on areas have been assessed and an essessary repairs have been or To ensure continued complain Director of of Maintenance wimaintain preventative mainter manual with a log for daily row make weekly rounds to obser Maintenance and Housekeepi provided by facility.	t to place paper has ed. mmon ill mpleted. cce, the ill nance ands.
Based on the compret resident, the facility mu	ensive assessment of a ust ensure that a resident	!		

Event ID: \$4XQ11

ADMLNISTING

1 / 1

FROM:FLORDA AGENCY HEALTH

5614965925

15:34

#668 P. 100/100 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 105021 A WING 02/18/2016 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC 1205 N 35TH AVE HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX TAG PREFIX (XS) MPLETION F 314; Continued From page 16 F 314 who enters the facility without sores unless the 1. Resident # 46 was not affected by cited care procedure as evidenced by individual's clinical condition demonstrates that heal resolved, they were unavoidable; and a resident having improved and right heal sores receives necessary treatment and services to promote healing, prevent improved. prevent new sores from developing. This REQUIREMENT is not met as evidenced 2- care nurse was provided with by: Based on observation, interview and record 1:1 education on proper care procedure to prevent review, the facility failed to ensure the appropriate provision of care was provided for 1 of 1 Residents reviewed for and avoid cross contamination to include proper handwashing with return (Residents #46), as evidenced by falling to demonstration. (see attendance sheet perform care in a manner to prevent the potential for contamination of the wounds for attached) Resident #46 3-Competency validation of dressing The findings included: changes was performed on both care nurses to ensure compliance. (see Review of the facility policy for Handwashing Hygiene states in part, 'Employees must wash their for at least competencies attached) 4-Weekly observations to be fifteen (15) seconds using non-more soap and water under the following conditions: Before and after changing a done by DON or designee for the next three months to ensure proper lather with soap and rub them together creating to all surface. dressing'. The Procedure states: 'Vigorously care procedure is being followed, reports will be taken to QA monthly. (see to all surfaces, for at least fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature. sample observation attached) Review of the facility policy for documents the Steps in the Procedure for non-disposable supplies to include: Wipe as indicated (i.e.

reusable supplies with outsides of containers that were touched by FORM CMS-2807 (07/08) Provious Virgons Obsoleta

Event ID: S4XQ11 Facility ID: 100911 ADMU

If continuation sheet Fa est Page 17 of 49

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wounds in a swipping neuton, she their present in another wad of gauze and with her gloved touching the side of the gauze that was going to touching the side of the gauze that was going to be in contact with the touch is her placed the Private Previous Versions Organics Associated Transfer of the Private Previous Versions Organics Associated Transfer of the Private Previous Versions Organics Associated Transfer of Transfer

motion over the entire wounds. She dashed the wounds with dry gaze. She then removed her gloves, washed her for 4 seconds and donned new gloves. She squeezed and care ointment in a medication cup and with a depressor placed the ointment on the wounds in a swiping motion. She then picked up

Facility 10: 100821 ADM Com If continuation, sheet Page 18 of 46

To:15614965924 ;9549817229

1/1

15:34 #668 P. PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIGHT INFORMATION) COMPLETION 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 issue, and dated the outside of the dressing. She then donned new gloves without washing her issue and repositioned the resident's issue on a pillow to have access to the linear three controls of the control of the with scissors cut off the Kling wrap dressing over the theel. The theel was observed to with scissors cut on the king wap dressing over the the heel. The the heel was observed to be an unstageable to see the king of the used scissors on the clean care supply field and without removing her gloves, washing her and donning new gloves, she cleansed the left heel with sterile normal saline and dried the area with dry gauze. In reaching for the dry gauze, the plastic bag containing containing on the floor. She proceeded to pick up the plastic bag off the floor and placed it on the clean supply field. She then took a box of gloves sitting on the clean supply field and placed the box on the resident's bed next to the first then removed her gloves, washed her

5614955925

washed her to seconds. Site went proceeded to place the box of gloves silting on the bed next to the resident's second on the bed next to the second on the bed next to the second on the second of the second on the second of the second on the second of the s Josephalle Eveni ID: SAXQ11 FORM CMS-2567(02-89) Previous Varsions Obsolsti

seconds and donned new gloves. She placed the 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 use scissors on the clean field and with a depressor placed the depressor placed the , covered the

and secured with Kling wrap. She then removed her gloves, dated the outside of the dressing and washed her for 5 seconds. She then

with a wad of gauze

Farálio ID: 100611

ADMINISTEASON

15:35 #668 P.024/098

		AND HUMAN SERVICES					RINTED: FORM APPRO	VED
STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONST	RUCTION		(X3) DATE SURVEY COMPLETED	_
		105021	8 WING				02/18/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET AL	DRESS, CITY, STAT	E, ZIP CODE	02/10/2010	
REHABI		HOLLYWOOD HILLS, LLC		1200 N 35 HOLLYW	TH AVE OOD, FL 33021			
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN EACH CORRECTIVE 089-REFERENCED 1 DEFICI	ACTION SHOULD TO THE APPROPE	BE COMPLET	
	dressing on the right gauze. She then play gauze. She then play gauze. She then play gauze. She then play heel play gauze. She then play heel play gauze siting the clean field, plaze dressing and secure previously used sice and secure previously used sic	le Melet, cut off the theel and placed the elsevised and the theel and placed the selsevised next to a clean wad of ceed the Melet on inferent on livith a selection was depressor anse the Melet of the selection with a selection was depressor and the selection was depressor and the gauze over the right ured with Kling wrap. Using he cut a place of the Omnifex of the Kling, placed the sort selection was depressed on the cut a place of the Omnifex of the Kling, placed the sort selection was depressed on the came melet on the clean field, and proceeded to place up the red was depended to place up the red was depended to place up the red was depressed to place up the red was depended to the cut medium and placed the depended was depressed to the place of the supplies and took the the selection was depressed to the supplies and took the the melet was then returned noved her gloves and for Seconds. She then took the the rack above the sink, his, paper package of pauze and to the Melet are went to the supplies melet on the supplies and took the the rack above the sink, his, paper package of pauze and to the Melet went						
RM CMS-266	Tem-sign freytous yarslors of	asslets Event ID: S4XQ11		actiny ID: 10081	n	if continuation	sheet Page 20 of	49
	Posall		<i>א</i> נדיון	1/20		3//8	114	

To:15614965924 ;9549817229

3/3

From:FLORDA AGENCY HEALTH

5614066026

#668 P. DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 105021 a 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX TAG F 314 Continued From page 20 F 314 the sink and rinsed the scissors for 4 seconds under running water, wrapped them in a paper towel, returned to the care 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 had been rendered in the Treatment Record. On at approximately 4:00 p.m. the Director of Nurses was apprised of the care observation of Staff A with Resident #46 to which she responded she cannot understand why Staff A did as poorly as she personally watched her perform care in the past, with no issues identified. F 315 (d) NO . PREVENT F 315 Based on the resident's comprehensive assessment, the facility must ensure that a assessment, the facility must enough an resident who enters the facility without an unless the 1- Resident #269 went to a urologist appointment on indwelling is not unless unless resident's clinical condition demonstrates that back with orders to remove was necessary; and a resident of receives appropriate was discontinued on . (see order treatment and services to prevent and progress note attached) and to restore as much normal function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, Interview and record review, the facility falled to provide follow up ca and determine the indication/necessity of

FORM CMS-2567(02-

use for 1 of 1 residents reviewed for Use (Resident #269)

> Event ID: S4XQ11 . Facility ID: 100511 ADMINISTEATON

If continuation sheet Pa eet Page 21 of 49

From	FLORDA AGENC	HEALTH		- · · · · · · · · · · · · · · · · · · ·	5:35 H668 F	
CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED FORM OMB NO	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		105021	B. WING	0		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	IP CODE	18/2016
REHAB		HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION	PRÉF TAG	TIX (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 315	admitted to the facility individual relention in A follow up Physicia address the resident plan nor if individual individ	aled Resident #269 was y on we with an with the indication of oted in the Physician Orders. 's progress note does not 's status, a the resident has an present. The Nursing niton the indiversity dated unvising ently dated now that the physician was the follow up care or plan ts indivelling	F	with proper f Restorative Nurse educ for assessment of all res admitted to the facility indwelling	facility without are not sisident's sident's s that ry. (see t atrached) int form was ents that are also and the ollow up. ated on the need idents that are with an for proper	
	resident has a [BIMS] summary soo Resident #269 as abi Intact. In: Intact. Intact. In: Intact. Int	re of 15, which indicates te to be interviewed and addition, the and s an indwelling and ed two care plans stus were initiated, however, teep bad below		4- An audit was conducturent residents in the ensure proper follow up have been scheduled for without a state of the scheduled for without a state of the scheduled for the sc	facility to composite the residents upport an conducted by residents with a the proper residents with a the proper residents with a	

She stated that there should be follow-up regarding the sin the chart but was unable to find any indication regarding the plan to assist the resident in the FORM CMS-2507(20/09 Previous/Parlson) Casoling

Event ID: S4XQ11

Facility ID: 100611 ADHINISTEATOR If continuation sheet Page 22 of 49
3/18/14

#668 P.

■-**--**:From:

15:35

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: FORM APPROVED OMB NO. CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING_ 105021 B, WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 36TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (X4) ID PREFIX COMPLETION F 315 Continued From page 22 F 315 of her 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 ADON acknowledged the lack of documentation throughout the chart and that she too could not see a clear picture of the plan of care. at 2:53 PM in an interview with the 1 East Desk Nurse stated that the resident has the for the relention 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 at 2:47 PM with Staff C, she stated she is not sure why the resident has an indexelling and does not know what the plan is, if any. the Resident #269 was observed several times during the day at Physical Therapy and in her the indwelling the indvelling the At 2:58 PM the resident stated she had a good day and upon surveyor inquiry regarding the indwelling indwelling state she stated they put it in in the hospital because she was having difficulty . However, she is not sure what they are doing about it now and has not seen the doctor or a regarding it since she has been discharged from the hospital.

that a follow up appointment had been made which was confirmed by the surveyor in calling FORM CMS-2871 (1997) Previous fedinos charful (1997) Even 10: SAXQ11

at 4:18 PM, the ADON confirmed

On E

AD MU. 100011

If continuation sheet Page 23 of 48

FORM CM5-2597(04-09) Provided Versions Officials

From:FLORDA AGENCY HEALTH 5614966925

15:36 #668 P.028/095

		AND HUMAN SERVICES			PRINTED: FORM APPROVE
STATEMEN'	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. USSO-USS (X3) DATE SURVEY COMPLETED
		105021	D. WING		02/18/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/16/2016
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC		1200 N 35TH AVE HOLLYWOOD, FL 33021	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFE TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F332 SS=D	been scheduled on stated upon survey would be seen on given willing to pay for the contact them 1921 at 102 DON, Administrator they acknowledded have had the indused have been to follow if Indicate ariser if in plan for the continue in place. This REQUIREMEN by: Based on observations and the service in	e to verify. The resident had all the receptionist and the receptionist or inquiry that the resident or inquiry that the resident if the facility were visit. She was going to and make them aware. The and Corporate Consultant, that Resident #269 should ling the locked Into bulated. The Administrator is keeping the good of the thing will be the property of the country of the count	F3:	16	e e of
	Λ				

Event ID: S4XQ11 Facility ID: 100811
ADMINESTIAL

CENT	RTMENT OF HEALTH ERS FOR MEDICARI	& MEDICAID SERVICES			FOR	D: MAPPROVE
ND PLAI	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) D.	O. 0938-039 ATE SURVEY OMPLETED
		105021	B. WING		- 1	
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0:	2/18/2016
REHAE (X4) ID		HOLLYWOOD HILLS, LLC		1200 N 36TH AVE HOLLYWOOD, FL 33021	•	
PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	TION OULD BE ROPRIATE	COMPLETION DATE
F 332	Continued From pag	ne 24				T
	The findings include	2	F 332			
į	1) On at 9: observation was comparative for practical Nurse (LP) Resident #266 was twas noted she had reviewing the Medical (Tay) for Resident interdications and plat interdications and plat interdications and plat with the plat in the plat included in the numbia divised this medical included in the numbia to be observed. Staff Resident #266's she had the Aspirin pi take.	40 a.m. medication pass dutucted with Licensed 1) Staff B for Resident #268. chosen for observation as it drops ordered. After attended to the medication of the medication of the medication cup and its sail the resident gets 35 2 fills, do you still want to on pass," Staff B was no pass observation will be red of pass observation will be red of pass of the medication of		3-All nurses were provided with education on med pass. 4 - Observations on med pass be conducted three times a week to or designee to ensure complian med pass policy and procedure next three months. Summary or observations to be reviewed with committee monthly. 5 - Resident # 264 and #268 suff adverse reactions from cited including administration of medication.	eing by DON cc of for the f h QA	
e control of the cont	conducted by review. MARS. The physician mg due at 8:30 a.m., 8:30	225 mg due due at 10 ml liquid daily dai				

To: 15614965924 ; 9549817229

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#668 P.

From:FLORDA AGENCY HEALTH

5014965925

15:36

PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING_ 105021 B. WING 02/18/2016 STREET ADDRESS. CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX COMPLETION DATE F 332 . Continued From page 25 F 332 until and at 3:40 p.m. and when asked how many pills she received during the medication pass observation on she confirmed she only received 2 pills, the and the pill. On 02/1 at approximately 4:00 p.m. an interview was conducted with the pharmacy consultant who was apprised of the medication pass observation conducted on state and Staff B failing to administer the 3 medications. due at that time. After checking his electronic medication record he confirmed those medications were not discontinued and should have been administered. He stated he could not understand why the nurse would omit those medications and they will speak with Staff B about this incident During a medication administration pass observation on the state of the state prescribed. The medication included: 0.4mg/24 hour 1 GC Staff C stated as she was getting ready to apply the newly opened that the QD. Staff C stated as she was getung ready to entry the newly opened to the previous had been removed at 7:55 AM for morning care. She then proceeded to apply the 9:17AM and then dated and initialed the Upon interview with Staff C at 10:00 AM she stated that she had not waited to remove the 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

FORM CMS-2582/

Providus Version Obsciete

Wy Washallo

Event ID:S4XQ11

Facility ID: 100811
ADMIN

If continuation sheet Page 26 of 49

3/18/12

To:15614965924 ;9549817229

From	FLORDA AGENC	Y HEALTH 6614	966928	=/====	16:36	668 P	
		AND HUMAN SERVICES				INTED: FORM A	PPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105021	B. WING		ĺ	02/1	8/2016
	PROVIDER OR SUPPLIER LITATION CENTER AT	HOLLYWOOD HILLS, LLC		STREET ADDRESS, CITY, STATE, 1200 N 35TH AVE HOLLYWOOD, FL 33021	ZIP CODE		2/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFID TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD E	E ATE	(X5) COMPLETION DATE
F 332	medication during to Upon interview with 11:12 AM he states order, been removed just placed. 3) During a medical observation on Resident #264, State administer three administer three Handheld 18 mag ex Handheld 18 mag ex	he resident did go without the heat time. In the Pharmacist, on the the Pharmacist, on the current the old the pharmacist, on the current the old the pharmacist the pharm	F 3:	32			
	inhalants should be they are in must be uniform thre	that all of the medication shaken before used because i of torm and the ingredients oughout, before ensures the resident receives					
	Medication Record, on three types of infi	niew of Resident #264's he stated that the resident is aler medications which in a specific order. He stated				1	

should be delivered in a specific order. He stated in the first type to be given is the search inhalant to be administered is the Anti Cholinergic, the Spiritual and third medication to be administered is the administered is the inhaler, the search inhalar the search i FORM CMS-2567(02-8)

Event ID: 54XQ11

Fecility ID: 100511

MOMIN

nuation shoot Page 27 of 49

3/18/16

5614965925

15:37

11/11

#668 P.

PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 105021 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 26TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIO F 332 Continued From page 27 F 332 after the hinaler the nurse should have the resident rinse their and spit it out after the hinaler. 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: dilators first and MDI's in this sequence: described of Steriods last; after Steriod, rinse and to walt one minute between puffs of the same medication and 5 minutes between different medications. F 362 483.35(b) SUFFICIENT DIETARY SUPPORT SS=E | PERSONNEL F 362 The Meal Schedule was reviewed and revised based on resident needs. The facility must employ sufficient support personnel competent to carry out the functions of The Dictary staff was in-serviced on the the dietary service. importance of following the meal schedule. Dietary staffing was reviewed and job This REQUIREMENT is not met as evidenced tasks were revised as needed to ensure that the current meal schedule/times Based on observations, interviews and record will be followed. 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: noted that the tray schedule provided for 2 East

Event

for & Carrallo

Event ID: 54X011 Feelily ID: 100011

if continuation sheet Page 28 of 49

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1/ 16:37 #668 P. PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 105021 6. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) F 362 Continued From page 28 F 362 read 11:40 AM for first tray deliver and 11:50 AM for the second lunch tray delivery. On at 12:38 PM, the first of two food carts arrived to A daily check will be conducted by the the 2 East dining hallway. Food service Food Service Director or designce in conjunction with ongoing monitor by delivery was being conducted by Staff J, K and various certified nursing assistants. At this time, the Consultant Dictitian on routine when Resident #45 was observed being moved visits to ensure the meal schedule is out the of dining second time since 11:35
AM and placed in the halfway just outside the followed. AM and placed in the nailway just ourside the dining _____, 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 ______ the hall. He inquired if the resident had eaten and if A consultant Dietitian and new CDM were hired to assist with plan of the food was good. The resident shook her correction and implement systems and stated no and continued speaking in issues to ensure compliance. 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 into the dining eat. On at 1:40 PM, Resident #60 was observed in the 2 East hallway screaming she wants lunch as she strolled 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 #119, who was sitting outside the dining since 11:35 AM, was taken via wheelchair to her set outside the dining set outside t observations revealed that the last tray was served at 2:01 PM and retrieved at 2:14 PM from the resident in On section at 8:34 AM, Staff L was observed standing with four residents in wheelchairs outside of the partially curtained off

5614965925

FORM CMS-2567(02-89) Performs Version Possolate Horse Cashallo

Event ID: S4XQ11 Facility ID; 100611 ADMa

ion sheet Page 29 of 49 3/18/16

11/11

From:FLOADA AGENCY HEALTH

5614965925

18:37

#668 P. PRINTED: 03/10/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0038-0391 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 A. BUILDING 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION F 362 , Continued From page 29 F 362 dining the 2 West Wing. Resident #186 drining the 2 veest vving. Resident #100
was observed calling out for food, "come,
come...I want food, food, "cod...". Upon surveyor
inquiry Staff L closed the dining further to obstruct the view. She stated that the residents in the hall near the elevator are waiting residents in the hair 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 the stated her tray and 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 le residents are walting and done in another wh space, out of the stream of the dining . 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 to the dining placed at the third table with two others residents who were in the midst of eating. Resident #186 then faid her 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. FORM CMS-2507 (122-88) Previous Versions Obsciego for Stable

Event ID: S4XO11

Facility ID: 109611 ADMIN

net Page 30 of 49 3/18/12

15:37 #668 P.036/095

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: 105021		A. BUILDI	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED		
		105021	B, WING		- 02/18/201		
	PROVIDER OR SUPPLIER LITATION CENTER AT	HOLLYWOOD HILLS, LLC		STREET ADDRESS, CITY, STATE, ZIP- 1200 N 36TH AVE HOLLYWOOD, FL 33021	CODE	710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	COMPLETION DATE	
F 362	Continued From pa	ge 30	F 36	52			
F 363	by the Tacility, doors who eat in their life delivery on the One 12:05 p.m. with a set 12:30 p.m. On 6271. The 12:05 p.m. with a set 12:30 p.m. On 6271. The 12:05 p.m. with a set 12:30 p.m. Don 10:01 p.m. on 6271. The 12:30 p.m. lunch cant tray deliver art trays: 12:55 p.m. both lunc delivered to the One of 12:00 p.m. both lunc delivered to the One of 12:00 p.m. both lunc of 16:00 p.m. at 1:00 p.m. at 1:0	er the funch trays did not observation of the second any was commenced however did not arrive. On the second at the cart trays had not been feast unit on the second at the cart trays had not been feast when second at the secon	F 363				
	Menus must meet the	e nutritional needs of		The dinner menu was adjus	nts received		
	dietary allowances of	the Food and Nutrition		adequate for the day	<i>r</i> .		
M CMS-258	finge Caba	Boolety Event ID: SexQ11		coustate 160011	ntinuation sheat P	ago 31 of 49	

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15:38

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#668 P.

PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLU IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING_ 02/18/2016 105021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIES 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (X5) COMPLETIC (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 363 F 363 . Continued From page 31 The current 4- week menu cycle was Board of the National Research Council, National reviewed by the Consultant Dietitian. All Academy of Sciences; be prepared in advance; and be followed. menus have been adjusted to meet minimum standards. All therapeutic and mechanically altered diet extensions This REQUIREMENT is not met as evidenced have been reviewed and revised as Based on observation, interview, and record needed to ensure all residents receive the review, it was determined that the resident correct diet as ordered. approved menu was not being followed. The Dietary staff was in-serviced on following the menu with proper . The findings include: portions and menu extensions. During the observation of the lunch meal service Daily monitor by the Food Service In the main kitchen on at 11:30 AM accompanied with the Administrator it was Director or designee will be conducted to ensure the approved menus are revealed that the approved menu was not being followed each day. as evidenced by the following: 1) Observation of the Chicken Enchilada revealed A consultant Dietitian and new CDM that it appeared to be an egg roll appetizer (2 rolls were hired to assist with plan of per serving). Further review revealed that the packaging box was labeled "Chicken Egg Rolls". correction and implement systems Further Investigation of the box revealed documented Nutrition Facts that 1 egg roll issues to ensure compliance. contained only 8 grams of which which at 1.6 grams of 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 serving to the residents did not meet the 4 ounce (28 gram) portion and only 16 grams (2 ounce) of entree was being served.
Interview with the Administrator at the time of the

the 4 cupce of salad was not prepared for all EDBM CMS.2567d forse Centallo

was not a chicken enchilada

observation revealed that the entree being served

2) Observation of the lunch tray line revealed that

Event ID: S4XQ11

Facility ID: 100811 Aprinectate If continuation sheet Page 32 of 49 3/18/16

15:38

18/10

#668 P.

To:15614965924 ;9549817229

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM MB NO	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIERICLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		105021	B. WING	_			02	/18/2016	
NAME OF	PROVIDER OR SUPPLIER			1 .	STREET ADDRESS, CITY, STATE	E. ZIP CODE			
REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC					I200 N 35TH AVE HOLLYWOOD, FL 33021				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD TO THE APPROP	96	COMPLETION DATE	
F 363	Continued From pa	ge 32	F	363					
		and mechanically altered	!		1 .				
	diets. The Food Se	rvice Manager stated that the	į.		1			i	
		ared by dietary staff and that as to which lunch menu was to			i				
		tletary staff for lunch meal			!				
	preparation.							i	
	a) Observation of the	ne lunch tray line revealed that							
	the 4 nunce serving	portion of portion of canned	İ		İ			1	
	pineapple was not p	prepared for all regular, and	1					1 .	
		he Food Service Manager			İ				
		d was not prepared by dietary was an error as to which	i		}				
		followed by the dietary staff for			1				
	the lunch preparation				!				
	4) Observation of th	e lunch tray line revealed that			}				
		e not purchased or available	ŧ		1				
		peutic and mechanically			1				
		ood Service Manager stated he dinner rolls was an error as			i			1	
		u was to be followed by the	1					1	
		h meal preparation.			i				
					!			[
		ew conducted with the Food the time of the observation of						i l	
		ice it was revealed that he			!			!	
		ree diets to be served is for						!	
		In a pureed form. The			Ì				
		are the the rice was to be			!			!	
		egetable juice and cooked ave been prepared in place of			İ				
	the salad menu iten				1			:	
F 364		TRITIVE VALUE/APPEAR,	F	364					
SS=E	PALATABLE/PREFI				i				
		ves and the facility provides ethods that conserve nutritive							

FORM CMS-2567(

Event 10: SAXQ11 Facility 10: 100611

ADMINISTRATO

16:38 #G68 P.038/095

		AND HUMAN SERVICES					APPROVED	
		& MEDICAID SERVICES	·			MB NO	. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING			(X3) DAT	'E SURVEY MPLETED	
		105021	B. WING	_		02	18/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2010	
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC			200 N 35TH AVE			
					IOLLYWOOD, FL 33021			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 364	Continued From pa	ge 33	F3	64	The facility will prepare cooked			
	value, flavor, and ar	opearance; and food that is		٠,	vegetables by methods that will con	serve	i 1	
	palatable, attractive			- 1	nutritive value, flavor, appearance		!	
	temperature.				palatability.			
		IT is not met as evidenced			The Dietary staff who prepares			
	by:			vegetables was in serviced on proj cooking methods to conserve nut				
	Based on observati	on and Interview, It was						
		facility failed to prepare by methods that conserve		1	value, appearance and palatability.			
		r, appearance; and that food			, , , , , , , , , , , , , , , , , , , ,			
	is palatable.	i, appearance, and that root		3	Ongoing monitoring by the Food	-		
	no ponsisto.			í		. }		
	The findings include:			}	Service Director or designee will be		- 1	
}	•			- !	conducted to ensure that vegetable			
	During the kitchen s			i	are cooked by methods that conser		- 1	
		led with the facility's Food		- 1	nutritive value, flavor, appearance	and :	1	
i		was noted that three		- 1	palatability.	- 1	- 1	
	pans of carrots were	observed bolling on top of		į	Ongoing monitor by the Consultar	st i	- 1	
		yor questioned why the ooked approximately 3 hours		- 1	Dietitian on routine visits will be			
		or the resident's lunch meal		i	conducted as well.	3	- 1	
	service. The Food S	ervice Manager stated that		- 1		Ì	- 1	
	vegetables are cook	ed early and some of them		í		į	- 1	
		eated for meal service. The		- 1	A consultant Dietitian and new Cl) MC	- 1	
	manager then stated	that the vegetables are then		- 1	were hired to assist with plan of	- 1	1	
1	cooled down and are	reheated/re-cooked just		- 1	correction and implement systems	. !	- 1	
		of the meal service. The		- 1	issues to ensure compliance.	1		
		loned the Food Service		1	issues to clisure compitation.	i		
i	manager and it was	discussed by the surveyor		1		Î	- 1	
	inai continued cookii	ng and heating of the carrots				i	1	
		f nutritive value, appearance, Food Service Manager		- }			- 1	
		ued cooking and reheating		1		- 1	f	
	the carrots for the lur			- !		- [1	
	Observation of the lu	nch meal by the survey team		1		1	1	
		that the carrots appeared		÷			1	
	nuncenceled and much							

overcooked and mushly in appearance. It was also rated that the majority of the lunch meals FORM CMS-2587(82-56) he visual for horse placeful.

Event 10:54

JULY WARMAN

Event ID: S4XQ11 Facility ID: 1000-Facility ID: 100011 If continuation

To:15614965924 :9549817229

From:FLORDA AGENCY HEALTH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5614966926

16:38

PRINTED: FORM APPROVED

#668 P.

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				MB NO.	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105021	B. WING			02/	18/2016
NAME OF P	ROVIDER OR SUPPLIER			\$7	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	100 N 35TH AVE		
REHABIL	ITATION CENTER AT	HOLLYWOOD HILLS, LLC		н	OLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEPICIENCY)	BE	COMPLETION DATE
E 364	Continued From pa	an 34	ε.	364			
F 304				204			
		rveyors revealed that there tion of the carrots by the		į			
F 369 SS≃D	(g) ASSISTI EQUIPMENT/UTER	VE DEVICES - EATING NSILS	F:	369			:
	The facility must pro and utensils for res	ovide special eating equipment idents who need them.					
	by: Based on observal review, it was deter provide physician o utensites (Rocker Kr sampled residents utensits.) The findings include During the observal dining noted the the lunch documented adapti Suit-up Fork, Built-	MENT is not met as evidenced snation, interview, and record telemmined that the facility failed to an ordered adaptive eating or Knife) for 1 (Resident #87), of 1 ints who require adaptive eating clude: envation of lunch meal in the main at 12:15 PM, it was unch meal card for Resident #87 appive equipment to include: suit-up Spoon, and Rocker Knife. of the residents funch meal		The state of the s	The facility will provide adaptive equipment/utensils as ordered. The Occupational Therapist alon the facility's full-time Registered Dietitian have reviewed all reside with current orders for adaptive utensils. An audit was conducted tray tickets to ensure all resident current order for adaptive eating utensil(s) are on the tray ticket in dicate to the kitchen staff whice adaptive utensil(s) are to be prove each resident.	g with ints eating of the s with a	
	revealed that she w fork, however the R The resident was ol cutting foods with it to the surveyor that Knife with meals. TI Nursing (ADON) w observation and it it to locate a Rocker I ADON stated to the	as given the built-up spoon ocker Knife was not included, beeved having difficulty le use of the fork and stated she is never given the Rocker he Assistant Director of the short of the book approximately 5 minutes (nife in the kitchen. The surveyor the the facility does t supply of the Rocker Knife.				The second secon	

FORM CMS-2567 (0)-B) Previous Ymbon Oberfly

for Sp (a hallo

Event ID: S4XQ11 Facility ID: 109611

If continuation sheet Page 35 of 49

3/18/16

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#668 P. **15:39** 5614965925 From:FLORDA AGENCY HEALTH PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 02/18/2016 105021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION
(BACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 369 F 369 Continued From page 35 During an observation of Resident #87 on at 8:50 AM it was noted that the resident An inventory was taken of all adaptive received her breakfast meal in the again the Rocker Knife was not included on the once cating utensils to ensure that any utensil that is currently ordered is available for breakfast tray. The resident again was observed oreantast 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 The Dictary staff was in serviced on meals "all of the time" and "needs the Rocker reading the trays tickets properly with Knife with meal to be able to cut foods." The emphasis on adaptive cating utensils. resident also stated that she keeps informing the Daily monitor by the FSD or designee staff that she is not receiving the Rocker Knife will be conducted to ensure all residents with meals. The Administrator was summoned to with an order for adaptive eating utensils confirmed that the the residents resident's Rocker Knife was not included on the are provided to them as ordered breakfast tray. The resident also stated to the Administrator that the Rocker Knife is not A consultant Dietitian and new CDM included with most of the meals and keeps were hired to assist with plan of informing staff that she is not receiving the correction and implement systems Rocker Knife.
On an interview was conducted with the issues to ensure compliance. 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 the physician on the physician on the physician on the physician on the physician on the physician on the physician on the physician on the physician on the physician of the ph F 372 SS=F PROPERLY

The facility must dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced

Based on observation and interview, it was determined that the facility failed to dispose of garbage and refuse properly.

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.

t2507(02-50)/Privious Vorsity p

Fecility (0: 100011 Event ID: S4XQ11 Aprilaustra

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X4) ID PREFIX TAG

NAME OF PROVIDER OR SUPPLIER

F 372 Continued From page 36

The findings include:

type 🖿

From:FLORDA AGENCY HEALTH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ring the kitchen sanitation tour conducted on

1) The ground area leading to the dumpster and around the dumpster was noted to have numerous areas of foul smelling standing

2) Other ground areas leading to the dumpster

and around the dumpster were noted to have a build-up of green algae type

3) The ground area around the dumpster was

4) The dumpster was noted to be so full that the

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

containers of trash were hanging out over the sides, in the front of the dumpster and the 2

noted to be littered with garbage and trash.

lids were not able to be closed.

the facility generates per day.

Manager the following concerns were noted

, accompanied with the Food Service

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

105021

5614965925

A BUILDING

#668 P.041/095 15:39 PRINTED: OMB NO. (X3) DATE SURVEY COMPLETED (XZ) MULTIPLE CONSTRUCTION 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XS) 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

addition and that the dumpster capacity is too to handle the amount of trash/garbage that F 431 (b), (d), (e) DRUG RECORDS, SSEE LABEUSTORE DRUGS & BIOLOGICALS

and black

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

F 431

1-Staff was in serviced on proper storage drugs and biologicals to include feeding and medications.

3/18/16

1/1

Lors Catallo

Facility ID: 100611 ADMINISTRATO

neel Page 37 of 49 If continuation s

To:15614965924 15:39

:9549817229

10/100

#668 P.

PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 105021 STREET ADDRESS, CITY, STATE, 21P CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 431 F 431 Continued From page 37 accurate reconciliation; and determines that drug records are in order and that an account of all 2-All closets containing controlled drugs is maintained and periodically feedings were locked and secured for proper storage. reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted 3-Daily rounds made by DON or designee to ensure all doors are locked professional principles, and include the appropriate accessory and cautionary and all supplies are kept in safe instructions, and the expiration date when storage. applicable. 4 - Storage # (1 East) has been In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked and appropiate staff given a locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (b) Storage ## (2 West) has been locked and appropiate staff The facility must provide separately locked, permanently affixed compartments for storage of given a key. controlled drugs listed in Schedule II of the Comprehensive Drug and and Control Act of 1976 and other drugs subject to 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 supplies.

5614965925

Costs provinces refusions Observed PORM CMS-2567(00

The findings include:

Fecility 10: 100511 ADMINISTRATOR

3/18/16

-/-

15:39 #868 P. 6614966926 From:FLORDA AGENCY HEALTH PRINTED: FORM APPROVED OMB NO, 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DAYE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIP IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 105021 NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX (X4) ID PREFIX E 431 F 431 Continued From page 38 observation on at 8:23 AM, Staff C was noted to be standing at the medication cart reviewing a she was interrupted by the DON (Director of Nursing) and 1 East Desk Manager. They Resident instructed her to enter the #264. At 8:27 AM, Staff C was ob erved 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 packages for Resident #264 in her medication book on top of the medication cart and closing it. She then walked into the the medication book on top of the medication cart. Upon surveyor intervention at 8:31 AM, she returned to the cart and retrieved the medication to begin the medication pass observation. Upon interview with Staff C at 10:00 AM she stated that she had not realized it but understood it needed to be placed in the locked cart and not accessible to others Upon interview with the DON during the morning of stated that she acknowledged she had interrupted Staff C 's process by asking her to step into the resident 's by doing so, Staff C did not follow the policy and procedure for securing medications. observation tour 2) During the conducted of the facility on 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 # (1 East) - An unlocked/non-secured supply In the

FORM CMS-2807102-66) Province Vontions Observed

Event ID: S4XQ11 Pecility 10: 100011 ADMI

shoot Page 39 of 49

3/18/16

11/11

in the facility; Grace of Provious vigitions Obsopies

to help prevent the development and and I

The facility must establish an Control

(1) Investigates, controls, and prevents

(2) Decides what procedures, such as isolation,

(a) Control Program

Program under which it -

Event ID: \$4XQ11 Facility ID: 100511 ADMINISTRATO- If continuation sheet Page 40 of 49 18/21

(a) Two utility hooks were installed one on dirty side of wash area and one on

clean side of wash area to hang

keep them off of the floor.

FORM CMS-250 TOR-80) Provided Versions Offspore

From:FLORDA AGENCY HEALTH

5614965925

15:40

PRINTED:

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		105021	B. WING			
AME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	DE	
		HOLLYWOOD HILLS, LLC		200 N 35TH AVE (OLLYWOOD, FL 33021		
REHABIL				PROVIDER'S PLAN OF COR	PECTION	(85)
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX YAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC
F 444	Cartinual Error of	neo 40	F 441			
F 441	Continued From pa should be applied	o an Individual resident; and				
	(3) Maintains a rec	ord of incidents and corrective				
				(b) The ceiling area of the c	lean wash	1
	(b) Preventing Spr	control Program	1	dryer dryer	een fixed	1
	determines that a	esident needs isolation to		and painted.		1
	prevent the spread	of states, the facility must	ļ			1
	the residen	t. st prohibit employees with a	1	(c) Laundry staff was in- se		
		or	i	the proper cleaning of Lau	ndry carts,	
	from direct contact direct contact will	with residents or their food, if		Laundry carts are being cle every use and logged, (see i		
	(3) The facility mu	st require staff to wash their		sheet)	11961 AICE	
	after each o	lirect resident contact for which	!	(d)Laundry staff was in- se	rviced on	
	professional pract	dicated by accepted		proper cleaning of lint com	partment,	
	•	•••	į	lint compartment is being		Ì
	(c) Linens	andle, store, process and	1	AM/PM by supervisor to a		
	transport linens so	as to prevent the spread of		cleaning and logging. Adm randomly is checking the d lint buildup.		
		ENT is not met as evidenced	: :			
	by:	ation and interview, it was	1			1
	determined that the	e facility failed to maintain an				1
	control p	rogram in the facility's laundry ensure that medical equipment				
	was properly sani	tized after utilization.	į			1
	The findings inclu	ded:				
	1) During observe	tion of the	f			1
	the facility launding	service area on a at	1			
	Divector, the follo	wing control issues	1			
	258 MOR-99) Previous Versio			Facility ID: 100811	continuation she	44

To:15614965924 ;9549817229

15:40 #868 P.

		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVE COMPLETED	
		105021	e, WING		02/	18/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REHABIL	ITATION CENTER AT	HOLLYWOOD HILLS, LLC		1208 N 35TH AVE HOLLYWOOD, FL 33821		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	DBE	COMPLETION DATE
F 441	Continued From pa	ge 41	F 44	1:		
	were noted:					
	the clean wash (b) Numerous (b) be peeling from the	(2) were noted to be stored in		(e)All trash cans have been replac new trash can step- on type with o lid.	ed with closing	er at agreement and the
	that the peeling pai linen. (c) Three of three is clean linens were r	nt could on resident clean aundry carts used to transport toted to have a heavy build up om of each cart, Upon	İ	(f)Vent sorrounding clean linen a cleaned and condensation was co	rea was rrected.	5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6
	interview during the that they are not cluse. (d) Observation of five commercial dn excessive build up states that the lint it provided document of three times a da documentation she	tour, the laundry staff stated paining the carts after each the lint compartment of five of yers was noted to have an of lint/trash. The Director raps are to be cleaned and lation of cleaning a minimum y. Review of the dryer cleaning trevealed the last cleaning	To be so we see window to the control of the contro	(g) No personal items are allowed linen area all personal items mus stored in lockers. Staff informed a Housekeeping Supervisor will en	be ind	
	tour, interview with that she initialed wi (e) Observation of revealed that the tr overflowing. Furthe overflowing trash w of stored clean line	the clean linen folding area ash container was full and er observation revealed that the vas coming into direct contact in.				
	and surrounding of black like like condensation that contaminate clean underneath.	age area noted that the vent eiling area had a build up of a				:
	revealed a persona	el jacket stored on a rack	i			ì
DRM CMS-2	567(02.00) Plevious Vogion			Facility ID: 100811 If continu	stion sheet 8/16	Page 42 of

15:40

14/14

#668 P.

PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. CENTERS FOR MEDICARE & MEDICAID SERVICES (K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING 8 WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIES 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFURENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG F 441 : Continued From page 42 F 441 housing clean linen (h) Observation of the door leading outside the (h) Door leading to outside door of clean clean linen storage area revealed a gap under the door. There was potential for linen storage has been repaired. rodents/animal entry as well as debris blown from , the outside inside. During a medication pass observation on
 at 8:18 AM, Staff C was observed to 2) Staff was provided with an in-service on the proper decontamination of reusable clean cuff with a Clorox Bleach equipment. (see signing sheet attached) wipe sparsely for 10 seconds and discard the wipe while she allowed the cuff dry. In addition, following resident Daily rounds to be completed by the use of the stethescope and cuff Control Nurse to ensure that with Resident #109, the reusable resident care staff is following proper procedure for equipment was not decontaminated and/or equipment. sterilized between residents, as per the facility policy titled, "Cleaning and Resident-Care Items and Equipment. Further, the manufacturer's guidelines states to wipe, by thoroughly wetting the exterior of the equipment or surface; allow the surface to stay wet for the 3 minutes and then dispose of used wipe and gloves. F 464 (9) REQUIREMENTS FOR DINING & 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 facility must provide one or more The carts with the east wing travs will designated for resident dining and activities. be brought up one after the other so These will must be well lighted; be well with nonsmoking areas identified; be adequately furnished; and have sufficient space that residents in that area can be served at the same time. No more than 17 residents will be permitted to sit in the to accommodate all activities. 5 tables designated to accommodate no more than 20 residents.

S-2607 (Provibus Versions Provides M. CO On Malle

bv:

This REQUIREMENT is not met as evidenced

Event ID: SAXQ11 Facility ID: 100811

AUM IN ISTRATOR

if continuation sheet Page 43 of 4

25 **111/11/11** 15:41 #668 P.**1110**/11

PRINTED:

		AND HUMAN SERVICES & MEDICAID SERVICES			ŗ	FORM MB NO.	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION	(X3) DAT	E SURVEY PLETED
		105021	B. WING			_	
NAME OF	PROVIDER OR SUPPLIER	10002	<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
REHABI	LITATION CENTER AT	HOLLYWOOD HILLS, LLC			N 36TH AVE LLYWOOD, FL 33021		
(X4) ID PREFIX TAG	FACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	i		,	-			,
F 464	Continued From pa		. F4	- 1 4	A new rehab dining program has		
1		tion and interview, the facility			mplemented in order to assist u		1
ł		idents had adequate space commodate them comfortably	i	1	esidents with their meals in a se	parate	1
		during the lunch meal, as	l	1	rea.		
ŀ		rvations of crowded dining		- 5	Staff educated on meal times and		ļ
		d floor East and West Wings.		1 8	ssisting residents to their assign	ed	
1	:			(lining area prior to food carts ar	civing.	3/18/16
1	The findings includ	B:	ì	1		•	. 5/10/10
	diving on the second floor residents in the din residents seated in The dining and the seated in The dining and the seated in The dining and the seated in the first table; 3 residents and three table, and the seated and the first table; 3 residents a seated and the seated and the fourth and the fourth and the fourth and the fourth and the seated and the fourth and	wheelchairs. doserved to have five 36 x s across from the nurse? s bites along the glass windows. ents in a wheelchair seated at idents seated (2 residents in a sident seated at a regular table; 4 residents seated (3 residents seated (3 residents seated (3 in wheelchairs) at the third eated (2 residents in a seident seated (2 residents in a resident seated (2 residents in pesidents seated (2 residents in pesidents seated (2 residents in seated (2 residents in seated (2 residents in seated (2 residents in seated (3 residents in seated (3 residents in seated (3 residents seated 12 residents seated 12 residents seated 12 residents seated 12 x 60 table, located by the levator. A resident was seated in the dining seated in the seated seated in the seated seated in the seated seated in the seated seated in the seated sea					
FORM CMS-2	567(02/99) Previous Verejons	Obsolete Event ID: S4XQ1			(ID: 100811 If continue	ion theel	Page 44 of 49
	Yer se Con	11-also 19.	OMV			1/8/	1/6
	/						

18/19

#668 P. 15:41 From:FLORDA AGENCY HEALTH 6614966926 PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA A BUILDING A. WING 105021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIO CON (X4) ID PREFIX 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 sealed 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 parking harking himself himself into the dining parking himself at the first table. It was noted that after the resident parked at the first table, there was a 2 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 At 12:42 PM an aide was observed pushing another resident in a wheelchair into the dining and as she was wheeling the resident into the dining asked the resident, who had the dining parked himself at the first table, to move for her so she could wheel another resident into the

request to stay at that table. profesion services for sold PORM CMS-2587/1001 Pro

the dining

dining The resident refused and another resident seated at the table was wheeled out of accommodate the resident's

Event ID: S4XQ11

Facility ID: 100011 MOMIN

ot Page 45 of 49

To: 15614965924 ;9549817229

1 / 1

From:FLORDA AGENCY HEALTH 6614965925 15:41 #668 P. PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING B. WING 105021 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES COMPLETIO (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 464 Continued From page 45 F 464 At 12:42 PM the second tray cart was observed to arrive to the second floor West Wing, Staff was observed to be bumping into each other and into residents in the dining At 12:45 PM observations revealed aides were moving residents that had not had their lunch tray from the crowded dining the hallway and the front of the elevator to be removed from the dining 1:55 PM without eating or being fed. At 1:11 PM observations revealed 9 residents seated in wheelchairs by the space to the mo the elevator and in front of the elevator waiting for their meal trays to arrive. Residents in the dining be observed by the residents parked by the elevator from this vantage point. At 1:34 PM observations revealed the aides were moving residents in and out of the dining accommodate those who had as yet not received their lunch. In addition, those residents who were removed from the dining before their lunch trays arrived were in clear view of other residents being served and eating their lunch. A new exit door has been purchased and F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST SS=D; CONTROL PROGRAM F 469; the existing air curtain that is in working order will be maintained on at all times

ORM CMS-2007 () Profision Versions Organic

The facility must maintain an effective pest

Event ID: S4XQ11 Facility ID: 100011

ADMINISTRATOr

If continueyon shoot Page 46 of 49

to minimize any potential pests from

entering the kitchen

-/-

To:15614965924 ;9549817229

From:	FLORDA AGENCY	HEALTH 6614	965926	15:41	#668 P.	
		AND HUMAN SERVICES			PRINTED: FORM / OMB NO.	APPROVEC
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		105021	B. WING		02/1	8/2016
	PROVIDER OR SUPPLIER LITATION CENTER AT	HOLLYWOOD HILLS, LLC	i	STREET ADDRESS, CITY, STATE, ZIP COD 1200 N 35TH AVE HOLLYWOOD, FL 33021	ÞΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
	and rodents. This REQUIREMEI by: Based on observal determined that the effective pest control to ensure that the a to ensure that the a to ensure that the a with the Food Servi numerous flying his production, food servi numerous flying his production, food servi numerous flying his production, food servi numerous flying his production, food servi numerous flying his production, food services are services and the services of t	that the facility is free of pests IT is not met as evidenced It is not met as evidenced It is not met as evidenced It is not met as evidenced It is not met as evidenced It is not met as the met is not as a facility failed to maintain an ol program in the mein kilchen rea was free of pests. It is not service sanitation tour It is a sold service sanitation tour It is a sold service sanitation tour It is a sold service sanitation tour It is a sold service sanitation tour It is a sold service sanitation tour It is a sold service sanitation tour It is a sold storage and walk-in refigerator), 3 It was noted during or located near the 3- rea was wide It was noted during or located near the 3- rea was wide It was noted during or located near the 3- rea was wide It was noted during or located near the 3- rea was wide It was noted during or located near the 3- rea was wide It was noted during or located near the 3- rea was wide It was noted during or located near the 3- rea was read with the fail of the read was noted and the service of the service of the service of the service of the pest control in the main the pest control in the main the service of the service o	F 469	A Pest Control company con- on-site visit to service, kitchen for any existing pests, schedule was changed from r wice a month and as needed visits are needed. At a minimum, a bi-monthly will be maintained by the Pes company to ensure the kitche free from pests. A daily check will be conduct Frood Service Director or desig monitor for pests in the kitche The Maintenace Director and Administrator will incorporat rounds in to their rounds sche Two blue lights designed to at flyes were added to the kitcher	e the entire . The nonthly to if more schedule it control en will be ed by the gene to en area.	

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, south Contains Objected FORM CMS-2567

Interview with the Director of Maintenance and review of the last 6 month service by the

Event ID: S4XQ11

Facility ID: 100811 ADHINISTRATON

If continuation sheet/Page 47 of 49

To: 15614965924 :9549817229

17/10

From:FLORDA AGENCY HEALTH 6614066026 16:42 / #668 P PRINTED: FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 105021 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX YAG PREFIX TAG COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 47 F 514 F 514 (I)(1) RES F 514 SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each 1-Staff was provided with education on resident in accordance with accepted professional proper documentation of standards and practices that are complete: accurately documented; readily accessible; and medications. (see attendance attached) systematically organized. 2-A weekly audit tool was created to The clinical record must contain sufficient information to identify the resident; a record of the ensure accuracy of all medication resident's assessments; the plan of care and documentation, audit to be conducted services provided; the results of any on a daily basis by nurse coordinators preadmission screening conducted by the State; for three months and to be turned in and progress notes. weekly to DON or designee. (see sample attached) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility falled to maintain accurate and complete clinical 3-Reports of all inaccuracies to be records as evidenced by falling to reconcile discussed in monthly O.A. medication with the Controlled Drug Record for 1 of 5 sampled residents (Resident # meetings with appropriate follow-269) reviewed for Unnecessary Medications. up needed The findings included: Review of the Controlled Record form for

every 4 hours (hrs) as needed for Review of Resident #269 's 2016
Medication Administration Record (2016) revealed 5, mg one tab was 67/02-09) Provide Vergions Officiales

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

5 milligrams (mg); one tablet (tab) by

EVONID: SYXQTI FACILITY TO HISTRIFTO Facility ID: 100811

for

1/1

#660 P.

From:FLORDA AGENCY HEALTH

5614965925

15:42

PRINTED: FORM APPROVED OMB NO. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING_ 105021 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC HOLLYWOOD, FL 33021 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG COMPLETION DATE F 514 Continued From page 48 F 514 documented as administered twice on and once on administered twice on and once on administered documented as administered. Review of Resident #269 's Controlled Drug tab was documented as administrated 4:15 PM; on tab on 1 at 4:15 PM; one tab on at 10 PM; one tab on 1 at 6:00 AM; one tab on 1 at 11 AM; one tab on 1 at 4:40 PM (in at 4:15 PM: one at at tab on the at 11 AM; one tab on the at 3:15 PM; and one tab on the at 4:40 PM for a total of eight doses of eight doses of eight doses of eight doses of eight doses of eight doses of eight doses of eight doses of eight doses of eight doses of eig on the 2016 2016 During an Interview with the Director of Nursing (DON) on a at 12:41 PM, the DON was apprised of the inaccuracy of the medication reconciliation between the and Controlled Drug Record for Resident #269. The DON confirmed that the nurses are to document all drugs given on the Controlled Drug Record as well as on the resident . .

FORM CMS-2587(02-6

Event ID: S4XQ11 Facility (D; 100811

ADMINISTRATION

If continuation sheet Page 49 of 49

3/18/16

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From:FLORDA AGENCY HEALTH 5814965925

15:42

PRINTED: FORM APPROVED

#668 P.

Agency for Health Care Adr STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA		LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			
	100611	B, WING		02/18/2016	
NAME OF PROVIDER OR SUPPLIES			STATE, ZIP CODE		
REHABILITATION CENTER A	T HOLLYWOOD HI 1200 N 35	TH AVE	021		
SIDMADY ST	TATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CORRECT!	ON (X5)	
PRESTY IFACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLI PRIATE DATE	ETE :
N 000 INITIAL COMMEN	ITS	N 000		E .	
' An unnuncunand	Re-licensure survey was	1	This plan of correction constitut		
conducted on	to solvey was		written allegation for complianc	e for the	
Rehabilitation Cer	nter at Hollywood Hills. The		deficiencies cited. Our submission	on of the	
facility had deficie	ncies at the time of the visit.	!	Plan of Correction is not an adm		
	S. C. Harris Blanching Ordon	N 054	that the deficiency exists or that		
N 054 59A-444(5), FA(C Follow Physician Orders		cited correctly. This plan of corr		
	rs shall be followed as		submitted to meet requirements established by state and federal la		
	not followed, the reason shall be esident's medical record during		established by state and lederal is	aws.	
1				:	
Based on observa review, it was dete error rate was 25, were identified wh	ule is not met as evidenced by: ation, interview and record ermined that the medication 9 percent. 7 medication errors tile observing a total of 27 ctting Resident #268 and				
The findings inclu	de:			į	
observation was of Practical Nurse (L Resident #268 wa	9:40 a.m. medication pass conducted with Licensed (PN) Staff B for Resident #268, is chosen for observation as it depends on the conduction of the conductio	or democrated a felicine considerated	1-LPN Staff B was provided with education on med pass. (see atta		16
reviewing the Med	dication Administration Record nt #268, Staff B prepared the		RECEIVED	5	
medications and	placed an pill and	1	1 8 2016	1	
etated 'it leave like	ill into the medication cup and this is all the resident gets		1 9 2010	į .	
right now, she onl	v has 2 pills, do you still want to		BY:		
observe the medi-	cation pass?' Staff B was		1131.		
advised this medi	cation pass observation will be	1		- '	
ABORATORY DIRECTOR'S OR PROV	aderisupplier reparsentative's Sig	NATURE	TITLE	(XO) PATE	-1.
boro	ze Carrallo		ADMINISTIM SOL	3//8	\mathcal{U}
TATE FORM	,	5460	\$4XQ11	leads volkunismos !!	1/0/ 42

15:42

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From:FLORDA AGENCY HEALTH

6614965926

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A SUMMATPLE CONSTRUCTION (X1) PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N STATE AVE 100811 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N STATE AVE 100811 STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N STATE AVE 100811 SUMMAN STATEMENT OF DEFICIENCES 100 N STATE AVE 100 N STATE AV							APPROVED
THE THE PROVIDER OR SUPPLIER STREET ADDRESS, DITY, STATE, ZIP CODE 1200 N ASTH AVE 1400 N STH AVE 1401 N SUMMARY STATEMENT OF DEPICIENCIES 1401 N SUMMARY STATEMENT OF DEPICIENCIES 1402 N SUMMARY STATEMENT OF DEPICIENCIES 1403 N SUMMARY STATEMENT OF DEPICIENCIES 1404 N SUMMARY STATEMENT OF DEPICIENCIES 1405 N SUMMARY STATEMENT OF DEPICIENCIES 1406 N SUMMARY STATEMENT OF DEPICIENCIES 1406 N SUMMARY STATEMENT OF DEPICIENCIES 1406 N SUMMARY STATEMENT OF DEPICIENCIES 1406 N SUMMARY STATEMENT OF DEPICIENCIES 1406 N SUMMARY STATEMENT OF DEPICIENCIES 1406 N SUMMARY STATEMENT OF DEPICIENCIES 1407 N SUMMARY STATEMENT OF DEPICIENCIES 1407 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPICIENCIES 1408 N SUMMARY STATEMENT OF DEPOCH OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF DEPOCH OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1408 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMMARY STATEMENT OF THE APPROPRIATE 1409 N SUMARY STATEMENT OF THE APPROP	ATEMEN'	OF DEFICIENCIES	I IYI PROVIDER/SUPPLIER/CLIA	A. BUILDING: _	CONSTRUCTION	COM	PLETED
HABILITATION CENTER AT HOLLYWOOD H ### HOLLYWOOD, FL 33621 ### HOLLYWOOD, FL 33621 ### HOLLYWOOD, FL 33621 #### HOLLYWOOD, FL 33621 #### HOLLYWOOD, FL 33621 ###################################			100611	B, WING		02/	18/2016
AND INCOMPLETED AND AND AND AND AND AND AND AND AND AN			1200 N 35	TH AVE	21		
Included in the number of opportunities required to be observed. Staff B then proceeded into Resident #268's stated to the resident she had the pill and pill for her to take. On medication reconciliation was conducted by reviewing the physician orders and MARs. The physician orders included and the pill and pill for her to take. On medication reconciliation was conducted by reviewing the physician orders and MARs. The physician orders included and the pill gold and the pill gold pill gold at at 3:30 a.m. at 3:30 a.m. at at 3:30 a.m. at at 3:30 a.m. at at 3:30 a.m. at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at 3:30 a.m. at at at at 3:30 a.m. at at at at 3:30 a.m. at at at at 3:30 a.m. at at at at at at at at at at at at at	REFIX			PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETE
pass observations. Staff B failing to administer the 5 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		included in the number to be observed. St Resident #26% She had the stake. On several stake. On several several stake. On several	when of opportunities required aff B then proceeded into a stated to the resident pill and pill for her to callon reconciliation was every given by the physician orders and an orders included a state of the resident pill and pill for her to callon reconciliation was every given by the physician orders and a state of the physician orders and a state of the physician orders and a state of the physician orders and the pill given as the medication pass conducted at 8-40 s.m. With a state of the pill given as the medication pass on the pill given between the pill given as the medication of the medication of the pill given and when a set of the pill given and when a set of the pill given and when a set of the pill given and when a set of the pill given and when a set of the pill given and when a set of the pill given and when a set of the pill given and given and the given given and given given and given given and given gi				

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if continuation sheet 2 of 42

16:43 #668 P.

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Agency (or Health Care Adm	inistration		- ADJAMA JAWAN	(X3) DATE	SURVEY
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		LETED
ANDPORT	Ur BURNEW HUN		A. GUILDING:			
		100611	B. WING		02/1	8/2016
			00500 507	STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	4200 N 25		MIE, DF CODE		
REHABIL	ITATION CENTER AT		DOD, FL 33	021		
(X4) (D	SUMMARY STA	TEMENT OF DEPICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO	N	(X3) COMPLETS
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N 054	Continued From pa	age 2	N 054			
	observation on prepared Resident prescribed. The m prepared Resident prescribed. The m previous and previous	2/24 hour 1 CD. the was getting ready to apply that the libeen removed at 7:55 AM for then proceeded to apply the sident's right image. 1 Stelf C at 10:00 AM she not walled to remove the one was being placed dged the time and figured she to give the resident's tit took much longer than the resident did go without the		2-Staff C was provided with 1:1 education on med pass to includ administration of different types inhalant medications. (see attach	of	
	11:12 AM he states Nitroglycerin order	nat ome. In the Pharmacist, on the current of the old should have oprior to the new the prior to the new the new the new the prior to the new				TOP A IS.
	Resident #264, Sta administer three	ation administration pass at 9:04 AM with aff C was observed to a inhalants to ng order with less than 35 each to include: Spiriva		3-All nurses were re-inserviced a provided with education on med		
AHCA Form I STATE FOR	M Ga	se Castallo	""ATOM	94XQ11	If continue	ion shool 3 of 4 18/11

16:43

#668 P. PRINTED;

QERCY FOR MEBILIN CARE ACITAINISTRATION (ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		100611	B. WING		02/18/2016
	ROVIDER OR SUPPLIER	STREET AD		SYATE, ZIP CODE	
K4) ID REFIX TAG	SACH DESIGNATION	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
	I puff the III and III	and Combinvent. Staff C failed to shake inhalants before the hard of the medication shake inhalants before the hard of the medication shaken before used because if orm and he ingredients or the higher than the properties of the higher than the higher than the higher than the higher than the higher than the higher than the higher than the higher than the higher than the higher than the higher than the higher than the sends hold have held that then ended to be a between each inhalant to be a higher than the sends hold have held with the higher than the needs to be a between each inhalant with the higher than the needs to be a between each inhalant with the higher than the needs to be a between each inhalant with the higher than the needs to be a between each inhalant with the staff after the surveyor's py the Pharmacist he staff after the surveyor's Pharmacists states to shake before each inhalation; give	N 05¢	4-Observations on med pass beir conducted three times a week by or designee to ensure compliance med pass policy and procedure fe next three months. Summary of observations to be reviewed with committee monthly. 5 - Resident # 264 and #268 suff adverse reactions from cited inc administration of medication.	DON of the QA ered no

To:15614965924 ;9549817229

From:FLORDA AGENCY HEALTH

5614965925

16:43

Agency for Healt	. O	imintentian			PRINTED FORM	APPROVED
STATEMENT OF DEFI	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		100611	B. WING		02/	18/2016
NAME OF PROVIDER	OR SUPPLIER			STATE, ZIP CODE		
REHABILITATION	CENTER AT	HOLLYWOOD HI 1200 N 36	TH AVE DOD, FL 33:	021		
(X4) ID PREFIX (EA TAG REG	SUMMARY STA CH DEFICIENCY ULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL SCIDENTIFYING INFORMATION)	PREFIX TAG	Provider's Plan of Correction (Each Corrective action shoul cross-referenced to the approi deficiency)	ON D BE PRIATE	COMPLETE DATE
N 054 Continu	ed From pa	ge 4	N 054			
Class II	11					
N 082: 59A- SS≖O Qualific	(3), FAC	Dietary Serv - Supervisor	N 082			
who: (a) is a paragre (b) Has degree standar Associa (c) Has Assista program Associa (d) Has by an a provide and has supervivor service paragraf (f) is a success Course Board for their co CEU s This St Based determine	qualified die phs 59A-4; successful program why de establishes successful program who de establishes successful nit correspor n, approved attion; or successful corredited co de 90 or mon estation from a sprior work sor in a head atton from a station from a station from a station from a confined management of the station from a countried of the station from a countried of the station from a countried of the station from a countried of the station from a countried of the station from a contribution of the station from the station of the stati	ary manager who has ledd the Dletary Manager's led through the Certifying anagers and is maintaining the continuing clock hours at 45 par period. Is not met as evidenced by: view and interview, it was individual designated by the		The Facility's Full-time Register Dietitian was appointed in writi the Director of Food and Nutrit Services effective A consultant Dietician and CDA hired to provide support. Ongoing evaluation will be cond by the Facility Administrator to a Qualified Dietary Services Sup is maintained as defined by regu guidelines.	ng as ion 4 were ducted ensure ervisor latory	
HCA Form TAYE FORM	Ja	g Casallo.	AD	Heneston	If continual	yon strong 5 of 42 18/16

To:15614965924 ;9549817229

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From:FLORDA AGENCY HEALTH

5614965925

15:43 #666 P. MAD / MAD

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TEMEN	or Health Care Adm t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		DATE SURVEY COMPLETED
		100511	B. WING		02/18/2016
	ROVIDER OR SUPPLIER	1200 N 3		STATE, ZIP CODE	
A) ID REFIX TAG	FACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET.
	to meet the require Manager, who has Dietary Manager's the Certifying Boar maintain certification CEU's (Continuing The finding Include During the review of facility's designated was revealed that valid certificate of Manager's Course for Dietary Manager's coveraled the facility services of the Central Manager's Course for Dietary Manager's Course for Dietary Manager's Services Supervise Manager's Services Supervise Manager's Course for Dietary Manager Services Supervise Manager Services Supervise Manager Supervise Manager Supervise Manager Supervise Manager Supervise Manager Supervise Manager Supervise Manager Supervise Manager M	ry Services Supervisor, falled ments as a Certified Dielary successfully completed the Course and certified through of for Dietary Managers and for Dietary Managers and an with the clock hours at 45 Education Units). If the employee file of the 10 Dietary Services Supervisor I he file did not contain a curren completion of the Dietary Services Supervisor I he file did not contain a curren completion of the Dietary and certification by the Board rs. Further review of the file file of the City		The Facility's Full-time Registered Dietitian was appointed in writing Director of Food and Nutrition Ser effective *** A consultant Dietitian and CDM whired to provide support in the kite Ongoing evaluation will be conduct the Facility Administrator to ensur Qualified Dietary Services Supervis maintained as defined by regulator guidelines.	ere hen. ted by a or is
N 101 SS=D	Medical Records (1)(j) FS Keep full records of discharges; medicincluding medical	59A-(2), FAC Resident of resident admissions and al and general health status, ecords, personal and social y and address of next of kin or	N 101	Staff was provided with education proper documentation of medications. (see attendance attach	

AMCA FORM JOSP ODD!
STATE FORM JOSP Carballo

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11 continuation know 8/07 42

5614965925

15:44 #668 P.060/095

PRINTED: FORM APPROVED

Agency for Health Care Adm				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A BUILDING		1
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	A			02/10/2010
NAME OF PROVIDER OR SUPPLIER	1200 N 35		STATE, ZIP CODE	
REMABILITATION CENTER AT		DOD, FL 33	021	
(X4) (D SUMMARY STA	TEMENT OF DEFICIENCIES	. 10	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX (EACH DEPICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL GROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLEY
N 101 Continued From pa	ge 6	N 101		i
other persons who	may have responsibility for the	1	2-A weekly audit tool was create	
	nt; and individual resident		ensure accuracy of all medic	
care plans, includin	g, but not limited to,		documentation, audit to be cond	lucted
	, service frequency and	1	on a daily basis by nurse coordin	ators
	ce goals. The records must be		for three months and to be turne	
	pection. The licensee shall cords on each resident in		weekly to DON or designee. (see	e i
	cepted professional standards		sample attached)	
and practices, which	h must be complete,		,	
	nted, readily accessible, and		3-Reports of all inaccuracies to b	e !
systematically organ	nized.		discussed in monthly QA meetin	
59A-12 (2) FAC			appropiate follow up as needed.	,
	d shall contain sufficient		.,,	1
	ly identify the resident, his			1
	ment, and results. Medical			1
	mplete, accurate, accessible			1
and systematically of	organized.			1
This Statute or Rule	is not met as evidenced by:			*
	view and interview, the facility			1
	curate and complete clinical			i
	ed by failing to reconcile			1
	with the Controlled Drug impled residents (Resident #			1
	nnecessary Medications			1
The findings include	ed:	ĺ		
Payley of the Centr	plied Record form for			:
	aled "Each dose signed for			
here requires charting	ng on the medication record".			
	al record for Resident #269			
revealed a Physician		- 1		
	ams (mg); one tablet (tab) by s (hrs) as needed for pain.	1		
: Review of Resident				
Medication Administ	ration Record (
revealed	5 mg one tab was	1		
. documented as adm				
CA Form 3020-0001	1.1/ .	m -	4XQ11	if continuation sheet 7 of
16 m.00	walls .			_ / _ /
Grant Ci		MUHIN	15781 1505V	3/18/1
,				,

15:44 #668 P.

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	for Health Care Adm	Inistration			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100611	B. WING		02/18/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	
REHABI	LITATION CENTER AT	HOLLYWOOD H: 1200 N 3	5TH AVE 000, FL 33	021	
(X4) ID PREFIX YAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLETE
N 101	Continued From pa	ge 7	N 101		
		for a total of three doses of ented as administered.			
	Record for the tab was documented at 4:00 PM; one tab tab on at 6 at 10 PM; one tab tab on at 6 at 10 PM; one tab to a tab on at 7 at 10 PM; one tab to a tab on at 6 at 10 PM; one tab to for the at 10 PM; on tab tab on the at 10 PM; on tab tab on the at 10 PM; on tab on the at 10 PM; on tab on t	1.45 PM; one tab on a	Andrea - Andreas - Communication - Communicati		ter a state of the company terms of the management of the company terms
	Class III				
N 110 SS≈D	400,141(1)(h) FS; 5 Environment - Safe,	9A-MANN (1) FAC Physical Clean, Homelike	N 110	A Pest Control company conduct on-site visit ***********************************	entire
		premises and equipment and ns in a safe and sanitary		schedule was changed from mont twice a month and as needed if m visits are needed.	hly to
	59A-111 (1) FAC The facility shall pro comfortable, and ho	vide a safe, clean, melike environment, which			:
ICA Form	The facility shall pro comfortable, and ho			0XQ11 XI 5TX HFG~	f continuation sheet 0 of

3/3/33 15:44

#668 P.062/096

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Agency	for Health Care Adm	inistration			FORM	APPROVED
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		100611	B. WING		02/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
REHABI	LITATION CENTER AT	HOLLYWOOD HI 1200 N 35	TH AVE DOD, FL 33	021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	GOMPLETE DATE
	belongings to the extension of the exten	to use his or her personal teen possible. I is not met as evidenced by: one and interview, it was facility lailed to maintain an and program in the main kitchen rea was free of pests. I out service sanitation tour and the main kitchen rea was free of pests. I out service sanitation tour and the service sanitation tour and the service sanitation tour and the service service sanitation to use and the service service service service service in food ving areas, food strappe and walk-in refrigeration, 3 reas, and dish machine area. All control of the service ser	N 110	At a minimum, a bi-monthly sch will be maintained by the Pest co company to ensure the kitchen w free from pests. A daily check will be conducted Food Service Director or designs monitor for pests in the kitchen: The Maintenace Director and Administrator will incorporate rounds in to their rounds sched Two blue lights designed to attra were added to the kitchen area.	ntrol ill be by the se to area. kitchen ule.	

15:44 #668 P.063/098

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	É CONSTRUCTION	(X3) DATE SURVEY
	100611	B, WING		
NAME OF PROVIDER OR SUPPLIER				02/18/2016
	511ac/	DORESS, CITY, S STH AVE	TATE, ZIP CODE	
REHABILITATION CENTER A	HOLLYV	/OOD, FL 330	21	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	MOUNT DO COUNT
N 111 Continued From pa	ige 9	N 111		
N 111 Specifics (2), FAC	Physical Environment -	N 111		
The facility shall pro	ovide:			į
(a) Housekeeping :	and maintenance consises			,
comfortable interior	ain a sanitary, orderly, and			i
(b) Clean bed and to condition:	oath linens that are in good	1 1		i
(c) Private closet se	ace for each resident;			
(d) Furniture, such space:	as a bed-side cabinet, drawer			1
	omfortable lighting levels in all			1
areas;		1 1		j
(g) The maintenance	safe temperature levels; and e of comfortable sound levels,			
Individual radios, T\	s and other such			:
of the resident's ch	Identwill be tuned to stations loice.			!
Based on observation	is not met as evidenced by: on and interview conducted on emined that the facility failed			
to provide housekee	ping and maintenance	!		
: Services necessary !	nether a nietnian			į
West, 2 East, and 2	able interior in 4 (1 East, 1 West) of 4 Resident Units.			ļ
The findings include	d;			1
accompanied with the Director, Director of	tour conducted on M and 1:00 PM e Administrator, Engineer Nursing and g concerns were noted;			The state of the s
1.) 1 East Wing:		j		i
a. The w		(a	en fixed.	has 3/18/1
FORM Jorge Car	. 01	** S4X0		If continuation about 10 o

15:45 #668 P.064/QP6

PRINTED: 03/10/2016

Agency for Health Care Adri	Inistration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	8. WING_		
NAME OF PROVIDER OR SUPPLIER	970557 A	202500 000	. STAYE, ZIP CODE	02/18/2016
REHABILITATION CENTER AT	HOLLYWOOD H: 1208 N 3	STH AVE		
TAG ; REGULATORY OR LI	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIENCY)	D BE COMPLETE PRIATE DATE
N 111 Continued From page	ge 10	N 111		
b The : sink had missing an hole in the floor nea	area on the floor around the d cracked tile. There was a r the sink.		(b) sink has been repair cracked tile replaced.	
was peeling. There \	eaint on the was not a trash can in the ond bed 's dresser/night and worn.		(c) has been painted an trash can has been placed in the bear. The bed dresser has been re	th placed.
geslivering, black so:	nirror above the sink was ots. The wall under the seeling and was scratched, was		(d)Room 119 mirror above the sin been replaced. Wall area under the television has been fixed and paint	
was in disrepair with the wooden door. The sink was desilverizing	es on the floor near the cracked. The scratches and gauges out of sonly existing mirror at the including mirror at the including mirror at the including mirror at the including mirror at the including mirror at the doorway to		(e) floor tiles near the been replaced, bath room door has been fixed. The min by the sink has been replaced.	TOF
f. Corridor Ralls throughout the 1 East deep scratches and s	- The wooden wall railing Wing was in disrepair with cuffs.	•	(f) Corridor rails in 1 East Wi have been painted.	ng
g. Storage # - feedings (page 1) as feedings (page 1)	and fibersource) as well ?		(g) Storage ## has been lock and appropriate staff given a key.	ed
h. Solied utility trash in bins and trash	contained overflowing on the floor,		(h)Building Service Staff and Clinic Staff have been in serviced in prope trash disposal in Soiled Utility.	al r
I. Community shower- wrapped around the	rail.	i	(i) All were loosened and or replaced to be hanging by the floor in-serviced.	Staff
EFORM Just Cons	tallo ""	AOM!		Inthysition sheet 11 of 42

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15:46 #668 P.

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Agency for Health Care Administration FORM APPROVED				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100511	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREPT AD	DRESS CITY	STATE, ZIP CODE	02/10/2016
REHABILITATION CENTER A	CHOLLYWOOD H: 1200 N 35			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES COMPLETE	
N 111 Continued From pa	ge 11	N 111		1
The refrigerator an dirt and debris.	four dirty "wet floor" signs floor next to the countertop. d freezer gaskets were full of		(j) Wet floor signs have been rem from Pantry. House Keeping stafi inserviced. Signs moved to Janito closet.	r i
k. 1East Activity were in disrepair w The walls had	The wooden entry doors th deep scrapes and scuffs. pealing paint.		(k) 1 East Activity heen repaired.	ave
l. Storage dirty floor. 2.) 1 West Wing:	- had a loose door knob and		(i) Lock has been replaced and flo cleaned.	or
a. The cand the floor at the	door jam 's paint was chipped, door was chipped. The d displayed the seems outside		(a) door jam's was fille painted. The rail bumper guard h fixed.	d and as been
b. Shower shampoo (2), mouth towels.	contained bottles of inwash, lotion and wet paper		(b) shampoo bottles removed mouthwash removed, wet paper to removed staff in-serviced to discar items from shower when finished	wels
wall of bed 2 display and scrapped walls.	ntry door was scraped. The ed 2 (1996) picture hangers There was a chair with tom inditioner vent was rusty.		bathing a resident (c) entry door has been the wall of the bed has been repair and painted, entry picture hangers	ed
d. Medication carts observed full of was	3 of 3 trash cans were te products with no cover.		removed and wall fixed, cushions discarded and A/C vent rust fixed.	
: 3.) 2 East:	The corridor handrails		(d) Medication waste covers purch and installed. Staff in serviced on v level and disposal.	ased ; vaste
throughoutwere wor	n.		(a) Wooden board	
a. The v	vooden board and C		and C have been replaced. The hole	
wall in the disrepair.	es. A hole was noted in the . The night table of bed 1 is in		the been fixed. The rable of bed 1 has been replaced.	
ACE FORM Jung	Parallo "		9XQ11 #0	onlinuption sheet 12 of 42

15:45 #668 P.066/095

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Agency for Health Care Adm	Inistration			PORM APPROVED
SYATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜLTA A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	100811	B, WING_		
NAME OF PROVIDER OR SUPPLIER		DDECC CITY	STATE, ZIP CODE	02/18/2016
REHABILITATION CENTER AT	HOLLYWOOD H: 1200 N 35			
PREFIX (EACH DEFICIENCY	Tement of deficiencies Must be preceded by Pull SC Identifying Information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CHOSS-REFERENCED TO THE APPROI DEFICIENCY)	DN (NS) D BE COMPLETE PRIATE DATE
N 111 : Continued From pa	ge 12	N 111		
b	entry door was scrapped. The		(b) door has been fixed baseboard behind bed B cleaned a painted. Night table for bed C has cleaned. (c) staples and nails ret the wall was painted. Floor tiles in been replaced.	nd been moved
The corner guard is	behind bed B is scratched.		(d) Entry door fixed, w behind bed B fixed, corner guard e) Walls fixed and paint	fixed.
night table of bed A	was in disrepair.		night table bed A has been replace	d
f The c	verbed table 's were		f) The overbed table wa	
rusted. The tub was			(g) frag fixed and painted. The bath tub we cleaned.	ne was
į peeling,	vall behind bed A had paint		(h) wall behind bed A wall and painted.	as fixed
l. Clean Linen Door handle was falling of	s- were in disrepair and the f.		(i) Clean Linen doors handle fixed fixed.	doors
door to the	/Activity The entry chipped. The air vents walls paint was peeling.		j) 2 East Dining entry fixed and painted, air vents c and walls painted.	leaned
4.) 2 West Wing:				
a. The file.	has missing		(b) fixed	fixed.
b. The missing/broken tile.	has was	ļ	replaced. Baseboard was fixed. Soi wheelchair removed and cleaned.	led

AHCA Form 3020-0001 STATE FORM

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17 continuation phree 13 of 42

15:45 #660 P.067/095

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Agency for Health Care Adm				FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIR	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100811	e wing_		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CIT	STATE ZIP CODE	32 10/2010
REHABILITATION CENTER AT	HOLLYV	STH AVE	3021	
TAG REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
d. Shower — to shower — to shower — call light e. Pantry — had Jacket, and more that f. 2 West Activity — The window silts were During an interview of tour or the Administrator, En — Directo were acknowledged, that the procedure wa items or items that ne Director of Engineerin nursing station has a lare placed, then he re Director of Engineerin needs a refresher coureport housekeeping? Administrator stated it quality assurance tool account of the procedure was the procedure of the procedure of the procedure was the procedure of	A soiled wheelchair The baseboard was poard outside of the property of the pro	N 111	(c) baseboard outside repaired. (d)Shower sear sear was fix light was replaced. (e)Staff in-serviced in all floors no place personal belongings in Pant place personal belongings in Pant search was replaced. (Jo West Activity pape been fixed window sills replaced. All other facility in common areas have been assessed and all nessessary repairs have been compliance, to Director of Maintenancewill and preventative maintenance manua with a log for daily rounds. In addit the ADM will make weekly rounds observe Maintenance and Housekeeping provided.	ed, call tto y r has 3/18/16 n teted. he ain l tion
N 2011 (1)(I), FS Right	t to Adequate and	N 201	1- Resident #269 went to a urolo	gist
SS=D Appropriate Health Ca	re		appointment on / / and can with orders to remove	ie i
	equate and appropriate			1
CA FORM GA GALAN	No Apr	הלצועו אי	11 11 11 11 11 11 11 11 11 11 11 11 11	18/2/

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#G68 P.

Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING 100611 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N 35TH AVE REHABILITATION CENTER AT HOLLYWOOD HE HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX ID PREFIX TAG N 201 Continued From page 14 Continue from page 14 N 201 health care and protective and support services, including social services; health services, was discontinued on I/III/III. (see order and progress if available; planned recreational activities; and note attached) therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the 2- Staff was educated on ensuring community, and with rules as adopted by the that residents who enter the facility agency. without an indwelling This Statute or Rule is not met as evidenced by: not catherized unless the resident's Based on observation, interview and record condition demonstrates that review, the facility falled to ensure the appropriate catherization is necessary. (see provision of care for 1 of 1 residents reviewed for wounds, (Residents #46), as evidenced by failing to perform care in attendance signing sheet attached) rare in a manner to prevent the potential for contamination of the wounds for Resident #46; 3- Restorative assessment form was and failure to reassess the need for a sampled residents (Resident #269), reviewed for updated to reflect residents that are admitted with and the with proper follow up. Restorative Nurse educated on the The findings included: need for assessment of all residents that are admitted to the facility with Review of the facility policy for Handwashing/Hand Hygiene states in part, 'Employees must wash their for at least an indwelling proper follow up and care plan. fifteen (15) seconds using i or non-antimicrobial soap and water under the following conditions: Before and after changing a 4- An audit was conducted of all dressing'. The Procedure states: 'Vigorously current residents in the facility to lather with soap and rub them together, creating to all surfaces for at least fifte ensure proper follow up lo all surfaces, for at least fifteen (15) seconds under a moderate stream of running appointments have been scheduled water, at a comfortable temperature'. for the residents without a to support an indwelling Review of the facility policy for Care documents the Steps in the Procedure for . (See attached) non-disposable supplies to include: Wipe reusable supplies with as indicated (i.e.

AHCA Form 3020-0001 STATE FORM

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Agency for Health Care Adm	inistration			TORMA PROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	100611	B. WING		02/18/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35	TH AVE	021		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETE	
N 201 Continued From pa	ge 15	N 201	Continue from page 15	i	
unclean	s admitted to the facility on tal admissions on a tal admissions on a to the facility on the facility on the facility on the facility on the facility on the facility on the facility on the facility of the f		5-A weekly audit will be cond by DON or designee of all resi with a to ensure proper are in place fuse of all resi and ord attempts of removal from MI place for those that are not nec attempts of removal from MI place for those that are not nec attempts of removal from MI place for those that are not nec attempts of removal from MI place for those that are not nec attempts of removal from MI proper handwashing with return demonstration. (see attendance si attached) 2-Competency validation of dres can surses to ensure compliance. competencies attached)	dents the to the ers for are in cessary. d with are and and ude theet	
Initially a dabbing memory over the ent wounds with dry ga gloves, washed her donned new gloves care ointment in a new gloves wounds in a swiping another wad of gau	eanse the wounds with otion and then a swiping re wounds. She dabbed the uze. She then removed her suffer of seconds and She squeezed wound neclication cup and with a laced the cintment on the motion. She then picked up		3-Weekly seed observations to done by DON or designee for the three months to ensure proper seed care procedure is being followed, will be taken to QA monthly. (see observation attached)	reports	
be in contact with the	the gauze that was going to emerge, she placed the		54XQ31 1	1 continuation angel 18 of 42	

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15:46 #666 P.

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Agency for Health Care Adm	Inistration			FORMAFFROYED
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				ľ
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, S	TAYE, ZIP CODE	
	1200 N 3	STH AVE		
REHABILITATION CENTER AT	HOLLYWOOD HI HOLLYW	OOD, FL 330	21	
	TEMENT OF DEFICIENCIES	i D !	PROVIDER'S PLAN OF CORRECTION	ON : (X5)
	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX	D BE COMPLETE
ALGODS ON GIVE		1 123	DEFICIENCY	
N 201 Continued From pa	10	N 201		:
Continued From pa	ige io	1,120,		1
	inds and secured with an	1 1		-
Omni fix dressing.	She then removed her gloves,	1 1		ì
	and dated the outside of	1		i
	hen donned new gloves	1 1		:
	r and repositioned the	1 1		
the back the se	n a pillow to have access to moved her gloves, washed	1		i
	ends, donned new gloves and	! !		
	f the Kling wrap dressing over	1		
	heel was observed to	. 1		
	She placed the used	1		i :
	an care supply field and	: 1		
without removing he	er gloves, washing her	1		i i
	loves, she cleansed the	1 1		4
	erile normal and dried	1 1		
the area with dry ga	auze. In reaching for the dry	1		1
gauze, the plastic b		1		:
	the clean field, fell on the floor.	1 1		
	pick up the plastic bag off the	1 1		
	on the clean care	1 1		!
	en took a box of gloves sitting	1		
	supply field and placed the			:
	's bed next to the	1 1		
	ed new gloves. She placed the	1		
	a medication cup and then	1 1		i
	ors she used to cut off the old	1		
	place of the Omni fix dressing			1
and secured the Kli	ng, placed the previously used	1 1		:
	e clean field and with a	1		1
		1 1		1
	e with a wad of gauze	1 1		1
. and secured with Ki	ling wrap. She then removed			
	e outside of the dressing and	1 1		
	for 5 seconds. She then			
	the box of gloves sitting on			
	resident's III , on the			
	field. She donned new gloves	1		
and with the same :	scissors she used to remove	1		

AHCA Form
STATE FORM

Jorg Partallo

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If continuation sheet 17 of 42

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/ 15:46 #668 P.

NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER AT HOLLYWOOD H SUMMAY STATEMENT OF DEFICIENCES REGULATORY OR ACT DESTREMENT OF DEFICIENCES OR THE REGULATORY OR ACT DESTREMENT OF DEFICIENCES OR THE REGULATORY OR ACT DESTREMENT OF DEFICIENCES OR THE REGULATORY OR ACT DESTREMENT OF DEFICIENCES OR THE REGULATORY OR ACT DESTREMENT OR OF PREFIX ACT DEFICIENCES OR THE REGULATORY OR ACT DESTREMENT OR OF PREFIX ACT DESTREMENT OR ACT DESTREMENT OR OF PREFIX ACT DESTREMENT OR ACT DESTREMENT OR OF PREFIX ACT DESTREMENT OR ACT DESTREMENT OR OF PREFIX ACT DESTREMENT OR OF PREFIX ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE ACT DESTREMENT OR OF PREFIX TAG N 201 CONTINUED TO THE TO THE TAG TAG N 201 TAG TAG N 201 CONTINUED TO THE TAG TAG N 201 TAG TAG N 201 TAG TAG N 201 TAG TAG N 201 TAG TAG TAG TAG TAG TAG TAG TA	33021 PROVIDER'S PLAN OF CORRECTIO	DRE COMPLE
REHABILITATION CENTER AT HOLLYWOOD H CALL SUBJECT STATEMENT OF DEFICIENCES STATEMENT OF DEFICIE	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DRE COMPLE
0/41 b SIMMANY STREMENT OF ESTIGNATION PREFIX ACC SECULTORY OR LOCIDITY TO PERFORMATION N 201 Continued From page 17 dressing on the right heel and placed the scissors on the clean field next to a clean wad of gauze. She then placed the SIC ontinued from however did not cleans the sile of the right heel with a sile depressor however did not cleans the sile for 3 seconds, donned new gloves and plotting up the wad of gauze shifting next to the used scissors on the clean field, placed the gauze over the right from the same and secured with Ring wrap. Using the same and secured with Ring wrap. Using previously used scissors sile or the clean field, placed the Ormil fix dressing and secure with Ring wrap and dated the dressing. She closed up the red bibhozard garbage bag, book her gloves off and washed her sile for 5 seconds. She look the bag out of the second up the page of the page of the placed the residence of the page of the p	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DRE COMPLE
PREFIX ACCOUNTED THE PROPERTY MANY THE PRECEDED BY FULL PREFIX ACCOUNTED THE PROPERTY MANY THE PRECEDED BY FULL THE PROPERTY MANY THE PRECEDED BY FULL THE PROPERTY MANY	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DRE COMPLE
dressing on the right heel and placed the scissors on the clean field next to a clean wad of gaute. She then placed the discount of the right heel with a feet of the right heel with a feet of the right heel with a feet of the right heel with a feet of the right heel with a feet of the right heel with a feet of the removad her gloves, washed her feet of the seconds, domen drew gloves and ploiding up the send of gaute stilling next to the used scissors on the right heel with a feet of the gaute over the right heel and the placed the gaute over the right heel and the placed the with right group. Joining the same scissors shed with Killing wrap. Joining the same scissors shed with Killing wrap to the right gand secured the Killing wrap and dated the dressing. She closed up the red bibhazard garbage bay, book her gloves off and washed her feet for 5 seconds. She took the bag out of the feet of clean gaute and box of		
Ornd fix tape holding them to her body then put them "an on the clean field. She then went out of the "are on the clean field. She then went out of the "are on the clean field. She then the used supplies in the bag then picked up the paper package of gauze. Ornsi fix tape, and olntments, placed them on a white form tray and placed the box of gloves that had been stilling on the resident's bed, on top of the supplies and took the blohazard bag out of the "all." She then returned "all to the "all." removed her gloves and washed her "all for 5 seconds. She then took the box of gloves now stilling on top of the supplies and put it in the rack above the sink, picked up the oliminents, paper package of gauze and Ornni lix tape, went to the "all care treatment cart, and placed the supplies "all into the cart. Returning the lot the sink and insed the sclosors for 4 seconds		

Agency for Health Care Administration

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#668 P.

STATEME: AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		30 12,760	
		100611			02/18/2016	
	PROVIDER OR SUPPLIER	4888 11 8		STATE, ZIP CODE		
REHABI	LITATION CENTER AT		000, FL 33	021		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	PREPIX	PROVIDER'S PLAN OF CORRECTION SHOUL	ON (X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE PRIATE DATE	
N 201	Continued From pa	ge 18	N 201		i	
	towel, returned to the	ne care treatment cart,				
	still in a namer tower	ver and placed the scissors, in the top drawer and closed			!	
	the cart. She then d	ocumented the				
	had been rendered	in the Treatment Record.				
	On at app	roximately 4:00 p.m. the			i	
	Director of Nurses v	vas apprised of the				
	care observation of	Staff A with Resident #46 to			i	
;		d she cannot understand why as she personally watched				
į		care in the past, with no			,	
į	issues identified.					
					į	
		realed Resident #269 was				
	admitted to the facili	ty on with an			-	
	indwelling to the	with the indication of oted in the Physician Orders.	.		1	
	A follow up Physicia:	n's progress note does not	1		!	
	address the resident	t's status, a the resident has an	- 1			
	indwelling	present. The Nursing				
į		ntion the Indwelling foley	- 1		:	
		In the admission note and			i	
	No nursing entries s	nursing entry dated			,	
	contacted to discuss	the follow up care or plan	i			
	related to the resider	nt's Indwelling				
	the resident 's urolo		- 1		1 1	
	The Minimum Data 5	Set (MDS) reveals that the	i		- 1	
	(BIMS) summary sco	ore of 15, which indicates				
!		le to be interviewed and	- 1			
		addition, the same and			1	
11	catheter is present		1			
CA Form 3	2000	1/-	i			
ATE FORM		fall	IN SA	X011	continues by sheet, 19 of 42	
	9	-	1000	スロリングアンチェリム ""	3/10/1	
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Agency for Health Care Adm	inistration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	8. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY. S	TATE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35	TH AVE	21	
PREFIX FEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 201 · Continued From pa	ge 19	N 201		,
	status were initiated, however, keep manage bag below			
Director of Nursing) Billion is Returned Return acceptable should be follow-up	13 PM, the ADON (Assistant stated that the reason for ention and that this is an			;
regarding the plan to fine that they have more meetings regarding concerns; however.	ing meetings and clinical residents to discuss care and this was not identified. The			
and make a follow u Indicated, attempt to ADON acknowledge	ney need to contact the doctor in appointment and if o remove the			
1 East Desk Nurse the state for resident may have not sure and could information. She st	33 PM in an Interview with the stated that the resident has retention and thinks the a doctors appointment but is not locate any additional ated that she was not sure as in 's plan is for the resident.			
C, she stated she is	at 2:47 PM with Staff not sure why the resident and does not ls, if any.			
several times during and in her room will At 2:58 PM the ses	esident #269 was observed the day at Physical Therapy the indwelling (1992) dent stated she had a good			
TATE FORM	wall-	MPT.	2913520L	17 continuation sheet 20 of 42 3/18/16

STATE FORM

To:15614965924 ;9549817229

From:FLORDA AGENCY HEALTH

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PRINTED: FORM APPROVED

#668 P.

Agency for I	Health Care Adm	inistration			· · · · · · · · · · · · · · · · · · ·
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING.	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100611	B. WING		02/18/2016
,	ADER OR SUPPLIER	HOLLYWOOD HI 1200 N 35		STATE, ZIP GODE	
(X4) ID PREFIX TAG	IEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
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Inc. In In In In In In In In In In In In In	inveiling in the hospital because in a should be were in a should be with a should be with a should be with a should be with a should be well as the way of the way confirms a Physician's officen scheduled on steed upon survey suid be seen on the way for the way of	use she was having difficulty , she is not sure what they are and has not seen the doctor or ng it since she has been			
the ha an sta ap Tr ha if i	ON, Administrator by acknowledged we had the Indwe d its necessity evaled that they we aled that they we pointment and pr be DON acknowle we been to follow indicated or set u	railvated. The Administrator re keeping the saying for it through the facility. doged that best practice would up with the MD and do a trial, an appointment with the trictated but understood that a			
· CI	ass III				1
N 203	(1)(n), FS F	Right to be Treated with Dignity	N 203		,
. Ti	ne right to be trea	ted courteously, fairly, and			1

AHCA Form

Jaze Pakulto

S4XQ11 ADMin

If continuation shoot 21 of 42

To:15614965924 :9549817229

From:FLORDA AGENCY HEALTH

Agency for Health Care Administration

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_	(X3) DATE COMPI	SURVEY
	02/11	8/2016
AN OF CORRECTION VE ACTION SHOULD ID TO THE APPROPRICIENCY)	N D BE RIATE	COMPLETE DATE
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ned to a sensor	у	

(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 100811 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION CENTER AT HOLLYWOOD H 1200 N 35TH AVE HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PE (EACH CORRECT! CROSS-REFERENC! DEF PREFIX TAG N 203 Continued From page 21 N 203 a written statement and an 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 fa-01/20/16 with diagnoses to include Dysphagla, requiring a feeding nutrition and hydration 1. Review of the initial Activity Assessment dated 1)Resident was assign completed by an Activity Assistant, documents the current activity interests of stimulation program in a group of 5 to 8 residents and in smaller time Resident #265 include Exercise, Being Outdoors, Watching TV, Movies and Music. The increments to better meet the residents Summary/Program includes, Resident will receive needs. 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.

AHCA Form 3070 obe productallo STATE FORM

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3/18/16

15:48

#666 P. PRINTED: FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 100811		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
REHABILITATION CENTER AT	HOLLYWOOD HI 1288 N 31	TH AVE	3021		
PREFIX (EACH DEPICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTING ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMP	
N 203 Continued From pa	ge 22	N 203			
p.m. multiple obser Resident #265. On resident was obser with her night gown which was not turne turned off and the v closed. At 2:30 p.m. her will in bed, h	on, facing the overhead TV ad on. The were were window drapes were pulled the resident was observed in aving the feedings ext to the bed. She remained		2) Audit was conducted of all ac residents to insure that the activi- that are being provided are adeq with their cognition and function status in order to improve their of life. (Audit form attached) 3) To ensure that all resident are attending the proper activities be	ties uate nal quality	
turned on and the window drapes clos clinical record reves feedings via feeding concluding at 6 AM day.	ed. Review of the resident's sled she receives see see starting at 2 PM and for a total of 16 hours per		their evaluation Staff was in-serv new activity calendar and a list o residents with their assign activit area will be provided weekly to a coordinator. (staff in-service attr	ice on f ies nurse	
the scheduled activing Resident #265 was in, to include at 10:4 Body Exercise; at 2:4:00 p.m. a group w	assessed as having Interest 5 a.m. Move & Groovo Your 30 p.m. Creative Art; and at atching of a TV show. bry Stimulation Attendance		Daily rounds will be conducted activities director or designee to attendance and any absenteeism communicated immediately to II further intervention. If any resident doesn't wish to participate on any day	ensure will be OT for	
participated in Group participated in Group documented), howe- observed to be in be observations, in her overhead TV which the Activity Participa	the Activity Director on on the state of the control of the contro		assigned activities an activity staf member will provide appropriate activities in	f :	
observed to be up in	a.m. Resident #265 was a wheelchair in street een the 2 beds opposite her			:	
EFORM Jerze Cale	elle "	" s ВДИ		3/18/16	

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#688 P. PRINTED:

Agency for Health Care Adn	ninistration			
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED
		i		
	100611	B WING		02/18/2016
	100911			02/10/2016
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, 8	STATE, ZIP CODE	
REHABILITATION CENTER A	1200 N 3	STH AVE		
REMABILITATION CENTER A	HOLLYWOOD H	00D, FL 330	021	
	ATEMENT OF DEFICIENCIES	JD.	PROVIDER'S PLAN OF CORRECTI	
PREFIX - (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
TAG REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	PRIMIE . LINE
		 		
N 203 Continued From pa	age 23	N 203		!
had Shawar abac	erved to be facing the over	1 1		
	the TV was not on. The lights	1 1		
	indow curtains were closed.			i
	9 a.m. Resident #265 was			
	the same spot, with the TV still			
	vere out and the window	ļ		
curtains were close		1 1		
On at 1:3	0 p.m. Resident #265 was	1 1		;
observed in her	in the same spot with	1 1		: 1
2 nurses at her side	e working on connecting the	1 1		1
feeding.	•	1		,
On at 3:11	p.m. Resident #265 was	i J		:
observed in her	in the same spot.	1 1	,	
	the resident in the next bed	1 1		1
	#265 could not see it from her	1 1		: 1
	overhead TV above Resident	1 1		
#265 remained off.		i i		
10-1-0-0-		ĺ		
	sory Stimulation Attendance	i I		! !
document	m the Activity Director on	1 1		: 1
	activity indicated.	1		1
	ity Participation record	!!!		([
	the resident received	! !		! !
	, listened to music, and was	i i		1
	265 was not observed to have	1 1		` 1
	ot between the 2 beds	1 1		}
opposite her bad.				
				i i
	Da.m. Resident #265 was			
	bed in her nightgown.			
	and the window curtains were	1		
closed.		1		i
	a.m. Resident #265 was			1
	bed in her nightgown.	i 1		
and the window cur	ras not on. The lights were out			
	tains were closed. 5 p.m. Resident #265 was			1
	in bed, in her nightgown with			, 1
	lights were out and the	l i		. 1
	,	i		
TATE FORM	Pentallo .	ms e.	XQ11	If continuation shoot 24 of 42
/ prol	centralo	ADM -		
4 1.	-	INDICE	~	3/18/12
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AHCA Form STATE FORM

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From:FLORDA AGENCY HEALTH

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15:46

#668 P.078/095

PLAN OF CORRECTION DENTIFICATION NUMBER DESCRIPTION NUMBER DESCRI	Agency for Health Care Adn STATEMENT OF DEFICIENCIES				FORM	APPROV
## OF PROMOBER OR SUPPLIER ## OF PROMOBER OR SUPPLIER ## ABBILITATION CENTER AT HOLLYWOOD HI ## 1200 N 35TH AVE ## 1200 N					(X3) DATE SURVEY	
### STREET ADDRESS CITY. STATE. ZIP CODE ####################################			A BOILDING	-	COM	PLETED
MABILITATION CENTER AT HOLLYWOOD H 1200 N 35TH AVE HOLLYWOOD, FL. 33821 SUMMANY STATEMENT OF DEFICIENCES TEXT ACCOMPRISED THE PROCESS OF FOLLY AGE OF THE PROPERTY OF THE PROCESS OF FOLLY AGE OF THE PROPERTY OF THE PROPER	NAME OF BROWNING AND AND	100611	B. WING		0219	0/2040
SUMMARY STATEMENT OF DEFICIENCES PROPERTY AND ACCORDED TO MANAGED		STREET	ODRESS, CITY,	STATE, ZIP CODE	1 02/1	8/2016
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AC SEGULATORY OR LSO INSTITUTION OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE COMPARIATE OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE COMPARIATE OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE COMPARIATE OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE COMPARIATE OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE COMPARIATE OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE COMPARIATE OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF THE PRECEDED BY FULL REGULATORY OR SHOULD BE CASES OF	(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY					
window curtains were closed. On all 2:15 p.m. Resident #265 was obsaved femaining 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 all 2:20 p.m. of the Activities Director walking down the first floor half recruiting residents to participate in an interactive singing activity on the first floor outside pation. On all 3:00 p.m. Resident #265 was not included in the singing activity on the outside pation. Review of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record received from the Activity Directors of the Sensory Stimulation Attendance record on documents no interaction. Review of the 1st Floor Activity Calendar revealed the days activities on "Which Resident M255 was assessed."	TAG REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO TH	ON SHOULD BE	COMPLET
On at 2:15 p.m. Resident #265 was observed remaining in bed in her hightpown with the TV not on. The lights were out and the window curtains were closed. Further, observation was made on the state 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 at 3:00 p.m. Resident #265 was so observed remaining in bed, in her rightpown 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 at 3:20 p.m., documents on a state of the received from the Activity Director on at 3:20 p.m., documents on a state of the st			N 203		'	
	On at 2:15 f. observed remaining the TV not on. The il window curtains were Further, observation 2:20 p.m. of the Active the first floor half rec in an interactive single outside patio. On at 3:00 p. observed remaining in the TV not on. Reside the Singing activity on the TV not on. Review of the Sensor of documents not observed from at 3:20 p.m., of the TV not on the Singing activity on the Singing activity of the Sensor of the Singing activity of the Singing activity of the Singing activity of the Singing activity of the Singing activity of the Singing activity of the Singing activity of the Singing activities activities act	n.m. Resident #265 was in bed in her niphtpown with ghts wore out and the e closed, was made on at the e closed, was made on at this Director walking down ruling residents to participate in a construction of the first floor. In Resident #265 was no bed, in her nightgown with int #265 was not included in the outside patio. If yetimulation Attendance he Activity Director an other Participation record on interaction. Activity Calendar revealed.				
	her bed. The TV was not and the window curtains on at 1:27 p.m. observed in her her bed. The TV was off way, the lights were out	in a wheelchair next to t on, the lights were out drawn. Resident #265 was in a wheelchair next to				
cobstret in her her her her her her her her her her	Gorge Cen	sall "	ADM L		If continuation shee: 3/18/	25 01 42

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTIPL A. BUILDING:	(XZ) MULTIPLE CONSTRUCTION	
	100611	B. WING		COMPLETED
NAME OF PROVIDER OR SUPPLIES		ADDRESS, CITY, STATE, ZIP CODE		02/18/2016
REHABILITATION CENTER A	THOLOWOOD # 1200 N 3	STH AVE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ND BE COMME
the into her bed. The rether resident feeding. Review of the 1st f the days activities (#268 was assessed include at 10:45 a.i. Conducted with the they have a "Slim" seen daily or 3-5 th everybody can come scheduled and the seen at the seen day to the seen at the seen day to the seen at the seen day to the seen at t	d an aide were observed in the resident of the door bed surves stated they are getting uses a state the survey are getting to be do so she can start the survey are getting to so she can start the survey are getting to so she can start the survey are getting to so she can start the survey are getting to so she can start the survey are getting to so she can start the survey are getting to survey are getting to survey are getting to survey are survey. And the residents are need to survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting the survey are getting to survey are getting the survey are getting to survey are getting the survey are getting the survey are getting the survey are getting to survey are getting the survey are getting the su			
both of his worse the right edges and a black up	, with long jagged sharp nknown beautiful observed	" Saxi	211 a	continuation where 20 or 4:

From:FLORDA AGENCY HEALTH 5614965925

15:49 #666 P.

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Agency for Health Care Administration STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIES	STREETA	ODRESS, CITY, S	TATE, ZIP CODE	
REHABILITATION CENTER A		6TH AVE /OOD, FL 330	21	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REPERENCED TO THE APPROVIDENCY)	D BE COMPLE
yellowish spongy Addition Add	whis right and a thick under the survey of the same of		(Constant)	
observed in his time he had a shave the hospital and he (name of aide) to contact that she will shave nails were observed.	5 p.m. the resident was bed. He stated the last re was last Thursday while in is waiting for a oome tomorrow and he knows him and cut his d to still be long, jagged with under the right			!
thick spongy resident stated (na tornorrow.				
	Partallo	MI SA	Ka11 "	Continuation sheet 27

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From:FLORDA AGENCY HEALTH

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15:49

PRINTED:

Statement of Deficiencies and Plan of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING,	(X2) MULTIPLE CONSTRUCTION A. BUILDING.		SURVEY LETED
	100611	B. WING		02/1	8/2016
name of provider or supplier			TATE, ZIP CODE		
REHABILITATION CENTER AT		5TH AVE 1000. FL 330	24		
(X4) ID SUMMARY STA	TEMENT OF DESIGNATION	10	PROVIDER'S PLAN OF C	***************************************	
PREPIX (EACH DEFICIENCY TAG REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION!	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REPERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLET DATE
N 203 Continued From pa	ge 27	N 203			
documentation the assistance with ADI include shaving eve Nail Care there was resident's long at 11:1	2016 and per constant of the c				
at booker, it was notice referred to by the sta according to their For example. Staff J loud from inside the who was out in the himself to the staff three resident names and stated "they are from the hallway dining these who were list feeders?"	allway next to the tray cart, s she pointed to a resident, ad loudly Maria at Staff J. to include Resident #270 eaders". Staff K then asked ig cart into the dining great into the other				
exited, she was heard feeder?, as the Certific entered the	PM, Staff K was observed tray. As she asking loudly, "is 201A is a ed Nursing Assistant (CNA) her. At 1:22 PM she was aying, "202B is a feeder".			i	
FORM JUNG!	Parall "	70 mc		# coglinuation sho	el 28 of 42

From:FLORDA AGENCY HEALTH 5614965925

16:40 #668 P.

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10/100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DAYE SURVEY COMPLETED	
	100611	9. WING		02/18/2016	
AME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY.	STATE, ZIP CODE		
REMABILITATION CENTER	NT HOLLYWOOD HI 1208 N 35	TH AVE	3021		
PREPIX (EACH DEFICIEN	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
stated that a feed assistance by the interview Staff K i	at 12:52 PM, Staff K er is someone who needs CNA to eat. During further evealed that she did not find to calling residents' feeders	N 203			
N 407. 400.141(1)(i), FS Every liconsed farapplicable standarball: (i) If the licensed in wholesome and no generally accepte for its residents as diets as may be physicians. In mal paragraph, the age standards recommended in the recommendation of the standard recommendation of	ility shall comply with all rds and rules of the agency and urnishes food service, provide a ourishing diet sufficient to meet d standards of proper nutrition di provide such therapeutic rescribed by attending ting rules to implement this ency shall be guided by nended by nationally recognized sand associations with	N 407	The dinner menu was adjusted for the tay. The current 4- week menu cycle we reviewed by the Consultant Dietitis All menus have been adjusted to minimum standards. All therapeut and mechanically altered diet extensions have been reviewed and revised as needed to ensure all resis receive the correct diet as ordered.	as an. seet ic	
The findings inclu- During the observ in the main kitcher accompanied with	de: ation of the lunch meal service n on Managed at 11:30 AM the Administrator it was approved menu was not being	,	A consultant Dictitian and new CE were hired to assist with plan of correction and implement systems issues to ensure compliance.		

15:49

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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 investigation of the post-order that the packaging box was leaded to the packaging box was leaded t	AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
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Interview with the Administrator at the time of the observation or the tunch tray line revealed that the est and ror at so which lunch meal preparation. 2) Observation of the funch tray line revealed that the salad was not prepared by line frequent, there was nerve as to which lunch meal preparation. 3) Observation of the lunch tray line revealed that the salad was not prepared by dietary staff and that there was an error as to which lunch meal preparation. 3) Observation of the lunch tray line revealed that the salad was not prepared by dietary staff and that there was an error as to which lunch meal preparation. 3) Observation of the lunch tray line revealed that the salad was not prepared by dietary staff and that there was an error as to which lunch meal preparation. 3) Observation of the lunch tray line revealed that the salad was not prepared by dietary staff and that there was an error as to which lunch meal preparation. 3) Observation of the lunch tray line revealed that the salad was not prepared by dietary staff and that there was an error as to which lunch meal preparation. 3) Observation of the lunch tray line revealed that the dounce serving portion of portion of canned pineapple was not prepared for all regular, and there was an error as an error as to which lunch meal preparation.					STATE. ZIP CODE	
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N 407 Continued From page 29 1) Observation of the Chicken Enchilada revealed that it appeared to be an egy orid lapsel revealed that it appeared to be an egy orid lapsel revealed that it appeared to be an egy orid lapsel revealed documented Nutrition Facts that 1 egy orid contained only 8 grams of the president serving, Interview with the Food Service Manager at the time of the observation revealed that the was unaware that the approved menu entree was unaware that the approved menu entree was unaware that the approved menu entree according to entree 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 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 cunce serving portion of portion of canned pinkapple was not prepared for all regular, and therapeutic diets. The Food Service Manager stated that the entree being served was not prepared for all regular, and therapeutic and mechanically altered pinkapple was not prepared for all regular, and therapeutic diets. The Food Service Manager stated that the entree being served was not prepared for all regular, and therapeutic diets. The Food Service Manager stated that the entree being served was not prepared for all regular, and the salad was not prepared by dietary staff for lunch was to provide by the dietary staff for lunch was to provide by the dietary staff for the function of the lunch was to provide by the dietary staff for the function of the lunch was to provide by the dietary staff for the function of the lunch was to provide the salad was not prepared by dietary staff for the function of the lunch was to provide the sa	(X4) IO	SUMMARY STA	TEMENT OF DESIGIPACIES			ON .
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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 which serving, Interview with the Food Service Manager at the time of the observation revealed that he was unaware that the approved menu entree serving to the residents did not meet the 4 ounce (28 gram) portion and only 16 grams (2 ounce) of entree was a being served, interview with the Administrator at the time of the observation revealed that the entree being served was not a chicken enchilade. 2) Observation of the funch tray line revealed that the 4 ounce of saiad 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 mel 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 detary staff and that there was an error as to which lunch menu was to be followed by the dietary staff for lunch menu was to following the menu with proper portions and menu extensions. Daily monitor by the Food Service Director or designed will be conducted to ensure the approved menus are followed each day. 2) Observation of the funch tray line revealed that the salad was not prepared by detary staff and that there was an error as to which lunch menu was to following the menu with proper portions and menu extensions. Daily monitor by the Food Service Monager stated that the salad was not prepared for all regular, and therefore the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the serv	N 407	Continued From page	ge 29	N 407		
	- The second of the second of	1) Observation of the dides the said of t	e Chicken Enchilada revealed e an ega roll appetizer (2 rolls revealed that the elected "Chicken Ega Rolls" of the box revealed of the control of the contro	T du)	following the menu with proper p and menu extensions. Daily monitor by the Food Servic Director or designee will be condi- ensure the approved menus are fe	e ucted to
		Gorge	walls "A	DML	XQ11 #6	onlinyation shoet 30 of 4

From:FLORDA AGENCY HEALTH 6614965925

#668 P. PRINTED: FORM APPROVED

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Agency for Health Care Adm	inistration			
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		a donormor	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	DENTIFICATION NUMBER.	A BUILDING		
	100611	e. WING		
	1		1	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35	TH AVE OOD, FL 33		
ARREST /EACH DESIGNER	atement of deficiencies Y must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
N 407 Continued From pa	age 30	N 407		İ
	the dinner rolls was an error as			i
to which lunch mer	nu was to be followed by the ch meal preparation.			
5) During an interv	iew conducted with the Food it the time of the observation of	į	1	
the lunch meal ser	vice it was revealed that he	ĺ		
was unaware the p	suree diets to be served is for			F I
all food menu item	s in a pureed form. The			1
manager was unav	ware the the rice was to be vegetable juice and cooked	ļ	1	
pureed and that a vegetable should h	have been prepared in place of			
the salad menu ite	ms.			
Class III				1
	50.00-1	NZ815		
NZ815: (2 SS=C; screening; prohibit		142015		
Backgrou	nd screening; prohibited	Ì	The RCHH policy was reviewed	
offenses	•		HR Manager and Department He	
(1) Level 2 backgr	ound screening pursuant to	Ì	All employees are required to have	
chapter 435 must	be conducted through the the following persons, who are	1	AHCA Level II. A reference chec	
considered employ	ees for the purposes of	l	also be obtained. If a former emp	
conducting screen	ing under chapter 435:	1	not willing to comply with a refe	
(a) The licensee, it	f an individual.		check request, this information v	rill be
(b) The administra	tor or a similarly titled person for the day-to-day operation of	i	added in the employee file.	i
the provider.	to the day-to-day operation of	1		
(c) The financial o	fficer or similarly titled individual		1	
who is responsible	for the financial operation of		1	
the licensee or pro	wider. o is a controlling interest if the	i		
agency has reaso	o is a controlling interest if the		1	
has been convicte	d of any offense prohibited by			
s. 435.04. For eac	h controlling interest who has			
been convicted of	any such offense, the licensee agency a description and	1		
//		į	1	i
AHCA Form 3020-000	1 1/2			If continuation sheet 31 of
ANCA FORM 3020-0009 STATE FORM	oulable	120 M.	84XQ11 N1 STKATON	3/16/
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From:FLORDA AGENCY HEALTH

5614965925

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	B. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIES	STREETA	DDRESS, CITY, S	TATE, ZIP CODE	
REHABILITATION CENTER A		5TH AVE /OOD, FL 330	21	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION IEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE COMPLETE
ilcense application (e) Any person, as statutes, seeking e provider who is expressions with the seeking expressions are or so have access to cite living areas; and a suthorizing statute or provider whose her to provider person directly to clients, E screening may be in employer or the lice. (2) Every 5 years for employment, or en that under liberation with the lander liberation of the l	required by authorizing imployment with a licensee or pected to, or whose proceed to, or whose proceed to, or whose proceed to, or whose proceed to, or whose proceed to, or whose proceed to, or whose proceed to, or whose proceed to, or whose proceed to, or the funds, personal property, or the proceeding to the procee	NZ615	(Privilence)	

STATE FORM

Gorge Carallo "" ADM "

3/18//1

16:60

#668 P.086/095 PRINTED:

Agency for Health Care Adm	inistration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100611	9. WING		02/18/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, 5	TATE, ZIP CODE	
REHABILITATION CENTER AT	HOLLYWOOD HI 1200 N 35	STH AVE OOD, FL 330	21	
PREFIX (EACH DEFICIENCY	Tement of Deficiencies MUST be preceded by full BC Identifying Information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
NZ815 Continued From pa	ge 32	NZ815		
943.05(2)(g) and (h retained print with the Department of I participation in the and national crimin required by level 2 in the licensee or the pacified agency is clearinghouse creat agency may accept requirements of this with level 2 screening the previous 5 years the previous 5 years professional licensery may accept in the previous 5 years the previous 6 years of the previous 6 years of the previous 6 years of the previous 6 years of the previous 6 years of the previous 6 years of the previous 6 years of the print of the years of the print of the years of	fully implemented in the ed under s. Limit has a satisfying the same proof of compliance gastandards submitted within to meet any provider or re requirements of the nent of Health, the full has been submitted within the ment of Health, the full has been so that the same provider or or an applicant for as, or the Department of or an applicant for a continuing care retirement agone so that the same provided that: and this limit is continuing care retirement and the same and this limit is the same provided that the same provided that is a same provided that is a same provided that is same provided that is same provided that is same and this limit is the same provided that is same provided that one provided that is same provided that is same provided that is same provided that is same provided that is same provided that is same provided that is same provided that is same provided that is same provided that is same provided that is same provided that it is same provided that is same provided that is same provided that it is same provid			
the agency with resp	pect to the offenses specified and the qualifying or			

AHCA Form STATE FORM

Jose Carall " ADMIN

5614965925

11 **(** N) Number 34 of 42

,	(K1) PROVIDERSQUPFLERICUA (X2) MULTIPLE CONSTRUCTION A BUILDING: 100611		(X3) DATE SURVEY COMPLETED	
100611			02/18/2016	
	DDRESS, CITY, S	TATE, ZIP CODE		
	5TH AVE 1000, FL 338	21		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLE IATE DATE	
idequalitying status of the person named in the request shall be maintained in a database. The request shall be maintained in a database. The request shall be maintained in a database. The request shall be posted on a secure where the recommendation of the regularity shall be posted on a secure website for retrieval by the licensee of designated agent on the licensee of a behalf. (4) In addition to the offensee listed in s. all persons required to undergo background screening pursuant to this part or authorizing statutes must not have a maintain pursuant to this part or authorizing statutes must not have a maintain pursuant to this part or authorizing statutes 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 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) 409.920, relating to Medicaid fraud. (e) 741.28, relating to Medicaid fraud. (e) 741.28, relating to the declaration of the selection of the company of the following to attempts, solicitation, and conspiracy to commit an offense listed in this selection of the commit of the selection of		·		

From:FLORDA AGENCY HEALTH 5614965925

16:51

#668 P. PRINTED:

Agency for Health Care Add	ministration			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	100611	e. WING		02/1	8/2016
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS. CITY, S	TATE, ZIP CODE		
REHABILITATION CENTER A	T HOLLYWOOD HE 1200 N 35				
(X4) ID · SUMMARY ST	ATEMENT OF DEFICIENCIES	000, FL 330	PROVIDER'S PLAN OF CORRECT	man i	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	COMPLETE DATE
NZ815 Continued From pa	ige 34	NZ815			
(I) \$ 477.566 personal identification (III) \$ 477.561 (IV) \$ 477.51 (IV)	, relating to oblaining a credit ident means. relating to fraudulent use of infense was a felony, relating to forgery, relating to torgery, relating to uttering forged relating to forging bank bills, romissory notes. Relating to the forging bank bills, romissory notes, relating to uttering forged lating, or promissory notes. Relating to the sale, ry, or possession with the seture, or obliver any of the sale, and the sale of the sale, relating to the sale, relating to tracketeering and idebts. The offense relating to the Florida Money a person who is currently ted with a licensee as of was screened and qualified.				
CA Form	0 4	!			
ATE FORM	rseCarallo ""	BDM		consignation and 3/19/)

From:FLORDA AGENCY HEALTH 6614966926

15:51

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ATEMEN ID PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		100611	8. WING		02/18/2016
ME OF I	PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, S	TATE, ZIP CODE	1 02.70.2070
HABI	ITATION CENTER A		S6TH AVE VOOD, FL 330	21	
K4) (D REFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTH CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPL HE APPROPRIATE DATE
VZ815	Continued From pa	ge 35	NZ815		<u> </u>
		ter than 30 days after receipt results by the person.			
	(5) A person who se	erves as a controlling interest			1
	, 2010, who	or contracts with a licensee or has been screened and	1		
	or s.	to standards specified in s. must be rescreened by			
	31, 2015, in complia	ance with the following escreening, such person has	1 1		
	a disqualifying offer	ise that was not a			
- 1	screening, but is a c	current disqualifying offense			į
	or she may apply fo	before the last screening, he r an exemption from the			i
	the employer, may o	g agency and, if agreed to by continue to perform his or her			
	duties until the licen	sing agency renders a lication for exemption if the			į
- 1	person is eligible to	apply for an exemption and est is received by the agency			
- 1	within 30 days after	receipt of the rescreening			
1.	shall be:	•			
- 1	conducted on or bef				
	must be rescreened (b) Individuals for when	by 2013. norn the last screening			
	conducted was between				:
	31, 2014.	orn the last screening			
- 10	conducted was between	een 2009,			
- li	hrough, 201 , 2015.	1, must be rescreened by			i
	6) The costs associ	ated with obtaining the			1
,		nust be borne by the licensee			

Joye Cartallo "ADMIN

it continuation sheet 36 of 42

16:51

PRINTEO: FORM APPROVED

#668 P.

Agenc	for Health Care Adm	inistration			FORM APPROVED
STATEM AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100611	B. WING		02/18/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, ST	ATE, ZIP CODE	DE 10/2010
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i	monetary liability on t action for damages a that, upon notice of a under chapter 435 or				
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Agency for Health Care Administration

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date- ar sreet date as	d an AHCA Level II ning eligibility determination			
review revealed St applications each of employers whom to dates of their AHC	:15 AM employee record aff E, F, G, and H's job documented a list of previous ney worked for between the A Level II background our hiring date the facility.			
Reference Checks and effective as of obtain additional at that helps determit employability, enst current people, pro organization." Furtion Reference Che immediately, reference Cheducted on every conducted conducted conducted conducted cond	oplicant-related information to the applicant's overall iring the protection of the perty, and information of the ner review of the facility's policy cks indicates "Effective ince checks are to be y job applicant and the emplate must be utilized."		The DCHU palier use socious d	aith the
Staff E, F, G and H documentation that reference checks of places employmen Director of Human 11:30 AM she conf	employee record review of rs files found no risdicates verification of conducted on their former t. In an interview with the Resource on measurement at irrued there were no reference for Staff E, F, G and H.		The RCHH policy was reviewed two HR Managers. All employees had a reference check and are on file.	have
conducted with the of Human Resource error of failing to no reference checks a Level II backgroun	:45 AM, an interview was Administrator and the Director to they acknowledged the to follow their policy on Job and not initiating a new AHCA d screening for employees who			i
AHCA FO 0001 STATE FORM	orge Centallo	10	s4xa11 M — 3	If continuation steels 41 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IRC Care Administration FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
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ELIZABETH DUDEK SECRETARY

, 2016

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

RE: Recertification & Relicensure Surveys

Dear Administrator:

On 2016 through 2016, Recertification and Relicensure surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit. You will not receive a copy of this letter and attachments in the mail; you will not receive this faxed report.

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

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



Facebook.com/ACHAFlorida .com/AHCAFlorida Twitter.com/AHCA_FL SlideShare.net/AHCAFlorida Page 2

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 ______, 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 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 § , 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)

or
Phone number: (850)
IDRCoordinator@ahca.myflorida.com

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

Rehabilitation Center At Hollywood Hills, Llc

Page 3

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://lahca.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.

Sincerely.

Arlene Mayo-Davis
Field Office Manager

AMD Enclosure

R6WB