

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments During the Recertification survey conducted on February 26, 2025 at Alliance Health and Rehabilitation Center, a nursing home, the Emergency Preparedness Plan was reviewed. Alliance Health and Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
K 000	INITIAL COMMENTS An unannounced Fire and Life Safety Recertification survey was conducted on February 26, 2025 at Alliance Health and Rehabilitation Center, 130 West Armstrong Avenue, a nursing home in Deland, Florida 32720. The facility is not in compliance with 42 CFR 483.90 (a), and National Fire Protection Association (NFPA) 101 (2012 edition) and NFPA 99 (2012 edition) requirements for nursing homes. Initial Plan Review: 1996 Addition: New or Existing: Existing NFPA 220 Construction Type: II (111) & V (111) Footage: 51,187 Fully Sprinkled Monitored Fire Alarm Generator: 400 kw	K 000		

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

TITLE

(X6) DATE

Electronically Signed

03/22/2025

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

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Number of beds: 120 Census: 108 The following is a description of the noncompliance:	K 000		
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to periodically test emergency lighting equipment and exit signs in accordance with NFPA 101 (2012). Failure to properly maintain emergency lighting devices can result in injury and/or loss of residents, staff, or other building occupants. The findings include: During record review with the Maintenance Director on 2/26/25 at 10:50 AM, the facility failed to provide written documentation in support of the maintenance of emergency lighting and exit signage. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for	K 291	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of Federal and State Laws code section 1280 and 42 CFR 483. 1. On 3/17/25, the 30 second and 1 1/2 hour functional test of the emergency lighting system and exit signage was completed by the Maintenance Director. 2. The Maintenance Director identified further concerns with the emergency lighting system and exit signage during the functional tests. On 3/20/25, the replacement parts were ordered and were installed on 4/1/25. Current facility	3/27/25

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 2 not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. During an interview with the Maintenance Director on 2/26/25 at 10:55 AM, he acknowledged that the emergency lighting and exit signage inspections were not conducted. He had no further comment. per: NFPA 101 (2012) 19.2.9.1., 7.9.3.1.1.(1-5) These findings were verified by the Maintenance Director at the times of record review and the Administrator at the exit conference on 2/26/25 at 4:30 PM.	K 291	residents have the potential to be affected by the deficient practice. 3. On 3/24/25, the facility Administrator/designee provided education for maintenance employees regarding NFPA 101 emergency light and exit sign testing requirements. 4. On 3/25/25, an alert was added to the facility TELS system to remind maintenance staff of the required 30-day interval and annual testing of emergency and exit sign lighting. Maintenance Director/designee to complete the 30 second required functional testing of the emergency lighting system and exit signage every 30 days for 3 months, or until substantial compliance is achieved. The Findings to be reviewed during the monthly QAPI Committee Meeting. Modifications implemented if indicated.	
K 324	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		3/27/25

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____		(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 324	<p>Continued From page 3</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain the kitchen hood fire suppression system as required by NFPA 17A (2009).</p> <p>The findings include:</p> <p>During record review with the Maintenance Director on 2/26/25 at 10:00 AM, the facility produced documentation dated 1/2/25 that revealed the suppression wet chemical tanks were overdue for hydrostatic testing. The last hydrostatic test was in 2011. Wet chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years.</p> <p>During an interview with the Maintenance Director on 2/26/25 at 10:05 AM, he acknowledged that the wet chemical tanks were overdue for hydrostatic testing and stated, "I was not aware</p>	K 324	<ol style="list-style-type: none"> 1. Kitchen/hood fire suppression system hydrostatic testing was completed on 3/10/2025. 2. Current facility residents have the potential to be affected by this deficient practice. No further follow up indicated for the kitchen/hood fire suppression system indicated based on test results. 3. On 3/24/25, the facility Administrator/designee provided education for maintenance employees regarding NFPA 101 kitchen/hood fire suppression system testing/maintenance. 4. On 3/25/25, an alert was added to the facility TELS system to remind maintenance staff of the next required test. Maintenance Director/designee to complete fire suppression system testing/maintenance as required. Findings to be reviewed during the monthly QAPI Committee Meeting. Modifications 		

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 4 that the chemical tanks were overdue." per: NFPA 101 (2012 Edition) 19.7.6., 4.6.12. per: NFPA 17A (2009 Edition) 7.5.1. These findings were verified by the Maintenance Director at the times of record review and the Administrator at the exit conference on 2/26/25 at 4:30 PM.	K 324	implemented if indicated.	
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain and test the fire alarm system in accordance with NFPA 101 (2012 edition). The findings include: During record review with the Maintenance Director on 2/26/25 at 9:40 AM, the facility failed	K 345	1. On 3/3/25, an approved vendor was contacted to complete the duct detector differential pressure testing. This testing was completed on 3/25/25. 2. Current facility residents have the potential to be affected by this deficient practice. No other fire alarm system inspection concerns identified. 3. On 3/24/25, the facility	3/27/25

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 5 to produce current documentation for the duct detectors' differential pressure testing. During an interview with the Maintenance Director on 2/26/25 at 9:45 AM, he acknowledged that the fire alarm system inspection could not be produced and stated he would call the vendor to complete the inspection. per: NFPA 101 (2012 Edition) 19.3.4.1, 9.6.1. per: NFPA 72 (2010 Edition) Table 14.4.2.2.(14)(g)(6) These findings were verified by the Maintenance Director at the times of record review and the Administrator at the exit conference on 2/26/25 at 4:30 PM.	K 345	Administrator/designee provided education for maintenance employees regarding NFPA 101 fire alarm system inspection, specifically duct differential pressure testing/maintenance. 4. on 3/25/25, an alert was been added to the facility TELS system to remind maintenance staff of the next required test. Maintenance Director/designee to complete fire alarm system specifically duct differential pressure testing/maintenance as required. Findings to be reviewed during the monthly QAPI Committee Meeting. Modifications implemented if indicated.	
K 761	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		3/27/25

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

PRINTED: 04/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105349	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 06 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER ALLIANCE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 W ARMSTRONG AVENUE DELAND, FL 32720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	<p>Continued From page 6</p> <p>19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain cross corridor fire doors in accordance with NFPA 80 (2010).</p> <p>The findings include:</p> <p>During the facility tour with the Maintenance Director on 2/26/25 from 1:00 AM to 4:30 PM in the 500 Hall, it was found that the cross corridor fire doors would not latch at floor level, because the floor latching device (keeper) was not installed.</p> <p>per: NFPA 101 (2012 Edition) 19.7.6., 4.6.12. per: NFPA 80 (2010 Edition) 5.2.3.5.2.(5)(9), 7.4.3.2.</p> <p>During an interview with the Maintenance Director on 2/26/25 at 3:25 PM, he acknowledged that the floor latching device (keeper) was not installed and stated his corporate staff said it was not needed.</p> <p>These findings were verified by the Maintenance Director at the times of observation and the Administrator at the exit conference on 2/26/25 at 4:30 PM.</p>	K 761	<p>1. On 3/24/25, a floor latching device was ordered and will be installed upon delivery. The device is anticipated to be delivered and installed by 4/7/25.</p> <p>2. On 3/25/25, the Maintenance Director observed other facility cross corridor doors to verify that latching devices are in place and functional, and all were found to be in good repair. Current facility residents have the potential to be affected by this deficient practice. Follow up based on findings.</p> <p>3. On 3/24/25, the Facility Administrator/designee provided education for maintenance employees regarding NFPA 80 cross corridor fire door maintenance and required latching devices.</p> <p>4. Maintenance Director/designee to monitor cross corridor fire doors to ensure latching devices are in place and functional monthly for 3 months. Findings to be reviewed during the monthly QAPI Committee Meeting. Modifications implemented if indicated</p>	