Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95030	A. BUILDING: **04 - MAIN LIC** B. WING _____	**05/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PALM BEACH HEALTH AND REHABILITATION	**600 BUSINESS PARK WAY** **ROYAL PALM BEACH, FL 33411**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 05/27/2025 at Royal Palm Beach Health and Rehabilitation Center, a nursing home in Royal Palm Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C.) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K 000		
K 222 SS=D	NFPA 101 Egress Doors Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 18/19.2.2.2.5 shall be permitted. (2) Delayed-egress electrical locking systems complying with 7.2.1.6.1 shall be permitted. (3) Sensor-release of electrical locking systems complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.4 shall be permitted. (5) Approved existing door-locking installations shall be permitted. 18.2.2.2.4 through 18.2.2.2.7, 19.2.2.2.4 through 19.2.2.2.7	K 222		6/25/25

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K 222	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain egress doors equipped with delayed egress locking arrangements in accordance with NFPA 101, for 2 of 7 sampled delayed egress exits. The findings included: On 05/27/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 11:00 AM, the Southeast Corridor exit, equipped with a delayed egress locking arrangement, did not operate when tested. 2. At 1:04 PM, the Northeast corridor exit, near Central Supply, equipped with a delayed egress locking arrangement, required greater than fifteen pounds of force to open the door. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 101 (2021 Edition) 4.6.12.1, 7.1.9, 7.1.10.1, 7.2.1.5.3.2, 7.2.1.6.1.1(3)(a-d), 7.2.1.6.1.1(4), 19.1.1.1.3, 19.2.1, 19.2.2.2.4(2), 19.7.3.1 Class III	K 222	Corrective Actions A. The SE corridor exits delayed egress locking arrangement was repaired on 5/28/2025. B. The NE corridor exits delayed egress locking arrangement was adjusted on 5/28/2025 so that it required less than 15 lbs. of force to open the door. Identification of Others Potentially Affected The Maintenance Director, or designee, evaluated all other egress doors with a delayed egress locking arrangement to ensure proper functionality and operating force. Systemic Changes On an ongoing basis as part of the facilitys life safety program, the Maintenance Director, or designee, will perform monthly testing of all facility egress doors with a delayed egress locking arrangement to ensure proper functionality. Quality Assurance The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly testing will be reviewed at the monthly QAPI meetings X 3 months. If substantial compliance is not met after 3 months,	

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K 222	Continued From page 2	K 222	results of the ongoing monthly inspections will be brought to QAPI meetings until substantial compliance is met.	
K 355 SS=F	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, 9.9, and NFPA 10 This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to install and maintain portable fire extinguishers in accordance with NFPA 101, for 12 of 18 sampled fire extinguishers. The findings included: On 05/27/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 10:30 AM, the Kitchen had two ABC fire extinguishers in cabinets that were greater than sixty inches to the top of the handle. Both extinguishers were sixty-three inches to the top of the handles. 2. At 10:44 AM, the East Corridor, near the Staff Development Office, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-three inches to the top of the handle. 3. At 10:55 AM, the East Corridor, near the	K 355	Corrective Actions On 6/9/2025 the following locations fire extinguishers were replaced with a shorter extinguisher so that the top of the new extinguisher is less than 60 inches from the floor: A. Kitchen. Two extinguishers. B. East Corridor. Near the Staff Development Office. C. East Corridor. Near the kitchen entrance. D. SE Corridor. Near room 100. E. South Corridor. Near room 100. F. SW Corridor. Near the Nurses Station. G. West Corridor. Near room 126. H. West Corridor. Near the Maintenance Office. I. Rehabilitation Suite. J. North Corridor. Near the exit. K. North Corridor. Near room 213. L. North Corridor. Near room 200.	6/25/25

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K 355	Continued From page 3 Kitchen entrance, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two inches to the top of the handle. 4. At 11:09 AM, the Southeast Corridor, near Room 100, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-three inches to the top of the handle. 5. At 11:12 AM, the South Corridor, near Room 100, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-three inches to the top of the handle. 6. At 11:25 AM, the Southwest Corridor, near the nurses' station, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-one and a half inches to the top of the handle. 7. At 11:31 AM, the West Corridor, near Room 126, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two inches to the top of the handle. 8. At 11:55 AM, the West Corridor, near the Maintenance Office, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two and a half inches to the top of the handle. 9. At 11:57 AM, the Rehabilitation Suite had a fire extinguisher in a cabinet that was greater than	K 355	Identification of Others Potentially Affected All fire extinguishers in cabinets were accounted for so no further evaluation was needed. Systemic Changes The Maintenance Director, or designee, will perform documented monthly inspections X 3 months of the facility fire extinguishers placed in cabinets to ensure the top of the extinguisher is less than 60 from the floor. Quality Assurance Results of the monthly inspections will be presented at the monthly QA meetings X 3 months. If substantial compliance is not met after 3 months, results of the ongoing monthly inspections will be brought to QA meetings until substantial compliance is met.	

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K 355	Continued From page 4 sixty inches to the top of the handle from the finished floor. The extinguisher was sixty and a half inches to the top of the handle. 10. At 12:20 PM, the North Corridor, near the exit, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty and a half inches to the top of the handle. A trash can was placed in front of the fire extinguisher which initially obstructed the cabinet door from opening until it was moved. 11. At 12:52 PM, the North Corridor, near Room 213, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-one inches to the top of the handle. 12. At 12:57 PM, the North Corridor, near Room 200, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two inches to the top of the handle. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 10 (2018 Edition) 6.1.3.8.1 NFPA 99 (2021 Edition) 16.10.1 NFPA 101 (2021 Edition) 9.9, 19.3.5.12 Class III	K 355		

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K 741	Continued From page 5	K 741		
K 741 SS=F	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18/19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 (Note smoking tower disposal receptacles are not ashtrays) This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the smoking areas in accordance with NFPA 101, for 2 of 2 smoking areas. The findings included:	K 741	Immediate Corrective Action 1. The Courtyard was cleaned of cigarette butts on the ground on 5/28/2025. 2. The designated smoking area near	6/25/25

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K 741	Continued From page 6 On 05/27/2025, at the following times, during the fire safety tour of the facility with the Administrator and the Maintenance Director, the following was observed: 1. At 11:50 AM, the Courtyard had more than eighty cigarette butts littered throughout the area. There were nine cigarette butts in the screened in porch area. An interview was conducted with the Administrator who stated that the Courtyard is a smoking area when it is raining. There were no ashtrays, metal can with a self-closing lid, or a fire extinguisher in the area. 2. At 12:07 PM, the Designated Smoking Area, near Rehabilitation, had more than one hundred cigarette butts littered throughout the area. An interview was conducted with the Administrator and the Maintenance Director concurrently with the observations and they acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 101 (2021 Edition) 19.7.4 (5-6) Photographic Evidence Obtained. Class III	K 741	rehabilitation was cleaned of cigarette butts on the ground on 5/28/2025. Method to Assess Others The Maintenance Director, or designee, performed documented inspections of the facilitys other smoking areas to ensure there were no cigarette butts on the ground. Systematic Process The Maintenance Director, or designee, will perform weekly inspections X 8 weeks of all smokers areas of the facility to ensure there are no cigarette butts on the ground. Quality Assurance The Administrator, or designee, is responsible for the oversight of this program. Documentation of the smokers areas inspections will be brought to the monthly QAPI meeting for review X 2 months. If substantial compliance is not met after 2 months, weekly inspections will continue and be brought to the monthly QAPI meeting until substantial compliance is met.	
K 923 SS=F	NFPA 99 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		6/25/25

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K 923	Continued From page 7 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3, 11.3.5 through 11.3.12.5, 11.6.5 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to properly store medical gas cylinders in accordance with NFPA 99, for 1 of 1 oxygen storage areas.	K 923	Immediate Corrective Action The six flammable liquid cans were removed from the outdoor oxygen storage area on 5/27/2025, during the survey.	

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K 923	Continued From page 8 The findings included: On 05/27/2025, at 12:15 PM, during the fire safety tour of the facility with the Maintenance Director, it was observed that the Outdoor Oxygen Storage area, detached from the building by approximately twenty-five feet, had six flammable liquid cans stored next to the full oxygen cylinders. There were twenty-three oxygen E-cylinders and one H-cylinder that were full. Two of the six flammable liquid cans had a mixture of gasoline and oil inside of them, and the other four were empty. The cans were each capable of holding one hundred and ten fluid ounces. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 99 (2021 Edition) 11.3.6.3, 11.6.2.1(1) NFPA 101 (2021 Edition) 2.1, 8.7, 19.3.2.4 Photographic Evidence Obtained. Class III	K 923	Method to Assess Others The facility only has one oxygen storage area so no further evaluation was needed. Systematic Process The Maintenance Director, or designee, will perform weekly inspections X 8 weeks of the outside oxygen storage area to ensure there are no flammable liquids stored in the area. Quality Assurance The Administrator, or designee, is responsible for the oversight of this program. Documentation of the outdoor oxygen storage area inspections will be brought to the monthly QAPI meeting for review X 2 months. If substantial compliance is not met after 2 months, weekly inspections will continue and be brought to the monthly QAPI meeting until substantial compliance is met.	

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CZ830 SS=F	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		6/25/25

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain their written, comprehensive emergency management plan (CEMP) in accordance with Florida Administrative Code (FAC). The findings included: On 05/27/2025, at 3:15 PM, during record review with the Administrator, it was revealed that the facility failed to produce a current approved written CEMP for emergency care during an internal or external disaster or emergency, which is required to be reviewed and updated annually. The last CEMP approval was 03/07/2023. The CEMP was supposed to be submitted by 10/01/2023 and expired on 11/30/2023. The first submission was on 03/21/2024 and was rejected on 04/30/2024. The first resubmission was on 08/09/2024 and was rejected on 09/17/2024. The second resubmission was on 04/21/2025 and is still pending. An interview was conducted with the Administrator concurrently with the record review and she acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. FAC 59A-4.126 (3), (4) Class III	CZ830	Immediate Corrective Action The Administrator reached out to the Palm Beach County Division of Emergency Management on 4/30/2025 for an update and was given a timeframe of 60 days until the CEMP would be reviewed and then approved. Method to Assess Others No other disaster preparedness documentation was identified for submission to the Palm Beach County Division of Emergency Management. Systematic Process The Administrator, or designee, will continue to ensure the facilitys CEMP is submitted to the Palm Beach County Division of Emergency Management within 60 days of the previous years approval date. Quality Assurance The Administrator is responsible for the oversight of this process. QAPI will be notified when the CEMP is submitted for annual approval until substantial compliance is made.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95030	A. BUILDING: **04 - MAIN LIC** B. WING _____	**05/27/2025**

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	105494	A. BUILDING **01 - MAIN FED** B. WING _____	**05/27/2025**

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ROYAL PALM BEACH HEALTH AND REHABILITATION CENTER	**600 BUSINESS PARK WAY** **ROYAL PALM BEACH, FL 33411**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety Recertification survey was conducted on 05/27/2025 at Royal Palm Beach Health and Rehabilitation Center, a nursing home in Royal Palm Beach, Florida. Royal Palm Beach Health and Rehabilitation Center is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1984 Existing NFPA 220 Construction Type: II (111) Number of beds: 120 Census: 98 The following is a description of the noncompliance.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available	K 222		6/25/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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.

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K 222	Continued From page 1 to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout	K 222		

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K 222	Continued From page 2 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain egress doors equipped with delayed egress locking arrangements in accordance with NFPA 101, for 2 of 7 sampled delayed egress exits. The findings included: On 05/27/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 11:00 AM, the Southeast Corridor exit, equipped with a delayed egress locking arrangement, did not operate when tested. 2. At 1:04 PM, the Northeast corridor exit, near Central Supply, equipped with a delayed egress locking arrangement, required greater than fifteen pounds of force to open the door. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 101 (2012 Edition) 4.6.12.1, 7.1.9, 7.1.10.1, 7.2.1.5.3.2, 7.2.1.6.1.1(3)(a-d), 7.2.1.6.1.1(4), 19.1.1.1.3, 19.2.1, 19.2.2.2.4(2), 19.7.3.1	K 222	The statements made on this plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. To remain compliant with all federal and state regulations, the facility has taken actions set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such as the deficiencies cited have been corrected by the date certain. Corrective Actions A. The SE corridor exits delayed egress locking arrangement was repaired on 5/28/2025. B. The NE corridor exits delayed egress locking arrangement was adjusted on 5/28/2025 so that it required less than 15 lbs. of force to open the door. Identification of Others Potentially Affected The Maintenance Director, or designee, evaluated all other egress doors with a delayed egress locking arrangement to ensure proper functionality and operating force. Systemic Changes	

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K 222	Continued From page 3	K 222	On an ongoing basis as part of the facility's life safety program, the Maintenance Director, or designee, will perform monthly testing of all facility egress doors with a delayed egress locking arrangement to ensure proper functionality. Quality Assurance The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly testing will be reviewed at the monthly QAPI meetings X 3 months. If substantial compliance is not met after 3 months, results of the ongoing monthly inspections will be brought to QAPI meetings until substantial compliance is met.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to install and maintain portable fire extinguishers in accordance with NFPA 101, for 12 of 18 sampled fire extinguishers. The findings included:	K 355	Corrective Actions On 6/9/2025 the following locations fire extinguishers were replaced with a shorter extinguisher so that the top of the new extinguisher is less than 60 inches from the floor:	6/25/25

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K 355	Continued From page 4 On 05/27/2025, at the following times, during the fire safety tour of the facility with the Maintenance Director, the following was observed: 1. At 10:30 AM, the Kitchen had two ABC fire extinguishers in cabinets that were greater than sixty inches to the top of the handle. Both extinguishers were sixty-three inches to the top of the handles. 2. At 10:44 AM, the East Corridor, near the Staff Development Office, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-three inches to the top of the handle. 3. At 10:55 AM, the East Corridor, near the Kitchen entrance, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two inches to the top of the handle. 4. At 11:09 AM, the Southeast Corridor, near Room 100, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-three inches to the top of the handle. 5. At 11:12 AM, the South Corridor, near Room 100, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-three inches to the top of the handle. 6. At 11:25 AM, the Southwest Corridor, near the nurses' station, had a fire extinguisher in a cabinet that was greater than sixty inches to the	K 355	A. Kitchen. Two extinguishers. B. East Corridor. Near the Staff Development Office. C. East Corridor. Near the kitchen entrance. D. SE Corridor. Near room 100. E. South Corridor. Near room 100. F. SW Corridor. Near the Nurses Station. G. West Corridor. Near room 126. H. West Corridor. Near the Maintenance Office. I. Rehabilitation Suite. J. North Corridor. Near the exit. K. North Corridor. Near room 213. L. North Corridor. Near room 200. Identification of Others Potentially Affected All fire extinguishers in cabinets were accounted for so no further evaluation was needed. Systemic Changes The Maintenance Director, or designee, will perform documented monthly inspections X 3 months of the facility fire extinguishers placed in cabinets to ensure the top of the extinguisher is less than 60 from the floor. Quality Assurance Results of the monthly inspections will be presented at the monthly QA meetings X 3 months. If substantial compliance is not	

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K 355	Continued From page 5 top of the handle from the finished floor. The extinguisher was sixty-one and a half inches to the top of the handle. 7. At 11:31 AM, the West Corridor, near Room 126, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two inches to the top of the handle. 8. At 11:55 AM, the West Corridor, near the Maintenance Office, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two and a half inches to the top of the handle. 9. At 11:57 AM, the Rehabilitation Suite had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty and a half inches to the top of the handle. 10. At 12:20 PM, the North Corridor, near the exit, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty and a half inches to the top of the handle. A trash can was placed in front of the fire extinguisher which initially obstructed the cabinet door from opening until it was moved. 11. At 12:52 PM, the North Corridor, near Room 213, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-one inches to the top of the handle. 12. At 12:57 PM, the North Corridor, near Room	K 355	met after 3 months, results of the ongoing monthly inspections will be brought to QA meetings until substantial compliance is met.	

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K 355	Continued From page 6 200, had a fire extinguisher in a cabinet that was greater than sixty inches to the top of the handle from the finished floor. The extinguisher was sixty-two inches to the top of the handle. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 10 (2010 Edition) 6.1.3.8.1 NFPA 99 (2012 Edition) 16.10.1 NFPA 101 (2012 Edition) 9.9, 19.3.5.12	K 355		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe	K 741		6/25/25

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K 741	Continued From page 7 design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the smoking areas in accordance with NFPA 101, for 2 of 2 smoking areas. The findings included: On 05/27/2025, at the following times, during the fire safety tour of the facility with the Administrator and the Maintenance Director, the following was observed: 1. At 11:50 AM, the Courtyard had more than eighty cigarette butts littered throughout the area. There were nine cigarette butts in the screened in porch area. An interview was conducted with the Administrator who stated that the Courtyard is a smoking area when it is raining. There were no ashtrays, metal can with a self-closing lid, or a fire extinguisher in the area. 2. At 12:07 PM, the Designated Smoking Area, near Rehabilitation, had more than one hundred cigarette butts littered throughout the area. An interview was conducted with the Administrator and the Maintenance Director concurrently with the observations and they acknowledged the findings. The findings were	K 741	Immediate Corrective Action 1. The Courtyard was cleaned of cigarette butts on the ground on 5/28/2025. 2. The designated smoking area near rehabilitation was cleaned of cigarette butts on the ground on 5/28/2025. Method to Assess Others The Maintenance Director, or designee, performed documented inspections of the facilitys other smoking areas to ensure there were no cigarette butts on the ground. Systematic Process The Maintenance Director, or designee, will perform weekly inspections X 8 weeks of all smokers areas of the facility to ensure there are no cigarette butts on the ground. Quality Assurance	

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K 741	Continued From page 8 reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 101 (2012 Edition) 19.7.4 (5-6) Photographic Evidence Obtained.	K 741	The Administrator, or designee, is responsible for the oversight of this program. Documentation of the smokers areas inspections will be brought to the monthly QAPI meeting for review X 2 months. If substantial compliance is not met after 2 months, weekly inspections will continue and be brought to the monthly QAPI meeting until substantial compliance is met.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a	K 923		6/25/25

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K 923	Continued From page 9 minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to properly store medical gas cylinders in accordance with NFPA 99, for 1 of 1 oxygen storage areas. The findings included: On 05/27/2025, at 12:15 PM, during the fire safety tour of the facility with the Maintenance Director, it was observed that the Outdoor Oxygen Storage area, detached from the building by approximately twenty-five feet, had six flammable liquid cans stored next to the full oxygen cylinders. There were twenty-three oxygen E-cylinders and one H-cylinder that were full. Two of the six flammable liquid cans had a mixture of gasoline and oil inside of them, and the other four were empty. The cans were each capable of holding one hundred and ten fluid ounces. An interview was conducted with the Maintenance Director concurrent with the observations and he acknowledged the findings. The findings were reviewed with the Administrator, the Regional Maintenance Director, and the Maintenance	K 923	Immediate Corrective Action The six flammable liquid cans were removed from the outdoor oxygen storage area on 5/27/2025, during the survey. Method to Assess Others The facility only has one oxygen storage area so no further evaluation was needed. Systematic Process The Maintenance Director, or designee, will perform weekly inspections X 8 weeks of the outside oxygen storage area to ensure there are no flammable liquids stored in the area. Quality Assurance The Administrator, or designee, is responsible for the oversight of this program. Documentation of the outdoor oxygen storage area inspections will be brought to the monthly QAPI meeting for	

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	105494	A. BUILDING **01 - MAIN FED** B. WING _____	**05/27/2025**

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ROYAL PALM BEACH HEALTH AND REHABILITATION CENTER	**600 BUSINESS PARK WAY** **ROYAL PALM BEACH, FL 33411**

(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 923	Continued From page 10 Director at the exit conference on 05/27/2025 at 5:30 PM. NFPA 99 (2012 Edition) 11.3.2.3, 11.6.2.1(1) NFPA 101 (2012 Edition) 2.1, 8.7, 19.3.2.4 Photographic Evidence Obtained.	K 923	review X 2 months. If substantial compliance is not met after 2 months, weekly inspections will continue and be brought to the monthly QAPI meeting until substantial compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105494	A. BUILDING _____ B. WING _____	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PALM BEACH HEALTH AND REHABILITATION CENTER	600 BUSINESS PARK WAY ROYAL PALM BEACH, FL 33411

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E 000	Initial Comments During the Fire & Life Safety Recertification survey, conducted on 05/27/2025 at Royal Palm Beach Health and Rehabilitation Center, a nursing home, Emergency Preparedness was reviewed. Royal Palm Beach Health and Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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.